

Professional Component

Teaching Physician Attestation

If a resident participates in a visit (Evaluation and Management services-outpatient and/or inpatient), the teaching physician needs to be present during the visit with the patient. The resident should mention the teaching physician's name in his/her documentation. The teaching physician should mention the residents name in his/her attestation. The resident may document all the elements of the visit (History, Examination, and Medical Decision Making). However, in order for the teaching physician to be able to bill for this visit, he/she needs to personally add an attestation to the resident's note.

Have a Question?

Call us at 305-243-5842 or email officeofbillingcompliance@med.miami.edu

The following are examples of acceptable Teaching Physician's Attestation:

"I performed a history and physical examination of the patient and discussed management plan with the resident_____. I reviewed the resident's note and agree with the documented findings and plan of care".

"I saw and examined the patient and agree with the resident_____documentation, except the heart murmur is louder, so I will obtain an echo to evaluate".

"I saw and evaluated the patient. I reviewed the resident_____note and agree, except that the picture is more consistent with pericarditis, than myocardial ischemia. Will begin NSAIDs".

"I saw and evaluated the patient. Agree with the resident_____note but lower extremities are weaker, now 3/5; MRI of L/S spine today".

More information is available at the Office of Billing Compliance website.

[Medicare Rule For Teaching Physicians](#)

PHYSICIAN'S VERIFICATION OF PRESENCE, WHERE A SURGICAL PROCEDURE IS PERFORMED, IN THE UMCARE SYSTEM, IS REQUIRED IN ORDER TO COMPLY WITH THE MEDICARE RULE FOR TEACHING PHYSICIANS.

Split/Shared Visits with Non-Physician Practitioners (NPP)

Shared visits are evaluation and management (E/M) services provided to the hospital inpatients or outpatients. These services are literally "shared" between the physician and a NPP. If both the physician and the NPP have a face-to-face encounter with the patient, the service can be billed under the physician's provider number and is reimbursed at 100 percent of the Medicare fee schedule, or under the NPP provider number and is reimbursed at 85% of Medicare fee schedule.

For a shared visit, the physician would provide and document some of the (visit) E/M service and the NPP would provide and document some of the (visit) E/M service.

It is not sufficient for the physician to document, "Seen and agree," nor is it sufficient to simply countersign the NPP note.

In addition, documentation of an attestation such as the one a physician would use with a resident/fellow is not applicable. The Medicare Rule for Teaching Physicians does not apply to NPPs.

The physician may see the patient before, after or at the same time the NPP sees the patient. The NPP may document the bulk of the note, but the physician must specifically document the elements of the visits he or she has personally performed.

Prepayment Review for Initial and Subsequent Hospital Evaluation and Management Services CPT® codes 99223 and 99233

Florida's Medicare Carrier, First Coast Service Options Inc. (First Coast) recently conducted data analysis due to the high Comprehensive Error Rate Testing (CERT) error rates for evaluation and management services pertaining to CPT® codes 99223 (initial hospital visit) and 99233 (subsequent hospital visit). The data indicates that the specialty of Internal Medicine is the primary contributor to the CERT error rate: Internal Medicine error rates are currently trending at 36.6 percent for CPT® code 99233 and 33.3 percent for CPT code 99223.

In response to the high percentage of error rates associated with hospital visits billed by Internal Medicine physicians, First Coast implemented a prepayment medical review audit effective October 21, 2014.

2015 Changes For Anesthesiology

In 2015 the following three codes have been deleted:

- **00452** - Anesthesia for procedures on clavicle and scapula; radical surgery
- **00622** - Anesthesia for procedures on thoracic spine and cord; thoracolumbar sympathectomy
- **00634** - Anesthesia for procedures in lumbar region; chemonucleolysis.

New TAP Block Codes

Physicians sometimes use transversus abdominis plane (TAP) catheters as an alternative to epidural analgesia after upper abdominal surgery or as an adjunct to anesthesia during an abdominal laparoscopic procedure. CPT® currently doesn't include a code specifically for a TAP catheter, so that service is billed using code 64999 (Unlisted procedure, nervous system) and a copy of the procedure report is submitted.

In 2015, there will be four new codes that differentiate between injection and continuous infusion, and whether the physician administer a unilateral or bilateral injection(s). The following procedure codes will replace code 64999.

- **64486** - Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)
- **64487** - ... by continuous infusion(s) (includes imaging guidance, when performed)
- **64488** - Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)
- **64489** - ... by continuous infusions (includes imaging guidance, when performed).

2015 Changes For Ob/Gyn

Question: When we report global Ob Care, it includes a "postpartum exam?" What is the definition of the post-partum exam?

Answer: The postpartum exam is any routine care the Ob-Gyn normally provides after the birth of the baby. This exam occurs within the six-week standard time frame for a Vaginal Delivery or eight-week period for Cesarean Delivery. Complications during the postpartum period could be billed separately, however routine checks, no matter how many there are, are included.

The American Congress of Obstetricians and Gynecologists' guidelines for perinatal care recommends that about four to six weeks after delivery, the mother should visit her physician for a postpartum review and examination. "This interval may be modified according to the needs of the patient with medical, obstetric, or intercurrent complications. A visit within 7-14 days of delivery may be advisable after a Cesarean Delivery or a complicated gestation,"

The review during the postpartum visit should include:

- history
- physical examination to evaluate the patient's current status
- evaluation of her adaptation to the newborn
- specific inquiries regarding breastfeeding
- assessment of weight, blood pressure, breasts and abdomen, as well as a pelvic examination
- evaluation of episiotomy repair and uterine involution
- a Pap test, if needed
- review or initiation of birth control
- counseling for preconception if the patient intends to have future pregnancies.

The ACOG guidelines indicate that the global service includes, among other things, uncomplicated outpatient visits until six weeks postpartum. Some payers use six weeks as the standard, this may vary based on payer.

2015 Changes For Ophthalmology

CCI Edits introduces a number of new edits involving a temporary Category III CPT® code, 0356T (Insertion of drug-eluting implant [including punctal dilation and implant removal when performed] into lacrimal canaliculus, each). The code, part of Category III, which describes new and emerging technology, was introduced effective July 1, 2014.

The code describes the insertion (and removal, when performed) of implants designed to help reduce postoperative inflammation and pain, as well as reduce of intraocular pressure in patients with glaucoma or ocular hypertension.

Effective Oct. 1, CCI has bundled these codes into 0356T:

- **67500** - Retrobulbar injection; medication (separate procedure, does not include supply of medication)
- **68440** - Snip incision of lacrimal punctum
- **68530** - Removal of foreign body or dacryolith, lacrimal passages
- **68700** - Plastic repair of canaliculi
- **68770** - Closure of lacrimal fistula (separate procedure)
- **68801** - Dilation of lacrimal punctum, with or without irrigation
- **68810** - Probing of nasolacrimal duct, with or without irrigation
- **68811** - ... requiring general anesthesia
- **68815** - ... with insertion of tube or stent
- **68816** - ...with transluminal balloon catheter dilation
- **68840** - Probing of lacrimal canaliculi, with or without irrigation.

2015 Changes For Otolaryngology and Gastroenterology

Effective January 1, 2015, CPT® is adding a new code 43180, Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus [eg, Zenker's diverticulum], with cricopharyngealmyotomy that includes the use of telescope or operating microscope and repair. This code will allow gastroenterologists or other specialists to identify the emerging procedure for non-surgical and non-incisive removal and repair of Zenker's diverticulum, endoscopic cricopharyngealmyotomy, transoral repair of Zenker's diverticulum.

2015 Changes For Orthopaedic

Sacroplasty: For Sacral Vertebroplasty the following two Category III codes will include imaging guidance:

- **0200T** - Percutaneous sacral augmentation (sacroplasty), unilateral injection(s), including the use of a balloon or mechanical device, when used, 1 or more needles, includes imaging guidance and bone biopsy, when performed
- **0201T** - Percutaneous sacral augmentation (sacroplasty), bilateral injections, including the use of a balloon or mechanical device, when used, 2 or more needles, includes imaging guidance and bone biopsy, when performed.

Arthroplasty: Total Disc Arthroplasty codes now include a second level cervical placement. The revised and new codes are as follows:

- **22856** - Total Disc Arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical; single interspace, cervical
- **22858** - ... second level, cervical (List separately in addition to code for primary procedure).

Two Category III codes for Arthroplasty procedures:

- **0375T** - Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), cervical, three or more levels
- **0376T** - ... each additional device insertion (List separately in addition to code for primary procedure)

Arthrodesis: The new codes for Arthrodesis procedures, are:

- **27279** - Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device

The following is a revised Sacroiliac Joint Arthrodesis code,

27280 - Arthrodesis, open, sacroiliac joint (, including obtaining bone graft), including instrumentation, when performed

Contrast injection: The following new code is for knee arthrography:

- **27370** - Injection procedure of contrast for knee arthrography

2015 Changes For Pain Management/Orthopaedics/Radiology

Kyphoplasty, Vertebroplasty Code Overhaul

Billing for Kyphoplasty and Percutaneous Vertebroplasty services will change in 2015. The following six new codes, that will represent the services based on the number of vertebral bodies and the spinal area treated, will be in effect:

Codes currently in effect such as 22520-22525, will be replaced with the following ones:

- **22510** - Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
- **22511** - ... lumbosacral
- **+22512** - ... each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)
- **22513** - Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic
- **22514** - ... lumbar
- **+22515** - ... each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure).

Important: Note that Each code will continue to represent both unilateral and bilateral injections.

The biggest change is the addition of "inclusive of all imaging guidance" to the descriptors. Each of the new codes also includes the "bulls-eye" symbol designation, which means the associated RVUs and service include moderate sedation. This is new for Kyphoplasty in 2015. The 2014 codes (**22523-22525**) did not include moderate sedation, so you could bill it separately.

The new Vertebroplasty code, **22510**, will also include the cervical spine region.

Because of the updated descriptors, the associated radiology codes for guidance will be deleted. We no longer be able to bill the following codes as part of your Vertebroplasty or Kyphoplasty services:

- **72291** – Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance
- **72292** – ... under CT guidance.

2015 Changes For Radiology

Check Bone Density Study with Vertebral Fracture Assessment

- **76641** - Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete
- **76642** - Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited

Also add the following three codes for breast tomosynthesis:

- **77061** - Digital breast tomosynthesis; unilateral
- **77062** - Digital breast tomosynthesis; bilateral
- **77063** - Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)

New Codes for Breast Ultrasound and Digital Tomosynthesis

Effective 2015, code **77082** (Dual-energy X-ray absorptiometry (DXA), Bone Density Study, one or more sites) for vertebral fracture assessment, will no longer be valid. This code will be replaced with two new codes for vertebral fracture assessment.

2015 Changes For Pathology

The [College of American Pathologists](#) (CAP) [estimates](#) overall payment to pathologists will increase 1%, Independent Laboratories will see a 3% increase compared to 2014. The CAP's impact table can be found [here](#).

Surgery Global Periods Medicare Proposed Changes 2017 & 2018

Perhaps the most radical change proposed by Medicare is the elimination of 10- and 90-day global periods. The proposal recommends phasing in the changes, with 10-day global procedures moving to 0-day global procedures, beginning in 2017, and 90-day global procedures moving to 0-day global procedures beginning in 2018.

This payment scheme, would allow billing for preoperative and postoperative care and other services provided, whether related or unrelated, without modifiers or additional payment reductions. Additionally, coordination of care among providers, where surgery is provided by one physician or group, and follow-up care provided by others, will not also be required.

With the postponed elimination of the global period, Medicare proposes to re-evaluate the reimbursement of surgical services.

2015 New Coding Requirements For Modifier -59

The Centers for Medicare & Medicaid Services (CMS) new coding requirements related to modifier -59. This modifier is the most widely-used modifier and indicates a service that is separate and distinct from another service. CMS is establishing the following four new modifiers (referred to collectively as -X{EPSU} modifiers) to define specific subsets of the -59 modifier:

- XE Separate Encounter: A service that is distinct because it occurred during a separate encounter
- XS Separate Structure: A service that is distinct because it was performed on a separate organ/structure
- XP Separate Practitioner: A service that is distinct because it was performed by a different practitioner
- XU Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service

These modifiers are valid before National Edits go into effect on January 2015. At this time, CMS will accept either a -59 modifier or a more selective - X{EPSU} modifier; however, the use of the more selective modifiers is encouraged.

Hospital Component

Hospital Outpatient Observation Services

Observation services are ordered by the physician who is required to sign and date the order, for patients who present to the emergency department and who then require to be observed and receive treatment.

In only rare and exceptional cases outpatient observation services span more than 48 hours. At 24 hours in observation, the physician should evaluate patient and document in the patient's record the findings of the evaluation including his/her decision regarding the patient. If the patient is required to stay up to 48 hours, at 48 hours, the physician needs to re-evaluate the patient and document the findings as well as his/her decision to admit patient to hospital or discharge patient home.

Medicare pays for observation services only to the physician who ordered hospital observation services and was responsible for the care of the patient while he/she stayed in observation status.

The following is a list of services that are not considered appropriate to bill as observation services (this list is not all inclusive):

- services that are not reasonable or necessary for the diagnosis or treatment of the patient
- outpatient blood or chemotherapy administration
- lack of/delay in patient transportation
- provision of a medical exam for patients who do not require skilled support
- routine preparation prior to and recovery after diagnostic testing
- routine recovery and post-operative care after ambulatory surgery
- when used as a substitute for inpatient admission
- when used for the convenience of the physician, patient or patient's family
- while awaiting transfer to another facility

Outpatient Surgeries – Observation Services

Coverage of outpatient observation services, after a surgical procedure is performed, is limited to situations where a patient exhibits an uncommon or unusual reaction or complication after a surgical procedure such as:

- The inability to urinate (requiring catheterization)
- The inability to keep solids or liquids down (requiring continued intravenous feeding)
- The inability to control pain (requiring intramuscular or intravenous analgesics)
- The inability to move the lower extremities and safely ambulate after spinal anesthesia (requiring continued bed rest and sensation assessment and monitoring)
- Unexpected surgical bleeding (requiring frequent dressing changes, and/or dressing reinforcement)
- Unstable vital signs (requiring continued monitoring and/or drug intervention)

and the patient's condition requires monitoring and treatment above and beyond the treatment provided during the four to six hours in recovery. Outpatient observation services should be ordered (signed and dated) by the physician after the patient spends 4 to 6 hours in recovery. The observation order should never be signed by the attending physician prior to the surgical procedure or recovery time.

“**Four (4) to six (6) hours**” is used as a guideline for a normal recovery period. Observation would only be appropriate after the patient spends 4 to 6 hours in recovery.

Additional Hospital Services

a. The following services may be billed in addition to observation services::

- An emergency department visit (APC 0610, 0611, or 0612) or
- A clinic visit (APC 0600, 0601, or 0602); or
- Critical care (APC 0620); or

b. No procedure with a “T” status indicator can be reported on the same day or the day before observation service is provided.

Two Midnight Rule

Hospital stays - two or more midnights

When a physician expects a patient to require a hospital stay for at least two midnights, it would be considered an inpatient admission. For example, if a patient presents to the ED with severe exacerbation of COPD that will require additional testing and monitoring for more than two midnights, the physician would order (physician's order must be signed and dated) inpatient admission.

Uncertainty as to length of stay

If the patient presents with an undetermined diagnosis and it is difficult for the physician to decide how long the patient requires to stay in the hospital, the physician should order (physician's order must be signed and dated) the patient to be admitted to observation services.

Time Counted toward the two midnights

Cumulative time spent at the hospital, including time spent receiving outpatient care will count towards the two midnight benchmark.

Physician Documentation supporting Inpatient Admission

In addition to the admission order (signed and dated by the physician) and the certification, documentation by the physician in the medical record should support that the inpatient admission was reasonable and necessary. The documentation must include:

- Patient history and comorbidities
- Severity of signs and symptoms
- Risk of adverse events
- Current medical needs requiring inpatient care (e.g., frequent two-to-four hour monitoring, IV medication requiring hospitalization, high risk of possible infection, etc.)

October 2014

Update of The Hospital Outpatient Prospective Payment System

In effect since October 1, 2014 with an implementation date of October 6, 2014, CMS released key updates to the 2014 hospital outpatient prospective payment system (OPPS).

With the OPPS update, CMS added a new assigned medical service for OPPS payment and four drugs and biologicals to OPPS pass-through status. Also, CMS updated the payment rates for HCPCS codes J9047 (Injection, carfilzomib, 1 mg) and J9315 (Romidepsin injection).

CMS incorporated in this update additions, changes, and deletions to HCPCS, ambulatory payment classification, HCPCS modifier, status indicators, and revenue codes.

Please click on the [MLN Matters®](#) article for details and billing instructions for various payment policies implemented as part of the October 2014 OPPS update.

New Brachytherapy Source Payment

The Social Security Act (Section 1833(t)(2)(H); mandates the creation of additional groups of covered outpatient department (OPD) services that classify devices of brachytherapy consisting of a seed(s) (or radioactive source) ("brachytherapy sources") separately from other services or groups of services. The additional groups must reflect the number, isotope, and radioactive intensity of the brachytherapy sources furnished. Cesium-131 chloride solution is a new brachytherapy source.

For additional information, please see [Medicare Learning Network](#) or http://www.ssa.gov/OP_Home/ssact/title18/1833.htm

Present on Admission (POA)

The Present on Admission (POA) Indicator requirement, and the Hospital-Acquired Conditions (HAC) payment provision only apply to Inpatient Prospective Payment Systems (IPPS) Hospitals.

At this time, the following hospitals are exempt from the POA Indicator and HAC:

1. Critical Access Hospitals (CAHs)
2. Long-term Care Hospitals (LTCHs)
3. Maryland Waiver Hospitals*
4. Cancer Hospitals
5. Children's Inpatient Facilities
6. Religious Non-Medical Health Care Institutions
7. Inpatient Psychiatric Hospitals
8. Inpatient Rehabilitation Facilities
9. Veterans Administration/Department of Defense Hospitals

Announcements & Trainings

Announcements

This is a reminder, that all CMS, RAC, AHCA, Cert, Zip and Managed Care audit requests, overpayment requests or any request for medical records correspondence should be forwarded to the attention of Osmany Rodriguez, Manager of External/Special Audits at the Office of Billing Compliance. Should you need to contact him, he can be reached via email at ORodriguez5@med.miami.edu, or at 305-243-5842.

Trainings

Fraud, Waste and Abuse Training

This is a reminder that Fraud, Waste and Abuse training is mandatory. This training applies to all faculty and staff. Please find step-by-step instructions below.

Once you login to [ULearn](#), please select the search button. Then search by title "Billing Compliance 2014". If you have any questions or need further assistance, please contact Ivis Matute at 305-243-5842.

Medical Compliance Services

Who are we?

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To make a report, visit the 'Cane Watch website at www.canewatch.ethicspoint.com or call toll free 877-415-4357

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