Office of Billing Compliance 2015 Coding, Billing and Documentation Program

Department of Medicine
Hospital Division

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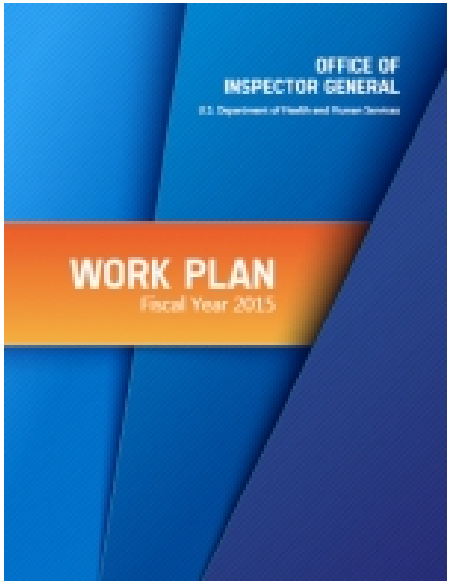
Documentation in the EHR - EMR

Volume of Documentation vs Medical Necessity

Annually OIG publishes it "targets" for the upcoming year. Included is EHR Focus and for practitioners could include:



Pre-populated Templates and Cutting/Pasting Documentation containing inaccurate or incomplete or not provided information in the medical record

- **REMEMBER:** More volume is not always better in the medical record, especially in the EMR with potential for cutting/pasting, copy forward, pre-defined templates and pre-defined E/M fields. Ensure the billed code is reflective of the actual service provided on the DOS only.

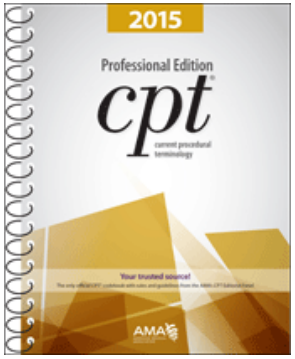
General Principles of Documentation

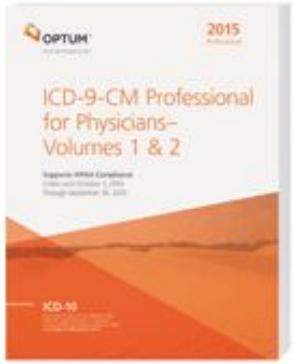
- All documentation must be legible to all readers. Illegible documents are considered not medically necessary if it is useless to provide a continuum of care to a patient by all providers. Documentation is for the all individuals not just the author of the note.
- Per the Centers for Medicare and Medicaid services (CMS) practitioners are expected to complete the documentation of services "during or as soon as practicable after it is provided in order to maintain an accurate medical record."
  - CMS does not provide any specific period, but a reasonable expectation would be no more than a couple of days away from the date of service.
  - Until the practitioner completes the documentation for a service, including signature, the practitioner cannot submit the service to Medicare. Medicare states if the service was not documented, then it was not done, and this includes a signature.
- An addendum to a note should be dated and timed the day the information is added to the medical record and only contain information the practitioner has direct knowledge is true and accurate.

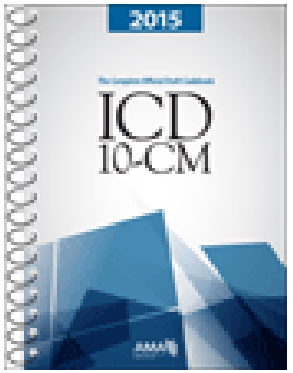
Inpatient, Outpatient and Consultations

Evaluation and Management E/M

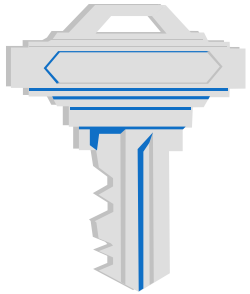
Documentation and Coding







E/M Key Components



- **History (H)** - Subjective information
- **Examination (E)** - Objective information
- **Medical Decision Making (MDM)** – The assessment, plan and patient risk

The billable service is determined by the combination of these 3 key components.

- All 3 Key Components are required to be documented for all E/M services.
- For coding the E/M level
  - Initial IP require all 3 components to be **met or exceeded** and
  - Subsequent IP require 2 of 3 key components to be **met or exceeded and one must be MDM**.

When downcoded for "medical necessity" on audit,
it is often determined that documented H and E exceeded what was deemed "necessary" for the visit (MDM.)

Elements of an E/M History

The extent of information gathered for history is dependent upon clinical judgment and nature of the presenting problem.

Documentation of the patient's history includes some or all of the following elements:

- Chief Complaint (**CC**) and History of Present Illness (**HPI**) are required to be documented for every patient for every visit

WHY IS THE PATIENT BEING SEEN TODAY

- Review of Systems (**ROS**)

- Past Family, Social History (**PFSH**)

History of Present Illness (HPI)
A KEY to Support Medical Necessity to in addition to MDM

- HPI is chronological description of the development of the patient's **present illness or reason for the encounter** from the first sign and/or symptom or from the previous encounter to the present.
  - The HPI must be performed and documented by the billing provider in order to be counted towards the level of service billed.

Focus upon present illness or reason for the visit!

- HPI drivers:
  - **Extent of PFSH, ROS and physical exam performed**

HPI

- Status of chronic conditions being managed at visit
  - Just listing the chronic conditions is a medical history
    - Their status must be addressed for HPI coding

OR

- Documentation of the HPI applicable elements relative to the diagnosis or signs/symptoms being managed at visit
  - Location
  - Quality
  - Severity
  - Duration
  - Timing
  - Context
  - Modifying factors
  - Associated signs and symptoms

Review of Systems (ROS)

- Constitutional
- Eyes
- Respiratory
- Ears, nose, mouth, throat
- Cardiovascular
- Musculoskeletal
- Gastrointestinal
- Genitourinary
- Psychiatric
- Integumentary
- Neurologic
- Allergy/Immunology
- Endocrine
- Hematologic/Lymphatic

ROS is an inventory of specific body systems in the process of taking a history from the patient. The ROS is designed to bring out clinical symptoms which the patient may have overlooked or forgotten. In theory, the ROS may illuminate the diagnosis by eliciting information which the patient may not perceive as being important enough to mention to the physician relative to the reason for the visit.

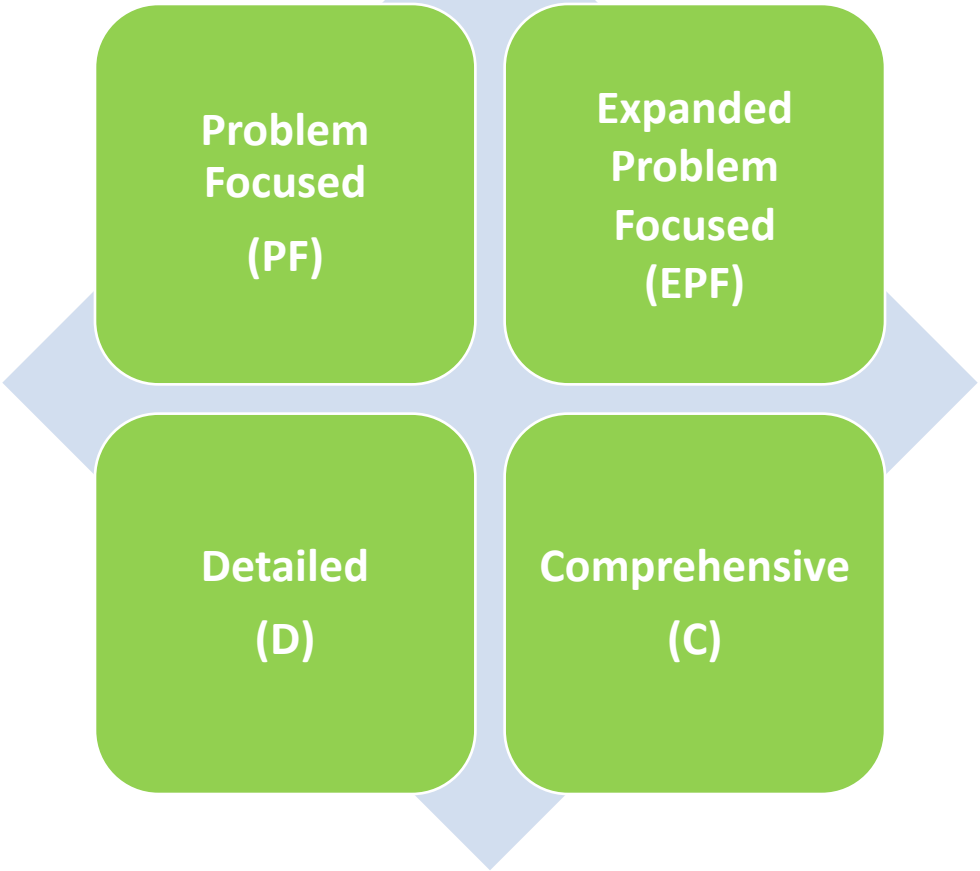
Past, Family, and/or Social History (PFSH)

- **Past history:** The patient's past medical experience with illnesses, surgeries, & treatments. May also include review of current medications, allergies, age appropriate immunization status
- **Family history:** May include a review of medical events in the patient's family, such as hereditary diseases, that may place a patient at risk or Specific diseases related to problems identified in the Chief Compliant, HPI, or ROS
- **Social history:** May include age appropriate review of past and current activities, marital status and/or living arrangements, use of drugs, alcohol or tobacco and education.

Record Past/Family/Social History (PFSH) appropriately considering the clinical circumstance of the encounter. Extensive PFSH is unnecessary for lower-level services. **Don't use the term "non-contributory" for coding a level of E/M**

Examination

4 TYPES OF EXAMS



Coding 1995: Physical Exam

BODY AREAS (BA):

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

CODING ORGAN SYSTEMS (OS):

- Constitutional/General
- Eyes
- Ears/Nose/Mouth/Throat
- Respiratory
- Cardiac
- GI
- GU
- Musculoskeletal
- Skin
- Neuro
- Psychiatric
- Hematologic/Lymphatic

1997 Sub-Specialty Physical Exam

- Cardiovascular
- Musculoskeletal
- Ears, Nose, Mouth and Throat
- Neurological
- Eyes
- Skin
- Psychiatric
- Genitourinary (Female) (Male)
- Respiratory
- Hematologic / Lymphatic / Immunologic
- General Multi-system Exam

1995 and 1997 Exam Definitions

Problem Focused (PF): 99231, 99212 or 99201

- '95: Limited exam of the affected body area or organ system. (1 BA/OS)
- '97=Specialty and GMS: 1-5 elements identified by bullet.

Expanded Problem Focused (EPF): 99232, 99213 or 99202

- '95: Limited exam of affected BA/OS and other symptomatic/related OS. (2-7 BA/OS)
- '97=Specialty and GMS: At least 6 elements identified by bullet.

Detailed (D): 99233, 99221, 99214 or 99203

- '95: Extended exam of affected BA/OS and other symptomatic/related OS.(2-7 BA/OS)
- 97=Specialty: At least 12 elements identified by bullet (9 for eye and psyc)

Comprehensive (C): 99222, 99223, 99215 or 99204 and 99205

- '95: General multi-system exam (8 or more organ systems) or complete single organ system (a complete single organ system is undefined by CMS).
- '97=Specialty: All elements with bullet in shaded areas and at least 1 in non-shaded area.

Medical Decision Making (MDM)

DOCUMENT EVERYTHING THAT EFFECTS YOUR SERVICE TODAY!!

Exchange of clinically reasonable and necessary information and the use of this information in the clinical management of the patient

Step 1:

- **Number of possible diagnosis and/or management options affecting todays visit. List each separate in A/P and address every diagnosis or management option from visit. Is the diagnosis and/or management options :**
  - "New" self-limiting: After the course of prescribed treatment is it anticipated that the diagnosis will no longer be exist (e.g. otitis, poison ivy, …)
  - New diagnosis with follow-up or no follow-up (diagnosis will remain next visit)
  - Established diagnosis that stable, worse, new,

Step 2:

- **Amount and/or complexity of data reviewed, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed.**
  - Labs, radiology, scans, EKGs etc. reviewed or ordered
  - Review and summarization of old medical records or request old records
  - Independent visualization of image, tracing or specimen itself (not simply review of report)

Step 3:

- **The risk of significant complications, morbidity, and/or mortality with the patient's problem(s), diagnostic procedure(s), and/or possible management options.**
  - # of chronic conditions and are the stable or exacerbated (mild or severe)
  - Rx's ordered or renewed. Any Rx toxic with frequent monitoring?
  - Procedures ordered and patient risk for procedure

Note: The 2 most complex elements out of 3 will determine the overall level of MDM

	Presenting Problem	Diagnostic Procedure(s) Ordered	Management Options Selected
Min Risk E-2, New –1 or 2, IP -1	• One self-limited / minor problem	• Labs requiring venipuncture • CXR EKG/ECG UA	• Rest Elastic bandages Gargles Superficial dressings
Low Risk E-3, NEW-3 IP - I	• 2 or more self-limited/minor problems • 1 stable chronic illness (controlled HTN) • Acute uncomplicated illness / injury (simple sprain)	• Physiologic tests not under stress (PFT) • Non-CV imaging studies (barium enema) • Superficial needle biopsies • Labs requiring arterial puncture • Skin biopsies	• OTC meds • Minor surgery w/no identified risk factors • PT, OT • IV fluids w/out additives
Mod Risk E-4, NEW-4 IP-2	• 1 > chronic illness, mod. Exacerbation, progression or side effects of treatment • 2 or more chronic illnesses • Undiagnosed new problem w/uncertain prognosis • Acute illness w/systemic symptoms (colitis) • Acute complicated injury	• Physiologic tests under stress (stress test) • Diagnostic endoscopies w/out risk factors • Deep incisional biopsies • CV imaging w/contrast, no risk factors (arteriogram, cardiac cath) • Obtain fluid from body cavity (lumbar puncture)	• Prescription meds • Minor surgery w/identified risk factors • Elective major surgery w/out risk factors • Therapeutic nuclear medicine • IV fluids w/additives • Closed treatment, FX / dislocation w/out manipulation
High Risk E-5. NEW-5 IP –3	• 1 > chronic illness, severe exacerbation, progression or side effects of treatment • Acute or chronic illnesses that may pose threat to life or bodily function (acute MI) • Abrupt change in neurologic status (TIA, seizure)	• CV imaging w/contrast, w/risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies w/risk factors	• Elective major surgery w/risk factors • Emergency surgery • Parenteral controlled substances • Drug therapy monitoring for toxicity • DNR

Initial Inpatient and Observation:

ALL Key Elements must be met or exceeded and be medically necessary

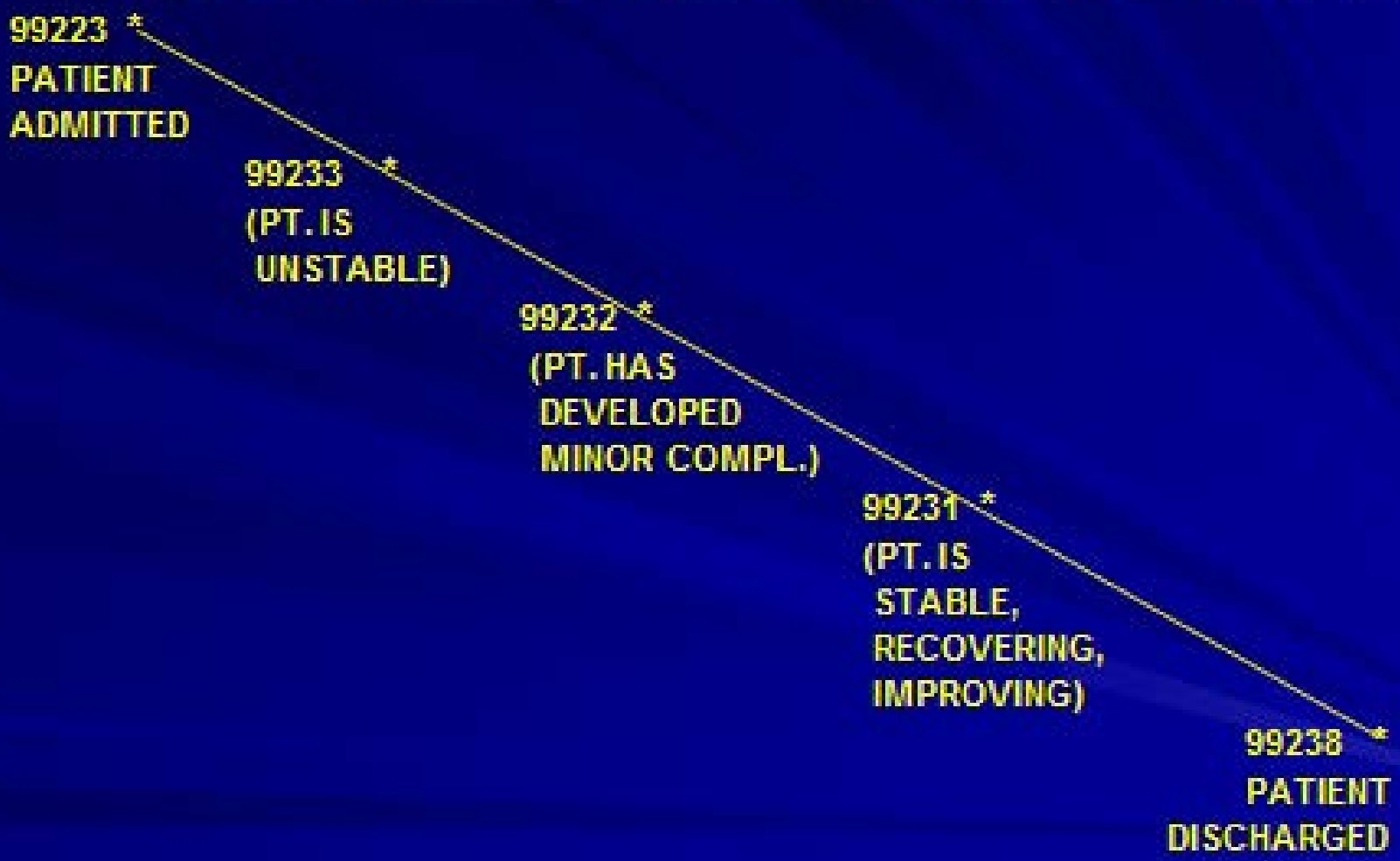
Key Elements H – E - MDM	99221 99218	99222 99219	99223 99220
CC	Always	Always	Always
History - HPI	4 +	4 +	4 +
History - ROS	2 – 9	10 +	10 +
History - PFSH	1 – 2	All	All
Exam	2 – 7 (DET)	8 + (COMP)	8 + (COMP)
MDM	SF/Low	Mod	High
Time	30 Min	50 Min	70 Min

Subsequent Inpatient or Observation Visit

2 of 3 Key Elements must be met or exceeded and be medically necessary

Key Elements H – E - MDM	99231 99224	99232 99225	99233 99226
CC	Always	Always	Always
History - HPI	1 – 3	1 – 3	4 +
History - ROS	None	1	2 – 9
History - Interval PFSH	None	None	None (Interval changes only)
Exam	1 (PF)	2 – 7 (EPF)	2 – 7 (DET)
MDM	SF/Low	Mod	High
Time	15 Min	25 Min	35 Min

USING DIFFERENT LEVELS OF CARE



Admission to Hospital - Two-Midnight Rule

- **If the physician expects a patient's stay to cross at least 2 midnights, and is receiving medically necessary hospital care, the stay is generally appropriate for inpatient admission.**

- Must have a clear inpatient order written and signed before discharge. Physician or practitioner must be:
- –Licensed by the state to admit patients to hospitals
- –Granted privileges by the facility to admit
- –Knowledgeable about the patients hospital course, medical care, and current condition at the time of admission
- Must have documentation to support certification
- Anticipated length of stay
- Discharge planning

Admission to Hospital - Two-Midnight Rule

Exceptions to the Rule

- Inpatient only procedures
- Newly initiated acute mechanical ventilation
- Not occurring, as would be anticipated, with a procedure
- Unforeseen Circumstances such circumstances must be documented:
  - –Death
  - –Transfer to another hospital
  - –AMA
  - –Unexpected clinical improvement
  - –Election of hospice care

Two-Midnight Rule vs Observation Care

If the stay is expected to be 0-1 midnights, the stay is generally inappropriate for an inpatient admission.

If the physician expects the patient to require less than two midnights of hospital care, or if it is uncertain at time of admission how long the patient will be expected to require hospital care, then the patient should be referred to "observation" regardless of the "level of care."

Without a reasonable expectation of a 2 midnight stay, inpatient admission is NOT dependent of "level of care".

•For example, the use of telemetry or an ICU bed alone does not justify inpatient admission.

Two-Midnight Rule vs Observation Care

An observation status patient may be admitted to an inpatient status at any time for medically necessary continued care, but the patient can never be retroactively changed from observation to inpatient (replacing the observation as if it never occurred).

Physician orders to "admit to inpatient" or "place patient in outpatient observation" should be clearly written. Be aware that an order for "admit to observation" can be confused with an inpatient admit. Likewise, an order for "admit to short stay" may be interpreted as admit to observation by some individuals and admit to inpatient by others.

Observation Care Services

Billing Guidelines

- **Procedure Codes: 99218, 99219, 99220, 99224-99226 and 99234-99236**
- Outpatient observation services require monitoring by a physician and other ancillary staff, which are reasonable and necessary **to evaluate the patient's condition. These services are only considered medically necessary when performed under a specific order of a physician**.
- **Outpatient observation services are not to be used for the convenience of the hospital, its physicians, patients, patients' families, or while waiting placement to another facility**.
- Outpatient observation services, **generally, do not exceed 24 hours**. Some patients may require a second day of observation **up to a maximum of 48 hours**.
- At 24 hours, the physician should evaluate patient's condition to decide if the patient needs to remain in observation for an additional 24 hours.

OBSERVATION CARE SERVICES

- Hospital observation services should be coded and billed according to the time spent in observation status as follows:

8 Hours or Less	> 8 Hours < 24 Hours	24 Hours or More
99218-99220 (Initial Observation Care)	99234-99236 (Observation or Inpatient Care)	99218-99220 (Initial Observation Care) 99224-99226 Subsequent Day different calendar day
Same Calendar Date • Admission paid o Discharge **not** paid separately	Same Calendar Date • Admission and Discharge Included	Same Calendar Date • Admission paid o Discharge **not** paid separately
Different Calendar Date • Admission and Discharge (99217) paid separately	Different Calendar Date • Use codes 99218-99220 • Discharge (99217) paid separately	Different Calendar Date • Admission and Discharge paid separately

Observation Care Services

- Subsequent Observation Care Codes are **TIME-BASED CODES** and time spent at bedside and on Hospital floor unit must be documented by the physician.

- At 48 hours, the physician should re-evaluate patient's condition and decide if patient needs to be admitted to the hospital or discharged home.

- Outpatient observation time begins **when the patient is physically placed in the observation bed. Outpatient observation time ends at the time it's documented in the physician's discharge orders.**

Discharge Day Codes -*TP Time Only*!

- **CPT 99238:** TP's management of patient's D/C **took < 30 minutes**.
- **CPT 99239:** Differs from 99238 because it **requires documentation of time > 30 minutes** spent managing the patient (final exam, Rx management, POC after D/C).
  - The hospital discharge day management codes are to be used to report the total duration of time spent by a physician for final hospital discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, even if the time spent by the physician on that date is not continuous, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.

    EXAMPLE: *"I saw and evaluated the patient today and agree with resident note. Discharge instructions given to patient and Rx's. To F/U in 5 days in clinic"*

The hospital required discharge summary is not documentation of patient discharge management for billing a 99238 or 99239 unless there is a statement that indicates that the attending personally saw the patient and discussed discharge plans on the day the code was billed.

Hospitalists Take Note!

Co-Management Documentation, Coding, and Billing

Documentation, coding and billing considerations that hospitalists should keep in mind include:

1. *Make sure you know what services are included in the surgeon's global surgical fee.* If you provide services that the payor determines are part of the global surgical package, there's a good chance you won't be paid for them. While the specific services included in the global surgical package may vary from one payor to another, in general, the global surgical package includes the following:

- 1. Subsequent to the decision for surgery (which is outside the global package), one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical);
- 2. Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;

Hospitalists Take Note!

Co-Management Documentation, Coding, and Billing

- 3. Writing orders;
- 4. Evaluating the patient in the postanesthesia recovery area;
- 5. Typical postoperative follow-up care1

The coding column in The Hospitalist addressed the issue of global surgical fees

- *Consider medical necessity.* Hospitalists can provide concurrent care (including performing the admitting history and physical) if they are treating a separate medical condition that will benefit from their expertise. This will usually require that you submit your claims using a different ICD-9 diagnosis code than the surgeon or other consultants on the case are using.

Present on Admission (POA) & Hospital-Acquired Conditions (HAC)

- POA is defined as being present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter (**including emergency department, observation, or outpatient surgery**) are considered POA;
- Under the Hospital-Acquired Conditions—Present on Admission (HAC-POA) program, accurate coding of hospital-acquired conditions (HACs) and present on admission (POA) conditions is critical for correct payment.
- **The importance of consistent, complete documentation in the medical record from any and all Physicians/Practitioners involved in the care and treatment of the patient is used to determine whether a condition is POA;**
- **It is crucial that physicians/practitioners document all conditions that are present on admission;**
- The Hospital must include the POA indicator on all claims that involve Medicare inpatient admissions. The hospital is subject to a law or regulation that mandates the collection of POA indicator information.

Teaching Physicians (TP) Guidelines

Billing Services When Working With Residents Fellows and **Interns**

All Types of Services Involving a resident with a TP Requires Appropriate Attestations In EHR or Paper Charts To Bill

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Evaluation and Management (E/M)

E/M IP or OP: TP must personally document by a personally selected macro in the EMR or handwritten at least the following:

- That s/he was present and performed key portions of the service in the presence of or at a separate time from the resident; AND
- The participation of the teaching physician in the management of the patient.

- **Initial Visit:** "I saw and evaluated the patient. I reviewed the resident's note and agree, except that the picture is more consistent with an upper respiratory infection not pneumonia. Will begin treatment with……."
- **Initial or Follow-up Visit:** "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."
- **Follow-up Visit:** "See resident's note for details. I saw and evaluated the patient and agree with the resident's finding and plans as written."
- **Follow-up Visit:** "I saw and evaluated the patient. Agree with resident's note, but lower extremities are weaker, now 3/5; MRI of L/S Spine today."

The documentation of the Teaching Physician must be patient specific.

Evaluation and Management (E/M)

Time Based E/M Services: The TP must be present and document for the period of time for which the claim is made. Examples :

- Critical Care Hospital Discharge (>30 minutes) or
- E/M codes where more than 50% of the TP time spent counseling or coordinating care

Medical Student documentation for billing only counts for ROS and PFSH. All other contributions by the medical student must be re-performed and documented by a resident or teaching physician.

Unacceptable TP Documentation

- Assessed and Agree
- Reviewed and Agree
- Co-signed Note
- Patient seen and examined and I agree with the note
- As documented by resident, I agree with the history, exam and assessment/plan

TP Guidelines for Procedures

Minor – (< 5 Minutes): For payment, a minor procedure billed by a TP requires that s/he is physically present during the entire procedure.

Example: *'I was present for the entire procedure.'*

Major – (>5 Minutes)

- SINGLE Procedure / Surgery — When the teaching surgeon is present or performs the procedure for a single non-overlapping case involving a resident, he/she or the resident can document the TP's physical presence and participation in the surgery.

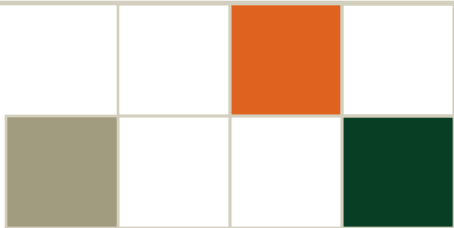
  Example: *"I was present for the entire procedure (or key and critical portions & description of the key and critical portions of the procedure and immediately available)."*

Endoscopy Procedures (excluding Endoscopic Surgery):

TP must be present during the entire viewing for payment.

- The viewing begins with the insertion and ends with the removal.
- Viewing of the entire procedure through a monitor in another room does not meet the presence requirement.

Critical Care



Critical Care:
Medical Review Guidelines

Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the requirements.

- **Clinical Criterion** – A high probability of sudden, clinically significant or life threatening deterioration of the patient's condition which requires a high level of physician preparedness to intervene urgently
- **Treatment Criterion** – Life or organ supporting interventions that require frequent assessment and manipulation by the physician.
  - Withdrawal of or failure to initiate these interventions would result in sudden, clinically significant / life-threatening deterioration in the patient's condition.

Time spent teaching or by residents may not be used in CC time and NPP time cannot be added to physician time.

CC Codes 99291 and 99292

Time	Codes
< 30 min	Appropriate E/M code
30-74 min	99291 x 1
75-104 min	99291 x 1 and 99292 x 1
105-134 min	99291 x 1 and 99292 x 2
135-164 min	99291 x1 and 99292 x 3

Critical Care Documentation & Criteria

MM5993 Related Change Request Number: 5993

The TP documentation must include:

- Time the teaching physician spent providing critical care (resident time and time teaching residents does not count toward the 30 minute minimum);
- That the patient was critically ill during the time the TP saw the patient (met clinical criterion of a high probability of sudden, clinically significant or life threatening deterioration of the patient's condition);
- What made the patient critically ill; and
- The nature of the treatment and management provided by the TP (treatment criterion of Life or organ supporting interventions that require frequent assessment and manipulation by the physician.)

- Combination of the TP's documentation and the resident's may support CC provided that all requirements for CC services are met. The TP documentation may tie into the resident's documentation. The TP may refer to the resident's documentation for specific patient history, physical findings and medical assessment as long as additional TP documentation is included to support their CC time.

Coding Critical Care With 2 ICU Teams

- If there are two ICU teams with alternating night coverage, and the circumstance comes up when the patient has been seen and rounded upon by one attending - only to decompensate and require additional time by the night attending. How should this be documented and billed?
  - **Each note must meet the critical billing criteria.**
- If the ICU Teams are the same credentials and sub-speciality, then the time must be added together and team 1 would bill a 99291 (and 99292 if applicable) and team two would bill 99292.
  - **MD to MD or NPP to NPP**
- If the ICU Teams are different credentials or sub-speciality, then each team would a bill a 99291 (and 99292 if applicable.)
  - **NPP and MD**

Procedures Bundled with Critical Care Services

- Introduction of needle or intracatheter, vein (**36000**)
- Venipuncture, age 3 years or older, necessitating physician's skill (**36410**)
- Collection of venous blood by venipuncture (**36415**)
- Collection of blood specimen from a completely implantable venous access device (**36591**)
- Arterial puncture, withdrawal of blood for diagnosis (**36600**)
- Nasogastric or orogastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report) (**43752,43753**)
- Radiologic examination, chest; single view, stereo, or two view (**71010, 71015, 71020**)

Procedures Bundled with Critical Care Services

- Temporary transcutaneous pacing (**92953**)
- Indicator dilution studies with dye or thermal dilution, including arterial and/or venous catheterization; with cardiac output measurement (**93561** and **93562**)
- Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day, subsequent day, nursing facility (**94002, 94003, 94004**)
- Continuous positive airway pressure ventilation (CPAP), initiation and management (**94660, 94662**)
- Continuous negative pressure ventilation, initiation and management (**94662**)
- Noninvasive ear or pulse oximetry for oxygen saturation, single, multiple, or continuous (**94760, 94761, 94762**)
- Analysis of clinical data stored in computers (eg., ECGs, blood pressures, hematologic data) (**99090**)

Non-Physician Practitioners (NPP's) or Physician Extenders

Who is a NPP?

- Physician Assistant (PA)
- Nurse Practitioner (NP)

Shared Visits

- The shared/split service is usually reported using the physician's NPI.
- When an E/M service is a shared encounter between a physician and a NPP, the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient and can be billed under the physician.
- If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the non-physician's NPI.
- Procedures **CANNOT** be billed shared

Shared Visits Between NPP and Physician

Shared visits may be billed under the physician's name if and only if:

1. The physician provides a medically necessary face-to-face portion of the E/M encounter (even if it is later in the same day as the PA/ARNP's portion); and
2. The physician personally documents in the patient's record the details of their face-to-face portion of the E/M encounter with the patient.

- If the physician does not personally perform and personally and contemporaneously document their face-to-face portion of the E/M encounter with the patient, then the E/M encounter cannot be billed under the physician's name and must be billed under the NPP.
- The NPP MUST be an employee (or leased) to bill shared. Documentation from a hospital employed NPP may not be utilized to bill a service under the physician.

Bill Independently and Not Shared

Billing Under The NPP NPI

- Does not require physician presence.
- Can evaluate and treat new conditions and new patients.
- Can perform all services under the state scope-of-practice.
- Can perform services within the approved collaborative agreement.
  - Recommend physician establish competency criteria and demonstration of performance of procedures within the collaborative agreement between the NPP and physician.

Scribed Notes

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- Record entries made by a "scribe" should be made upon the direction of the physician. A scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently or obtain any information independently except to ROS and PFSH. They cannot obtain the HPI, any portion of the PE or MDM.
- The scribe must note "written by xxxx, acting as scribe for Dr. yyyy." Then, Dr. yyyy indicating that the note accurately reflects work and decisions made by him/her and then authenticate with signature.
- It is inappropriate for an employee of the physician to round at one time and make entries in the record, and then for the physician to see the patient at a later time and note "agree with above…".
- AAMC does not support someone “dictating” as a scribe by an NPP, as scribing is over the shoulder immediate documenter with no services personally performed by the scriber. In this case, the physician should be dictating their own visit. Scribes can do EMRs under their own password.

Scribed Notes

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- Individuals can only create a scribe note in an EHR if they have their own password/access to the EHR for the scribe role. Documents scribed in the EHR must clearly identify the scribe's identity and authorship of the document in both the document and the audit trail.
- Scribes are required to notify the provider of any alerts in the EPIC System. Alerts must be addressed by the provider.
- Providers and scribes are required to document in compliance with all federal, state, and local laws, as well as with internal policy.
- Failure to comply with this policy may result in corrective and/or disciplinary action by the hospital and/or department under the University of Miami Medical Group disciplinary policies applicable.
- Verbal orders may neither be given to nor by scribes. Scribes may pend orders for providers based upon provider instructions.
- The following attestation must be entered by the scribe:
- **"Scribed for [Name of provider] for a visit with [patient name] by [Name of scribe] [date and time of entry].**
- The following attestation should be entered by provider when closing the encounter:
- **"I was present during the time with [patient name] was recorded. I have reviewed and verified the accuracy of the information which was performed by me." [Name of provider][Date and time of entry].**

ICD-10

Looks like a go!

Diagnosis Coding
International Classification of Disease (ICD-10)

- ICD-10 is scheduled to replace ICD-9 coding system on October 1, 2015.
- ICD-10 was developed because ICD-9, first published in 1977, was outdated and did not allow for additional specificity required for enhanced documentation, reimbursement and quality reporting.
- ICD-10 CM will have 68,000 diagnosis codes and ICD-10 PCS will contain 76,000 procedure codes.
- This significant expansion in the number of diagnosis and procedure codes will result in major improvements including but not limited to:
  - Greater specificity including **laterality, severity of illness**
  - Significant improvement in coding for primary care encounters, external causes of injury, mental disorders, neoplasms, diabetes, injuries and preventative medicine.
  - Allow better capture of socio-economic conditions, family relationships, and lifestyle
  - Will better reflect current medical terminology and devices
  - Provide detailed descriptions of body parts
  - Provide detailed descriptions of methodology and approaches for procedures

Clinical Trials

Requirements for Billing Routine Costs for Clinical Trials

Effective for claims with dates of service on or after January 1, 2014 it is **mandatory** to report a clinical trial number on claims for items/services provided in clinical trials/studies/registries, or under CED.

Professional

- For professional claims, the 8-digit clinical trial number preceded by the 2 alpha characters of CT (use CT only on paper claims) must be placed in Field 19 of the paper claim Form CMS-1500 (e.g., CT12345678) or the electronic equivalent 837P in Loop 2300 REF02(REF01=P4) (**do not use CT on the electronic claim, e.g., 12345678)** when a clinical trial claim includes:
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- **Modifier Q0** (investigational clinical service provided in a clinical research study that is in an approved clinical research study) and/or
- **Modifier Q1** (routine clinical service performed in a clinical research study that is in an approved clinical research study), as appropriate (outpatient claims only).

Hospital

- For hospital claims that are submitted on the electronic claim 837I, the 8-digit number should be placed in Loop 2300 REF02 (REF01=P4) when a clinical trial claim includes:
- Condition code 30;
- ICD-9 code of V70.7/ICD-10 code Z00.6 (in either the primary or secondary positions) and
- Modifier Q0 and/or Q1, as appropriate (outpatient claims only).

Items or services covered and paid by the sponsor may not be billed to the patient or patient's insurance, this is double billing.

WHO IS RESPONSIBLE FOR OBTAINING APPROVAL FROM THE MAC(S) FOR AN INVESTIGATIONAL DEVICE EXEMPTION (IDE) CLINICAL TRIAL?

- The principal investigator (PI) is responsible for assuring that all required approvals are obtained prior to the initiation of the clinical trial. For any clinical study involving an IDE, the PI must obtain approval for the IDE clinical trial from the Medicare Administrative Contractor (MAC) for Part A / Hospital.
- Additionally, for clinical studies involving an IDE, the PI is responsible for communicating about the trial and the IDE to the Medicare Part B (physician) MAC.
- Once approval has been received by the MAC, the following needs to take

place:

  - The Study must be entered in the Velos System within 48 hours.
  - The PI is responsible for ensuring that the IDE or the no charge device is properly set up in the facility charge master to allow accurate and compliant charging for that device before any billing will occur.

Investigational Device Exemption (IDE)

Hospital Inpatient Billing for Items and Services in Category B IDE Studies

- Payment for the device may not exceed the Medicare-approved amount for a comparable device that has been already FDA-approved.

Routine Care Items and Services

- Hospital providers shall submit claims for the routine care items and services in Category B IDE studies approved by CMS (or its designated entity) and listed on the CMS Coverage Website, by billing according to the clinical trial billing instructions found in §69.6 of this chapter http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c32.pdf, and as described under subsection D ("General Billing Requirements").

Investigational Device Exemption (IDE)

Category B Device. On a 0624 revenue code line, **institutional providers must bill the following for Category B IDE devices for which they incur a cost:**

- Category B IDE device HCPCS code, if applicable
- Appropriate HCPCS modifier
- Category B IDE number
- **Charges for the device billed as covered charges**
- If the Category B IDE device is provided at no cost, outpatient prospective payment system (OPPS) providers must report a token charge in the covered charge field along with the applicable HCPCS modifier (i.e., modifier – FB) appended to the procedure code that reports the service to furnish the device, in instances when claims processing edits require that certain devices be billed with their associated procedures. For more information on billing 'no cost items' under the OPPS, refer to chapter 4, §§20.6.9 and 61.3.1 of this manual.

WHEN THE TRIAL ENDS OR REACHES FULL ENROLLMENT?

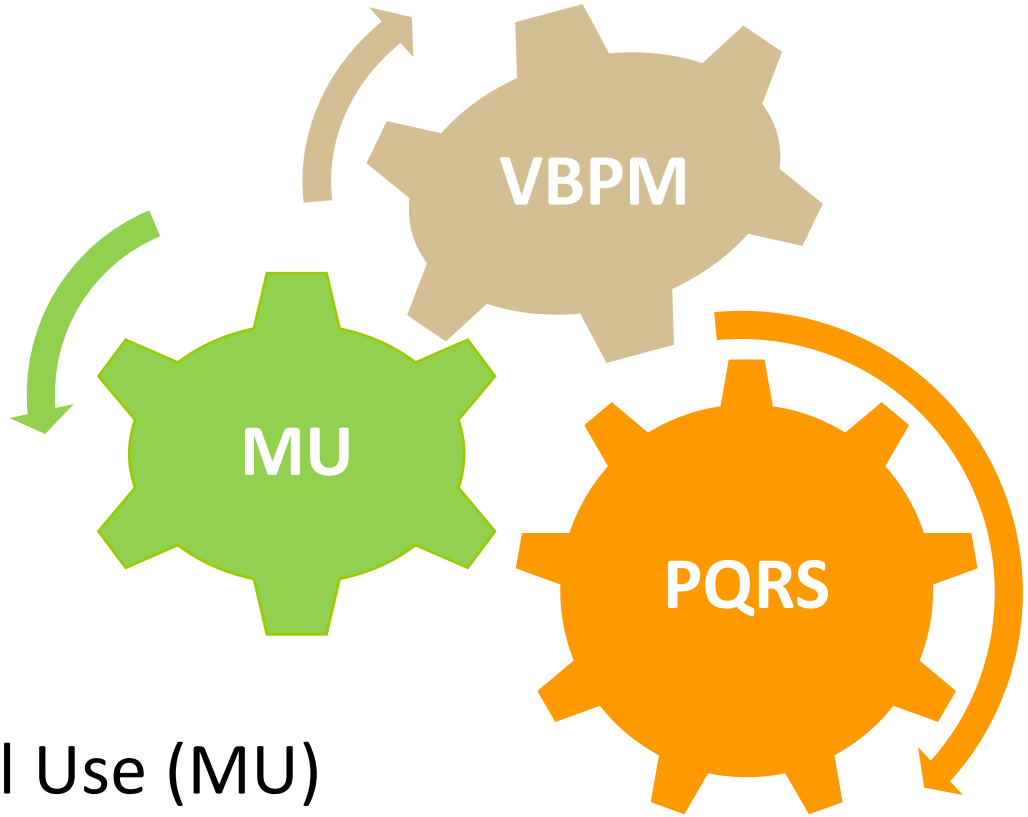
When the trial ends, whether due to reaching full enrollment or for any other reason, the PI must work with their department resource and/or the relevant Revenue Integrity Office (s) to inactivate the item in the charge master so that it may no longer be used.

If the device is approved by the FDA and is no longer considered investigational or a Humanitarian Device Exemption (HDE) and will continue to be used at UHealth, the PI must work with their department resource and/or the relevant Revenue Integrity Office (s) to inactivate the investigational device in the charge master and to ensure that a new charge code is built for the approved device. At this point, ongoing maintenance responsibility would transfer to the relevant Revenue Integrity Office (s).

UHealth/UMMG
2015 PQRS

Patient Safety and Quality Office

CMS Quality Improvement Programs



- ✓Meaningful Use (MU)
- ✓Physician Quality Reporting System (PQRS)
- ✓Value Based Payment Modifier (VBPM)

CMS Quality Programs
Medicare Part B Payment Reductions

PROGRAM	POTENTIAL MEDICARE PAYMENT REDUCTION					
	2015	2016	2017	2018	2019	2020
Meaningful Use	1%	2%	3%	4%	5%	5%
PQRS	1.5%	2%	2%	2%	2%	2%
VBPM		4%	4%	4%	4%	4%
TOTAL PENALTIES	**2.5%**	**8%**	**9%**	**10%**	**11%**	**11%**

2015 PQRS Eligible Providers

Physicians	Practitioners	Therapists
MD	Physician Assistant	Physical Therapist
DO	Nurse Practitioner	Occupational Therapist
Doctor of Podiatric	Clinical Nurse Specialist*	Qualified Speech-Language Therapist
Doctor of Optometry	CRNA	
DDS	Certified Nurse Midwife	
DMD	Clinical Social Worker	
Doctor of Chiropractic	Clinical Psychologist	
	Registered Dietician	
	Nutrition Professional	
	Audiologists	

PQRS

- Reporting Requirements:
  - ✓Reporting Period= Full CY
  - ✓Report **9** Measures from **3** National Quality Strategy Domains

- Reporting Options:
  - Claims, EHR, **Registry**
    - Individual or GPRO

NATIONAL STRATEGY DOMAINS					
Communication & Care Coordination	Effective Clinical Care	Efficiency & Cost Reduction	Patient Safety	Person & Caregiver-Centered Experience & Outcomes	Community/ Population Health

Physician Impact

Workflow and documentation changes

TO DO:

✓Study Measure Specifications

✓Ensure documentation meets measure requirements

✓Bill PQRS quality code when required in MCSL/UChart

✓Document chronic conditions/secondary diagnoses

✓Use UChart Smart Phrases

✓Ensure medical support staff completes required documentation

HIPAA, HITECH, PRIVACY AND SECURITY

- **HIPAA, HITECH, Privacy & Security Health Insurance Portability and Accountability Act – HIPAA**
  - Protect the privacy of a patient's personal health information
  - Access information for business purposes only and only the records you need to complete your work.
  - Notify Office of HIPAA Privacy and Security at 305-243-5000 if you become aware of a potential or actual inappropriate use or disclosure of PHI, including the sharing of user names or passwords.
  - **PHI is protected even after a patient's death!!!**

- **Never share your password with anyone and no one use someone else's password for any reason, ever –even if instructed to do so.**

✓If asked to share a password, report immediately.
✓If you haven't completed the HIPAA Privacy & Security Awareness on-line CBL
✓module, please do so as soon as possible by going to:

http://www.miami.edu/index.php/professional_development__training_office/learning/ulearn/

HIPAA, HITECH, PRIVACY AND SECURITY

- **HIPAA, HITECH, Privacy & Security**
- Several breaches were discovered at the University of Miami, one of which has resulted in
- a class action suit. As a result, **"Fair Warning"** was implemented.
- **What is Fair Warning?**
- • **Fair Warning** is a system that protects patient privacy in the Electronic Health Record
- by detecting patterns of violations of HIPAA rules, based on pre-determined analytics.
- • **Fair Warning** protects against identity theft, fraud and other crimes that compromise
- patient confidentiality and protects the institution against legal actions.
- • **Fair Warning** is an initiative intended to reduce the cost and complexity of HIPAA
- auditing.
- UHealth has policies and procedures that serve to protect patient information (PHI) in
- oral, written, and electronic form. These are available on the Office of HIPAA Privacy &
- Security website: http://www.med.miami.edu/hipaa

Available Resources at University of Miami, UHealth and the Miller School of Medicine

- If you have any questions or concern regarding coding, billing, documentation, and regulatory requirements issues, please contact:
  - ***Gemma Romillo, Assistant Vice President of Clinical Billing Compliance and HIPAA Privacy; or***
  - ***Iliana De La Cruz, RMC, Director Office of Billing Compliance***
    - ***Phone: (305) 243-5842***
    - **Officeofbillingcompliance@med.miami.edu**

- Also available is The University's fraud and compliance hotline via the web at www.canewatch.ethicspoint.com or toll-free at 877-415-4357 (24hours a day, seven days a week).
- Office of billing Compliance website: **www.obc.med.miami.edu**

QUESTIONS