Accurate Documentation and Billing
Evaluation & Management

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Documentation Requirements for E&M levels

- Rules apply in all U.S.A
- Are defined by the AMA:
  - "Current Procedural Terminology" (CPT) Manual
- Apply to ALL payers:
  - **government** (Medicare/Medicaid) and
  - **private** (insurance companies)
- Improper documentation can lead to severe fines, criminal prosecution, and loss of privileges to see some groups of patients.
- http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp
- *www.cms.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf*

Evaluation and Management
Basic, Common Types

- **New patient**: the one that
  - is self-referred and
  - **has not been seen** by any member of the Division or Group **in the last 3 years*.***
- **Consult**: a patient, **known or unknown to any member of the group**:
  - **1)** You are asked to Evaluate/ give opinion about a problem,
  - **2)** You document the reason of the consult in the medical record, and send report to requesting physician,
  - **3)** You have not agreed to assume total care for the patient before seeing him/her. ***(documentation of the request for consult should be present in the medical record)***

http://www.cms.hhs.gov/transmittals/downloads/R788CP.pdf

Evaluation and Management
Basic, Common Types

- **Established patient**: Any patient who
  - is not being seen in consultation and
  - that has been seen by you or any member of the group, anywhere, within the last 3 years

("been seen" includes open-access endoscopy or any other "face-to-face" procedure)

Evaluation and Management
Basic, Common Types

- **Initial hospital care**:
  - admission work.
- **Subsequent hospital care**:
  - daily hospital care.
- **Critical Care Hospital**:
  - Hospitalized patient who is "critically ill, or injured with high probability of life threatening deterioration" , and
  - Attending expends 30 minutes or more taking care of the patient

Payment for E&M Service

- Each type and each level of service has assigned an RVU or "Relative Value Unit"
  - Federal Register publishes RVUs each year.
- Each payer gives a predetermined amount of money per each RVU (Medicare 2016 = $36.10)
- Examples:

Level 5 O/P New = 4.6 RVU x 36.10= $ 166.06
Level 3 O/P New = 2.6 RVU x 36.10= $ 93.86
Level 5 Established = 3.2 RVU x 36.10= $ 115.52
Level 3 Established = 1.4 RVU x 36.10= $ 50.54
Level 1 Established = 0.6 RVU x 36.10= $ 21.66

Medicare Conversion Factor

- 1998 36.69
- 2001 37.27
- 2003 36.79
- 2004 37.33
- *2005 37.89*
- *2006* ***37.89***
- *2007 37.89*
- *2008 38.08 (peak)*
- *2009 36.06*
- *2010 36.87*
- *2011 33.97*
- 2012 34.03
- 2013 34.02
- 2014 35.82
- 2015 35.80
- 2016 36.10
- 2017 35.89
- 2018 35.99
- 2019 36.04

Doing It Right!

- Understand Documentation Guidelines
- Perform the Medical Service
- Document what you did (according to the guidelines)
- Bill what you documented
- Collect what you billed

Components of E&M Encounter

- ***History*** (requires **all 4**):
  - A) **Chief complaint** [stated reason for the visit (symptom/ problem/ condition/ diagnosis)] **+**
  - B) **History of present illness +**
  - C) **Review of Systems +**
  - D) **Past Medical, Social, & Family History**
- ***Physical Exam***
- ***Decision Making*** (requires **2 of 3**) :
  - A) **Diagnosis**/Management options,
  - B) Evaluation of **data** = **Data** Complexity,
  - C) **Risk** of Disease/Test/Management decision

Level of Care in E&M

- **Determined by:**
  1) The presence of ***"medical necessity"***
  (usually expressed in "Chief Complaint")
- **2)** The degree of ***documentation*** of the ***three components*** in the encounter note:
  - ***History +***
  - ***Physical Exam +***
  - ***Decision making (MOST IMPORTANT)***

- ***Within "decision making", the "Risk Table" level is the best determinant of billable "level of care".***

Level of Care in E&M
Sets of Rules

- ***New patient, Initial care, Consult:***
  - All 3 components are required.
  - Level is determined by the **LOWEST OF THE THREE** required components.

- ***Established patient, or Subsequent hospital care:***
  - Only 2 components are required.
  - Level is determined by the LOWER OF THE **TWO HIGHEST or REQUIRED** components

New Patient, Initial Hospital Care, Consult (In- or Out-Patient)

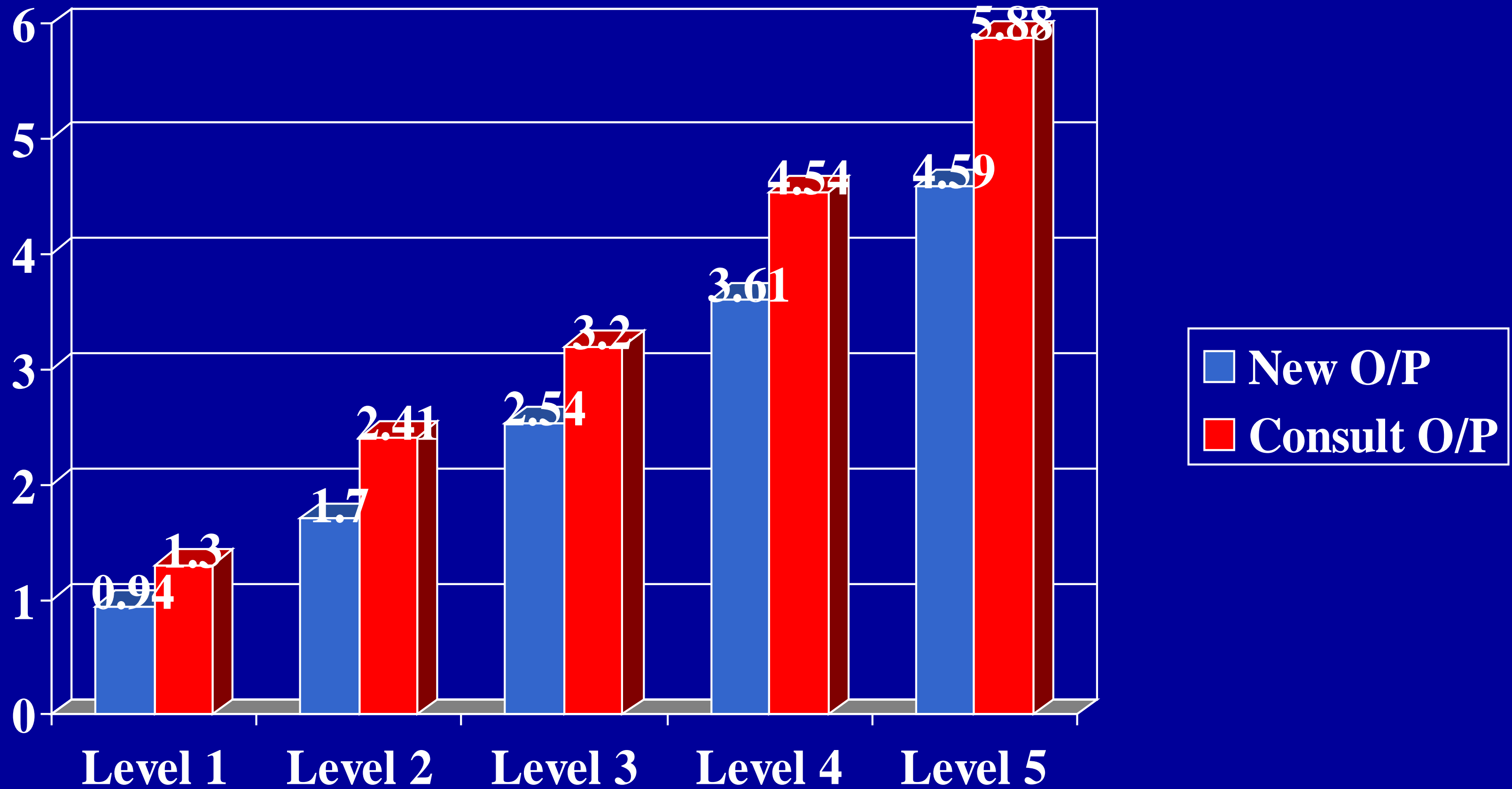
ALL 3 COMPONENTS ARE REQUIRED

LEVEL = **{lowest of the three components}**

(History, Physical Exam , Decision Making)

Out-Patient RVU

New-Patient vs Clinic Consult

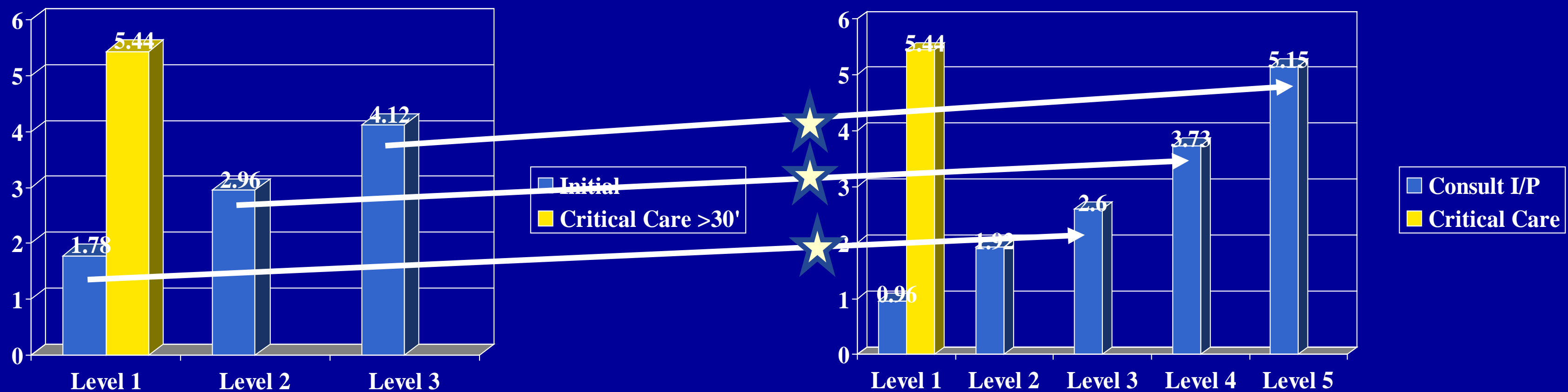


New = 78% of a Consult RVU

In-Patient RVU

Initial Hospital Care, vs
Consult, vs
Critical Care >30’

★ Equal documentation



Critical Care RVU is more than the highest Initial Hospital Care or Consult

At identical requirements, Consults have higher RVU than Initial Hospital Care

Medicare and Consults

- “Change Request (CR) 6740” as of January 1st of 2010:
  - consult codes were eliminated from the Medicare fee schedule (22% fee-reduction equivalent).
- Medicare no longer recognize or pay for services billed as:
  - Outpatient consult codes 99241-99245 or
  - Inpatient consult codes 99251-99255
- Bill “Equivalent Code” to Medicare (see later).
- Other payers still pay for Consult Codes.

Types of History

	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
(Formula)	(CC-1-0-0)	(CC-1-1-0)	(CC-4-2-1)	(CC-4-10-3)
History of Present Illness	1-3 descriptors	1-3 descriptors	4 descriptors or status of 3	4 descriptors or status of 3
R.O.S	0	1 related to problem	2-9 systems	10 systems
Past History: Medical, Social, Family	0	0	1 area	All 3 areas

"Chief Complaint" (CC) gives "medical necessity"

	New Level 5 Consult Level 5 Initial Hospital Level 3	New Level 4 Consult Level 4 Initial Hospital Level 2
History (All)	Chief Complaint HPI: 4 descriptors or 3 status ROS = 10 ← Limiting factor Past Hx: M,S,F = all 3	Chief Complaint HPI: 4 descriptors or 3 status ROS = 10 Past Hx: M,S,F = all 3
PE (All)	2 elements in 9 systems	2 elements in 9 systems
Decision (2 of 3)	Dx/Management options = 4 pts Data Complexity = 4 pts Risk (Dz/Test/Rp) = HIGH	Dx/Management options = 3 pts Data Complexity = 3 pts Risk (Dz/Test/Rp) = MODERATE

Title Color = Outpatient Service

Title Color = Inpatient Service

Comprehensive History

- Chief Complaint (gives “medical necessity”):
  - **Always Required**
- **History of Present Illness (HPI)**
  - **4 descriptors, or**
  - **status of 3 diseases**
- Review of Systems (R.O.S)
  - **10 systems**
- Past Hx: Medical, Family & Social
  - **All 3 areas**

History of Present Illness

Recognized Descriptors of Symptoms

- Location
- Quality
- Severity
- Duration
- Timing
- Context
- Modifiers
- Associated signs and symptoms

Point to Remember
Clinical History

- If the **clinical history can not be obtained** from the patient or other source (e.g.: patient in coma/ expressive aphasia/ intoxicated/ confused/ demented and alone), you should:
  - **Document the condition of the patient** and other circumstances and **receive full credit for a "comprehensive history"** {chief complaint, present illness (4), ROS (10) and Past M,S&F Hx (3)}

History of Present Illness
Clinical Vignettes

- **4 descriptors**:
  - A) 38 y/o with chronic HCV, Dx 1998 at blood donation. Has fatigue for 3 years **(duration)** , very intense **(severity)** over last 6 mo., better in the morning **(timing)** , helped by mid-afternoon nap **(modifier)**
  - B) Adult male, mute and unable to write, brings note and labs showing that has chronic HCV. **(full-history credit b/o impossibility to obtain more information)**

- **3 status**:
  - Patient has heartburn worsening in last month. DM with glucose 160-220. Hepatitis C with persistent fatigue.

Comprehensive History

- Chief Complaint (required)
- History of Present Illness
  - 4 descriptors or
  - status of 3 diseases)
- **Review of Systems (10 systems)**
- **Past History: Medical, Social & Family (3 areas)**

Recognized Areas for R.O.S. (14)

- Constitutional
- Skin
- Eyes
- Ear/Nose/Throat
- Respiratory
- Cardiovascular
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Lymphatic
- Psychiatric
- Neurologic
- Endocrine
- Hemo/Immune

You need to have at least 1 item in the system to be able to count it

Points to Remember
ROS

- **All positive findings in the ROS must be described.**

Points to Remember
ROS and Past M,F&S Hx

- ROS and Past M,S&F history can be obtained by ancillary personnel but **“a note by the physician should confirm or supplement the information”.**

Risk: “Positive” ROS

- You can obtain full credit for ROS and Past M,S&F history by actualizing the previous one (s), or stating “no change” **only if you describe the “date and location of previous ROS / Past M,S&F history note”**

Use of “Templates” can facilitate your documentation and remind you of the requirements of each “Level of Care”

There are approved “Templates” at UofL, Jewish, & Norton Hospitals

http://louisville.edu/medschool/medicine/gastro/hospitalforms.htm

CERNER & EPIC GI Consult Template History

- Reason of Consult or Chief Complaint:
  - .
- Present Illness: Main sign/symptom (**1/1/4/4/4 descriptors**): (location, quality, severity, duration, timing, context, modifiers, associated signs/symptoms)
  - .
  - *Unable to obtain Complete H.P.I., R.O.S., Past Medical, Social, nor Family History due to inability of the patient to give the information (due to medical condition: _) and because other reliable source is not available at this time: _ ;* (*when appropriate, write YES and describe condition, to request* Credit as Comprehensive History)
- Focused Past History: (**0/0/1/3/3 areas**)
  - Medical:
  - Social:
  - Family:

CERNER & EPIC GI Consult Template
History

- <u>R.O.S. Admission:</u> (**0/1/2/10/10 systems**)
  - Constitutional: No fever, no chills, no loss of appetite, no weight loss, no fatigue
  - Skin: No rash, no itching
  - Eyes: No blurred vision, no redness, no eye pain
  - HENT: No Tinnitus, no abnormal smell, no dysgeusia, no painful swallow
  - Respiratory: No dyspnea, no DOE, no orthopnea
  - Cardiovascular: No edema, no palpitations
  - GI: No nausea, no vomiting, no diarrhea, no blood in stool, no dysphagia
  - GU: No dysuria, no hematuria
  - Musculoskeletal: No leg cramps, no arthralgia
  - Lymphatic: No lymphadenopathy
  - Psych: No depression, no confusion
  - Neurological: No numbness, no tremor

In the R.O.S., delete the “no” in any positive findings

PHYSICAL EXAM

Sub-Types of Physical Exam (11)

- ***General Multi-System* (Recommended)**
- Cardiovascular
- Respiratory
- Genito-Urinary
- Hematologic/Lymphatic /Immunologic
- Neurological
- Dermatologic
- Musculoskeletal
- ENT
- *Psychiatric*
- *Ophthalmologic*

General Multisystem Exam
Recognized Systems (14)

- Constitutional
- Skin
- Eyes
- Ear/Nose/Throat
- Breast
- Neck
- Respiratory
- Cardiovascular
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Lymphatic
- Psychiatric
- Neurologic

Types of Multi-System Exam

	Focused	**Expanded Focused**	**Detailed**	**Comprehen-sive**
1997 Rules	**1** element	**6** elements	**12** elements	**2** elements **x** **9** areas
1995 Rules	1 element	1 element x 2 areas	All elements in 1 area plus 1	1 element x 8 areas

If you follow 1997 rules, minor deficiencies will be “protected” by 1995 rules

Multi-System Exam
Systems and Elements

- **Constitutional:** General appearance; 3 Vital Signs
- **Skin:** Inspection; Palpation.
- **Eyes:** Conjunct/lids; Pupils/Iris; Fundus.
- **HENT:** Ext. ear/nose; Hearing; Otoscopy; Rhynoscopy; Lips/Teeth/Gums; Oropharynx.
- **Breast:** Inspection; Palpation.
- **Neck:** Neck exam; Thyroid exam.
- **Respiratory:** Effort; Palpation; Percussion; Auscultation.
- **Cardiovascular:** Palpation; Auscultation; Carotids; Aorta; Femoral arteries; Pedal; varices/edema.

For a system to count, 2 or more of its elements have to be documented

Multi-System Exam
Systems and Elements

- **Abdomen:** General exam; Liver/Spleen; Hernia; Anus/Rectum/Perineum; FOBT if indicated (never).
- **GU Male:** Scrotal contents; Penis; Prostate.
- **GU Female:** External genitalia/vagina; Urethra; Bladder; Cervix; Uterus; Adnexa.
- **Lymphatic:** 2 or more of: Neck, Axillae, Groin, Other.
- **Musculoskeletal:** Gait/station; Digits/nails; Joints/bones & muscles of 1 area (head/neck; spine/ribs/pelvis; RU extremity; LU extremity; RL extremity; LL extremity).
- **Neurologic:** Cranial nerves; Deep tendon reflexes; Sensation testing.
- **Psychiatric:** Judgment/insight; Orientation; Memory; Mood/affect.

For a system to count, 2 or more of its elements have to be documented

Physical Exam Rules

- All **abnormal** physical exam findings **must be described.**

- All “pertinent-negative physical exam findings” should be described (e.g.: no splenomegaly)

CERNER & EPIC GI Consult P.E. Template

- **Physical exam:** (**1/6/12/2x9/2x9**)
  - Constitutional: No distress, Well developed (there are always >/= 3 vital signs in the chart)
  - Skin: Normal Inspection; Normal Palpation
  - Eyes: Normal conjunctiva/eyelids; Normal pupils/iris; Normal fundus
  - HENT: Normal external ear/nose; Normal lips/gums; Normal oropharynx
  - Neck: Normal neck inspection; Normal thyroid palpation
  - Respiratory: Normal Effort; Normal Palpation; Normal Percussion; Normal Auscultation
  - Cardiovascular: Normal palpation; Normal auscultation; Normal carotid pulses; Normal femoral pulses; Normal pedal pulses; Normal Aorta; No edema
  - Abdomen/GI: Normal general palpation/auscultation; Normal liver and spleen; No hernias; Normal rectal exam; FOBT not indicated
  - Lymphatic: Normal neck lymph nodes; Normal axillae lymph nodes; Normal groin lymph nodes
  - Musculoskeletal: Normal gait/station; Normal digits/nails
  - Neurologic: Normal craneal nerves; Normal deep tendon reflexes
  - Psychiatric: Normal judgment/insight; Normal orientation; Normal memory; Normal mood/affect

All abnormal findings should prompt deletion of “normal descriptor” + description of abnormality
Our template has 12 systems and only 9 of them are needed; you may delete the rest.

P.E.: Most relevant 9x2 (+1)

- **1) 3 vital signs (RN)**
- **1) General appearance**
- ***2) Skin inspection***
- ***2) Skin palpation***
- **3) Conjunctiva**
- **3) Pupils**
- ***4) Respiration effort***
- ***4) Lung auscultation***
- **5) Heart auscultation**
- **5) Edema**
- **6) Abdomen palpation**
- **6) Liver/spleen**
- ***7) Gait/station***
- ***7) Digits/nails***
- **8) Lymph nodes Neck**
- **8) Lymph nodes Axillae**
- ***9) Insight/judgment***
- ***9) Mood/affect***
- **(Male breast inspection)**
- **(Male breast palpation)**

Elements of Decision Making

(need only two)

- **Data Complexity**
- **Diagnosis / Management Options**
- **Risk (Disease/ Test/ Treatment)**

Levels of
Complexity of Data

- **Four levels** (counted by adding total points) **:**
  - **4 points** (Extensive) **,**
  - **3 points** (Moderate) **,**
  - **2 points** (Limited) **,**
  - **1 point** (Minimal) **.**

Amount & Complexity of Data

(Cabot Marsh Corp & Marshfield Clinic)

https://c.ymcdn.com/sites/www.txosteo.org/resource/resmgr/imported/EM%20AuditTool%20from%20Practicum.pdf

		ADD
Review/order Laboratory or Pathology test	1	
Review/order Radiology Test	1	
Review/order Medicine Test	1	
Discuss test result with performing MD: radiology, pathology, medicine (each type)	1x_	
Request old Record or Plan more History from other	1	
Summarize old Record or Obtain History from other	2	
Independent Review: image, tracing, biopsy (each type)	2x_	
	TOTAL=	

Extensive = 4 pts, Moderate = 3 pts, Limited = 2 pts, Minimal = 1 point

Points to Remember
Complexity of Data

- **Document:**
  - **Decision to obtain**:
    - **a)** more "History" from family/care-taker (1 point),
    - **b)** old records (1 point)
  - Results of **discussion with MD** who performed test (image, laboratory or diagnostic test) (1 point)
  - Direct **visualization & interpretation** of test (image, tracing, specimen) ***(describe your interpretation)*** (2 points).
  - **Relevant findings** from old records or additional history **must be documented** ("old records reviewed" is not enough). (2 points)

Levels of
Diagnosis and Management Options

- **There are Four Levels** (counted by adding total points) **:**
  - **4 points** (Extensive) ,
  - **3 points** (Multiple) ,
  - **2 points** (Limited) ,
  - **1 point** (Minimal)

Number of Diagnoses or Management Options

(Cabot Marsh Corp & Marshfield Clinic)

https://c.ymcdn.com/sites/www.txosteo.org/resource/resmgr/imported/EM%20AuditTool%20from%20Practicum.pdf

DIAGNOSIS CATEGORY	#	X	Points/each	=	ADD
Self limited Dx (MAXIMUM = 2)		X	**1**	=	
Establish Dx, stable/ better		X	**1**	=	
Establish Dx, worse		X	**2**	=	
New Dx, no w/u (MAXIMUM = 1)		X	**3**	=	
New Dx plus w/u		X	**4**	=	
				TOTAL	

Extensive = 4 pts, Multiple = 3 pts, Limited = 2 pts, Minimal = 1 point

Point to Remember

Number of Diagnoses

- **A) By status of multiple problems:**
  - 1) **Hepatitis C**: responding to therapy (1)
  - 2) **GERD**: symptoms worsening (2)
  - 3) **DM**: good control (1)
- **B) By differential diagnosis:**
  - **Epigastric pain**: PUD, vs GB dz., vs Pancreatitis, vs Gastritis. (4)

Not Recommended

RISK

of Complication, Morbidity or Mortality
from Disease Severity, Testing, or Management

- Points given by the ***single highest risk*** *(non-additive).*
- ***High Risk*** = 4 points
- ***Moderate Risk*** = 3 points
- ***Low Risk*** = 2 points
- ***Minimal Risk*** = 1 point

High Risk of Complication

Disease, Treatment or Management **(only one)** (4 points)

- **Ac/Ch illness w threat to life/body function**
- Drug with risk & monitoring
- Elective major surgery
- Chronic illness with severe exacerbation, progression or treatment side effect
- Cardiovasc imaging with contrast + risk
- Abrupt neuro change
- Severe side effect
- Elective endoscopy or surgery with risk
- DNR /De-escalate decision
- Emergency endoscopy surgery, angio, or Bx
- **Parenteral narcotic**
- **Cardiac EPS study**
- **Discography**

Likely to be Level 5 (Level 3 Initial Hospital Care)

Aids to Document Decision Making and Critical Care

- **Data**: (1/1/2/3/4)
- **Summary of Worked Data**: (**1/1/2/3/4points**)
  - **Studies Ordered or Reviewed (1 point):** ( ) Labs; ( ) Radiology; ( ) Medical Test; ( ) Requested old records or called other for more information.
  - **Studies Discussed with Performing Specialist (1 point):** ( ) Radiologist: _ ; ( ) Medical Test: _ ; ( ) Pathologist: _
  - **Studies Interpreted by our team (2 points):** Test and Interpretation: _
  - **Summarized Old Records (2 points):** Most important finding was: _
- **Impression/Diagnosis and Management**: (**1/1/2/3/4**)
  - [(New+W/U(4), New (3), Worsened (2), Stable (1), Improved (1), Self-Limited (1)]
- **RISK** (**Minimal/Minimal/Low/Moderate/High**):
- **Critical Care**: (“Dot phrases” (CERNER), or “Smart Phrases” (EPIC)

EPIC & CERNER CMS Risk Tables
HIGH

- Statement of RISK = **HIGH**: Due to Disease severity and/or required testing and/or management, the RISK of complications, morbidity and/or mortality is HIGH. Risk based in one or more of the following:
  - 1. One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment.
  - 2. Acute or chronic illnesses or injuries that pose a threat to life or bodily function.
  - 3. An abrupt change in neurologic status.
  - 4. Cardiovascular imaging studies with contrast with identified risk factors (TIPS).
  - 5. Cardiac electrophysiological tests.
  - 6. Diagnostic Endoscopies with identified risk factors.
  - 7. Discography.
  - 8. Elective major surgery (open/percutaneous/endoscopic) with identified risk factors.
  - 9. Emergency major surgery (open/percutaneous/endoscopic).
  - 10. Parenteral controlled substances.
  - 11. Drug therapy requiring intensive monitoring for toxicity (immunosuppression, IV Diuretics, Insulin).
  - 12. Decision not to resuscitate or to de-escalate care because of poor prognosis.

EPIC & CERNER CMS Risk Tables
MODERATE

- Statement of RISK = **MODERATE**: Due to Disease severity and/or required testing and/or management, the RISK of complications, morbidity and/or mortality is MODERATE. Risk based in one or more of the following:
  - 1. One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment.
  - 2. Two or more stable chronic illnesses.
  - 3. Undiagnosed new problem with uncertain prognosis.
  - 4. Acute illness with systemic symptoms.
  - 5. Acute complicated injury.
  - 6. Physiologic tests under stress (any cardiac stress test, ACTH Stim Test),
  - 7. Diagnostic endoscopies with no identified risk factors.
  - 8. Deep needle or incisional biopsy.
  - 9. Cardiovascular imaging studies with contrast and no identified risk factors.
  - 10. Obtain fluid from body cavity.
  - 11. Minor surgery with identified risk factors.
  - 12. Elective major surgery with no identified risk factors.
  - 13. Prescription drug management.
  - 14. Therapeutic nuclear medicine
  - 15. IV fluids with additives (K, Mg, MVI, TPN).
  - 16. Closed treatment of fracture or dislocation without manipulation.

EPIC & CERNER CMS Risk Tables
LOW

- Statement of RISK = **LOW**: Due to Disease severity and/or required testing and/or management, the RISK of complications, morbidity and/or mortality is LOW. Risk based in one or more of the following:
  - 1. Two or more self-limited or minor problems.
  - 2. One stable chronic illness.
  - 3. Acute uncomplicated illness or injury.
  - 4. Physiologic tests not under stress.
  - 5. Non-cardiovascular imaging studies with contrast.
  - 6. Superficial needle biopsies.
  - 7. Clinical laboratory tests requiring arterial puncture.
  - 8. Skin biopsies.
  - 9. Over-the-counter drugs.
  - 10. Minor surgery with no identified risk factors.
  - 11. Physical therapy.
  - 12. Occupational therapy IV fluids without additives.

EPIC & CERNER CMS Risk Tables
MINIMAL

- Statement of RISK = **MINIMAL**: Due to Disease severity and/or required testing and/or management, the RISK of complications, morbidity and/or mortality is MINIMAL. Risk based in one or more of the following:
  - 1. One self-limited or minor problem.
  - 2. Laboratory tests requiring venipuncture.
  - 3. Chest x-rays.
  - 4. EKG/EEG.
  - 5. Urinalysis.
  - 6. Ultrasound.
  - 7. Rest.
  - 8. Gargles.
  - 9. Elastic bandages.
  - 10. Superficial dressings.

Initial Hospital Care L3 or In-patient Consult L5 vs Critical Care L1

- **Some "Initial Hospital Care L3" or "In-Patient Consult L5" may be "Critical Care L1" if :**
  - **The patient is "critically ill, or injured with high probability of life threatening deterioration" , and**
  - **The Attending expends 30 minutes or more taking care of the patient**
- Initial Hospital Care L3 = 4.12 RVU,
- In-Patient Consult L5 = 5.15 RVU, and
- Critical Care L1 = 5.44 RVU

	New Level 5 Consult Level 5 Initial Hospital Level 3	New Level 4 Consult Level 4 Initial Hospital Level 2
History (All)	Chief Complaint HPI: 4 descriptors or 3 status ROS = 10 systems Past M,S,F = all 3 areas	Chief Complaint HPI: 4 descriptors or 3 status ROS = 10 systems Past M,S,F = all 3 areas
PE (All)	2 elements in 9 systems	2 elements in 9 systems
Decision (2 of 3)	Dx/Management options = 4 pts Data Complexity = 4pts Risk (Dz/Test/Rp) = HIGH	Dx/Management options = 3 pts Data Complexity = 3 pts Risk (Dz/Test/Rp) = MODERATE

Title Color = Outpatient Service

Title Color = Inpatient Service

Moderate Risk of Complication

Disease, Treatment or Management (3 points)

- **Prescription drug**
- 2 Chronic Stable illness
- Chronic illness w mild exacerbation
- Liver or kidney Bx
- Undiagnosed problem w. uncertain prognosis
- Elective major surgery
- Minor surgery w risk
- Acute illness w systemic symptoms.
- Obtain fluid from cavity
- Dx. Endoscopy/ cardiac cath w/o risk
- Cardiac Stress Test
- **IV fluids + additives (K, Mg, P, TPN, vitamins)**

Likely to be Level 4 (Level 2 Initial Hospital Care)

	New Level 3 Consult Level 3 Initial Hospital Level 1	New Level 2 Consult Level 2	New Level 1 Consult Level 1
History (All)	**Chief Complaint** **4 descriptors or 3 status** **ROS = 2- 9** **Past M,S,F = 1**	**Chief Complaint** **1 descriptor** **ROS = 1**	**Chief Complaint** **1 descriptor**
PE (All)	12 elements	6 elements	1 element
Decision (2 of 3)	**Dx/Mgmt options = 2 pts** **Data Complexity = 2 pts** **Risk (Dz/Test/Rp) = LOW**	**Dx/Mgmt options = 1 pt** **Data Complexity = 1 pt** **Risk (Dz/Test/Rp) = MINIMAL**	**Dx/Mgmt options = 1 pt** **Data Complexity = 1 pt** **Risk (Dz/Test/Rp) = MINIMAL**

Low Risk of Complication

Disease, Treatment or Management (2 points)

- **OTC drugs**
- **Diet**
- One stable Ch. Illness
- Acute uncomplicated illness
- Two or more self-limited illness
- Pulmonary Function test
- Arterial puncture
- **IV fluids w/o additives**
- Non-cardiovascular radiographies w contrast
- Physical/Occupational therapy.

Likely to be Level 3 (Level 1 Initial Hospital Care)

Minimal Risk of Complication (1 point)

- **Venipuncture** (laboratory tests)
- **Rest**
- **Urine analysis**
- Self limited or minor problem
- X-Ray without contrast
- Ultrasound
- EKG, EEG, Gargle,dressing, …
- Superficial wound dressing

Likely to be Level 2 or 1

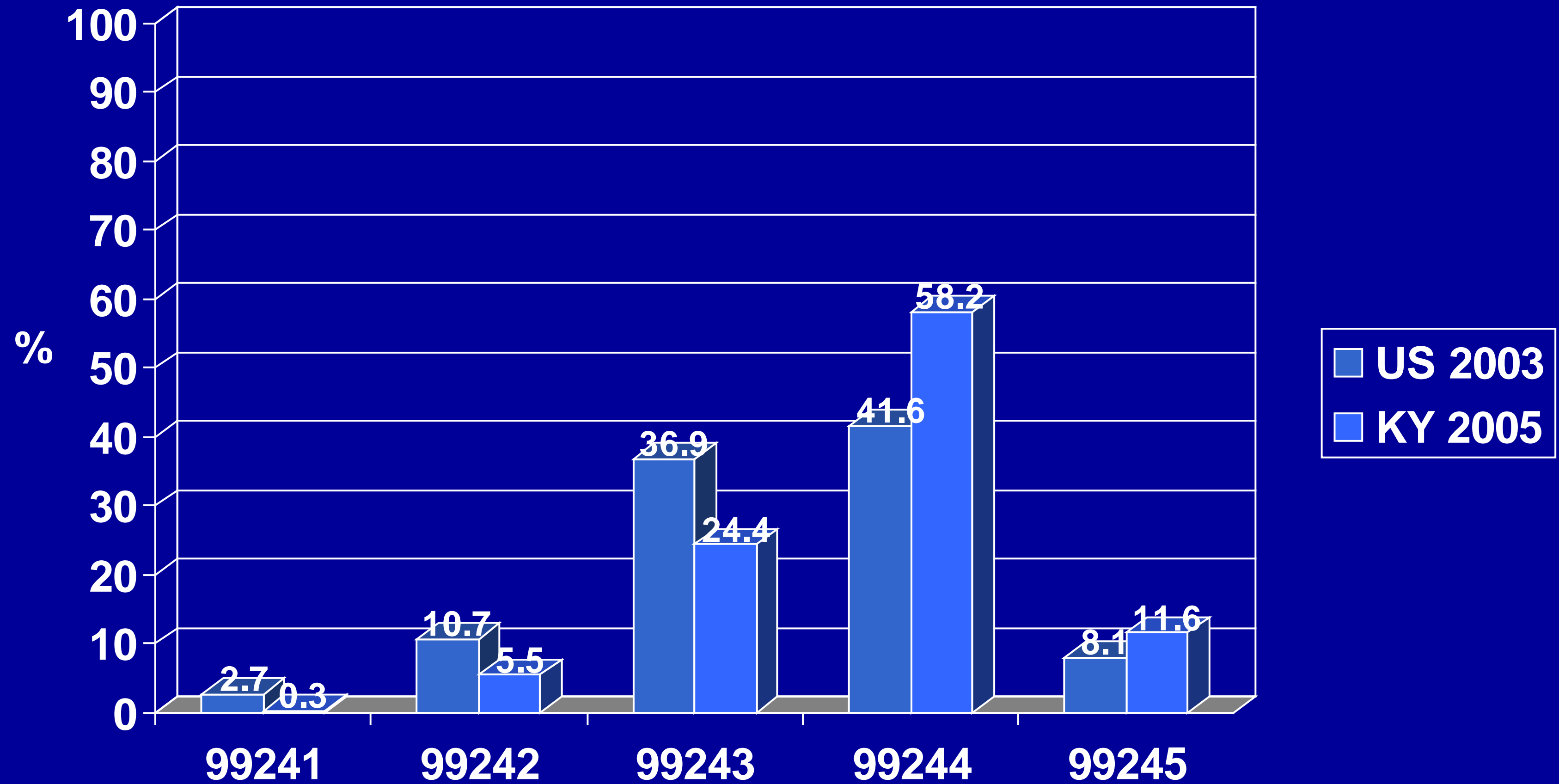
Office & Hospital Services

Equivalence to bill consults to Medicare

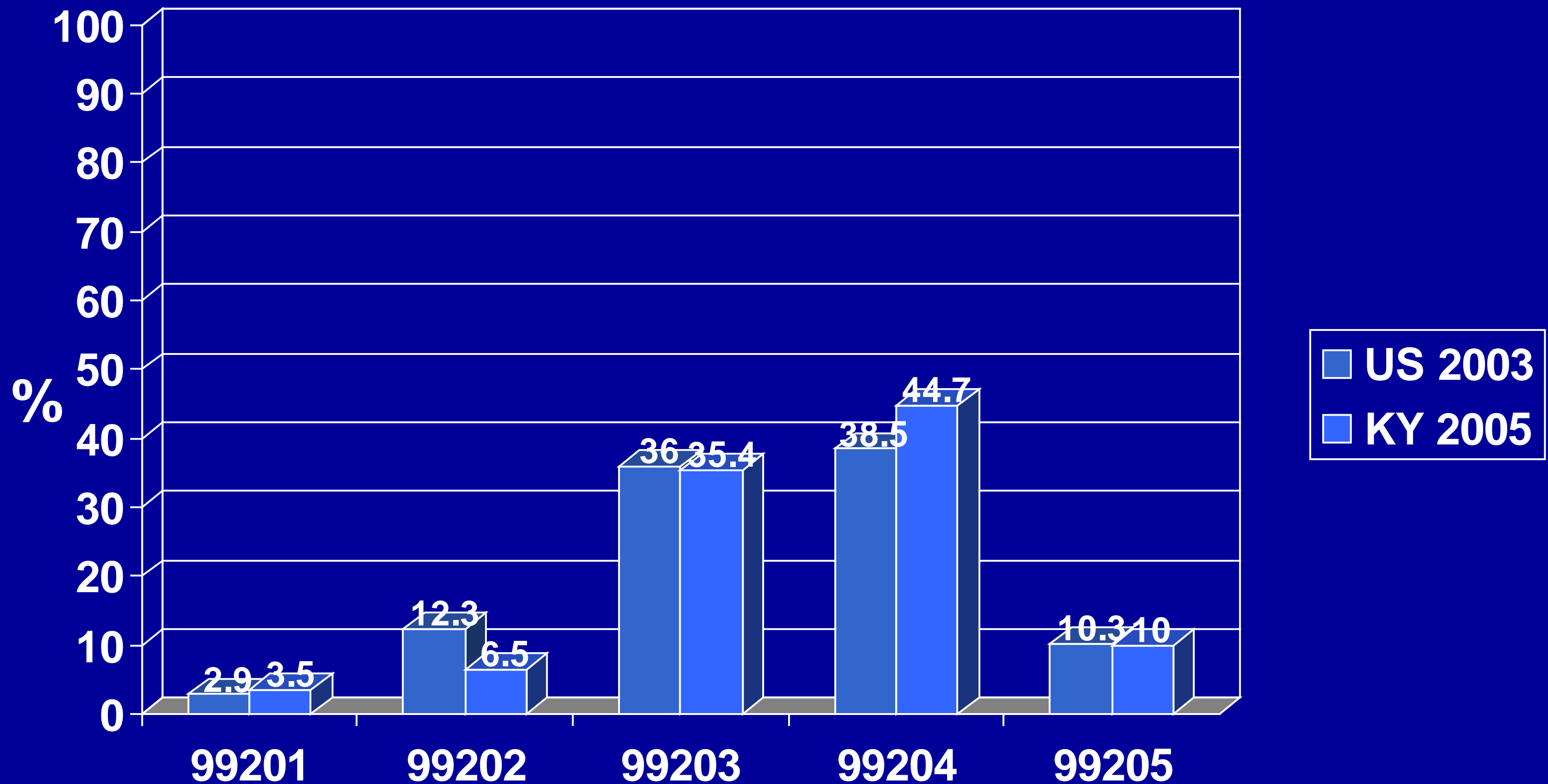
	OP New-5 **(99205)** (60 minutes)	**OP New-4** **(99244)** (45 minutes)	**OP New-3** **(99243)** (30 minutes)	**OP New-2** **(99242)** (20 minutes)	**OP New-1** **(99241)** (10 minutes)
	OP Consult-5 **(99245)** (80 minutes)	**OP Consult-4** **(99244)** (60 minutes)	**OP Consult-3** **(99243)** (40 minutes)	**OP Consult-2** **(99242)** (30 minutes)	**OP Consult-1** **(99241)** (15 minutes)
	IP Consult-5 **(99255)** (110 minutes)	**IP Consult-4** **(99254)** (80 minutes)	**IP Consult-3** **(99253)** (55 minutes)	**IP Consult-2** **(99252)** (40 minutes)	**IP Consult-1** **(99251)** (20 minutes)
	Initial Hosp-3 **(99223)** (70 minutes)	**Initial Hosp-2** **(99222)** (50 minutes)	**Initial Hosp-1** **(99221)** (30 minutes)		
History	Comprehensive (CC-4-10-3)	Comprehensive (CC-4-10-3)	Detailed (CC-4-2-1)	Expanded Focused (CC-1-1-0)	Focused (CC-1-0-0)
Physical Exam	Comprehensive (2x9)	Comprehensive (2x9)	Detailed (12)	Expanded Focused (6)	Focused (1)
Decision Making	High (4-4)	Moderate (3-3)	Low (2-2)	Straightforward (1-1)	Straightforward (1-1)

If you do a Hospital Consult Level 1 or 2 in a Medicare Patient, it cannot be billed

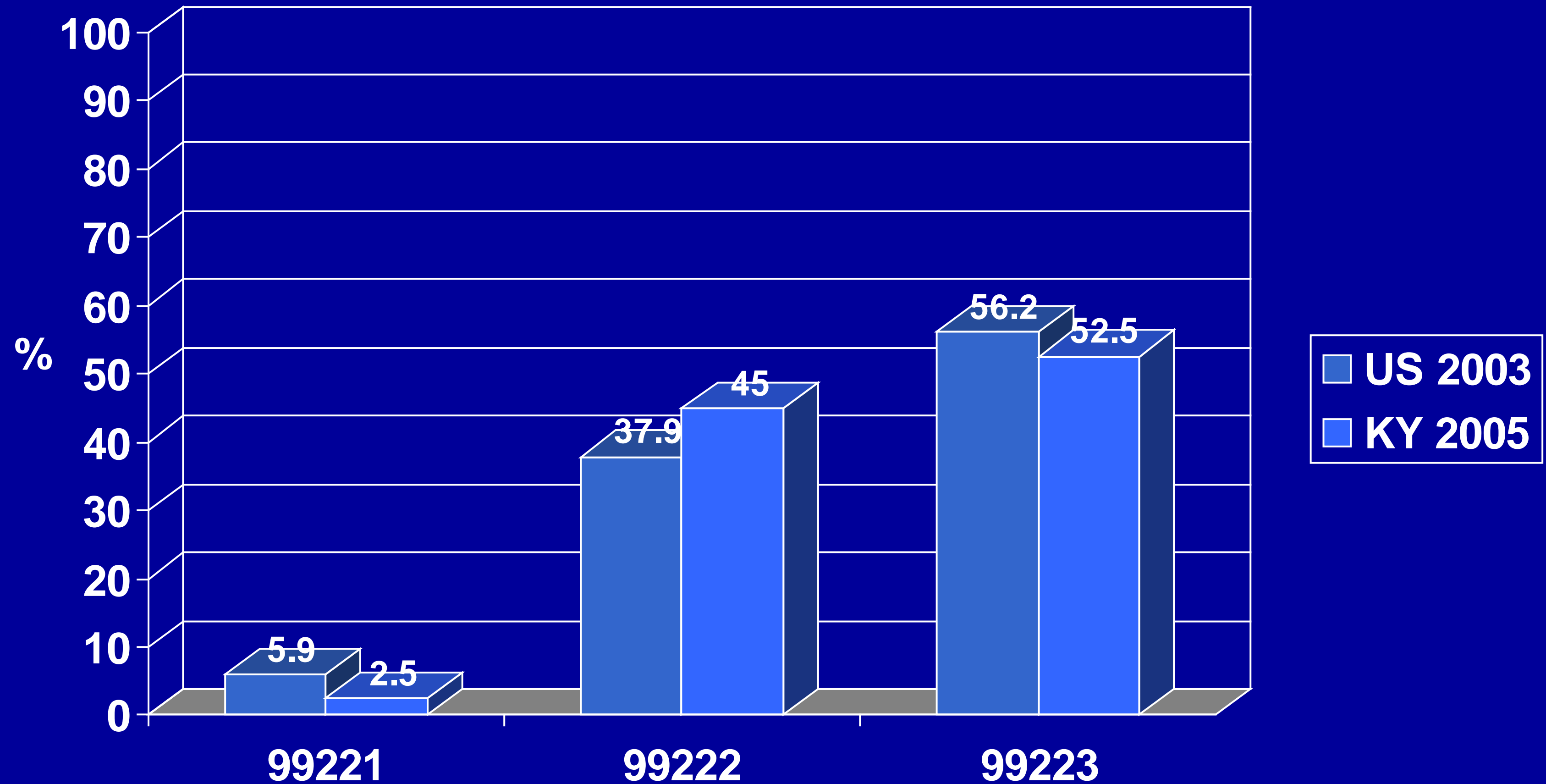
Office Consult (8%)
GI National Medicare 2003



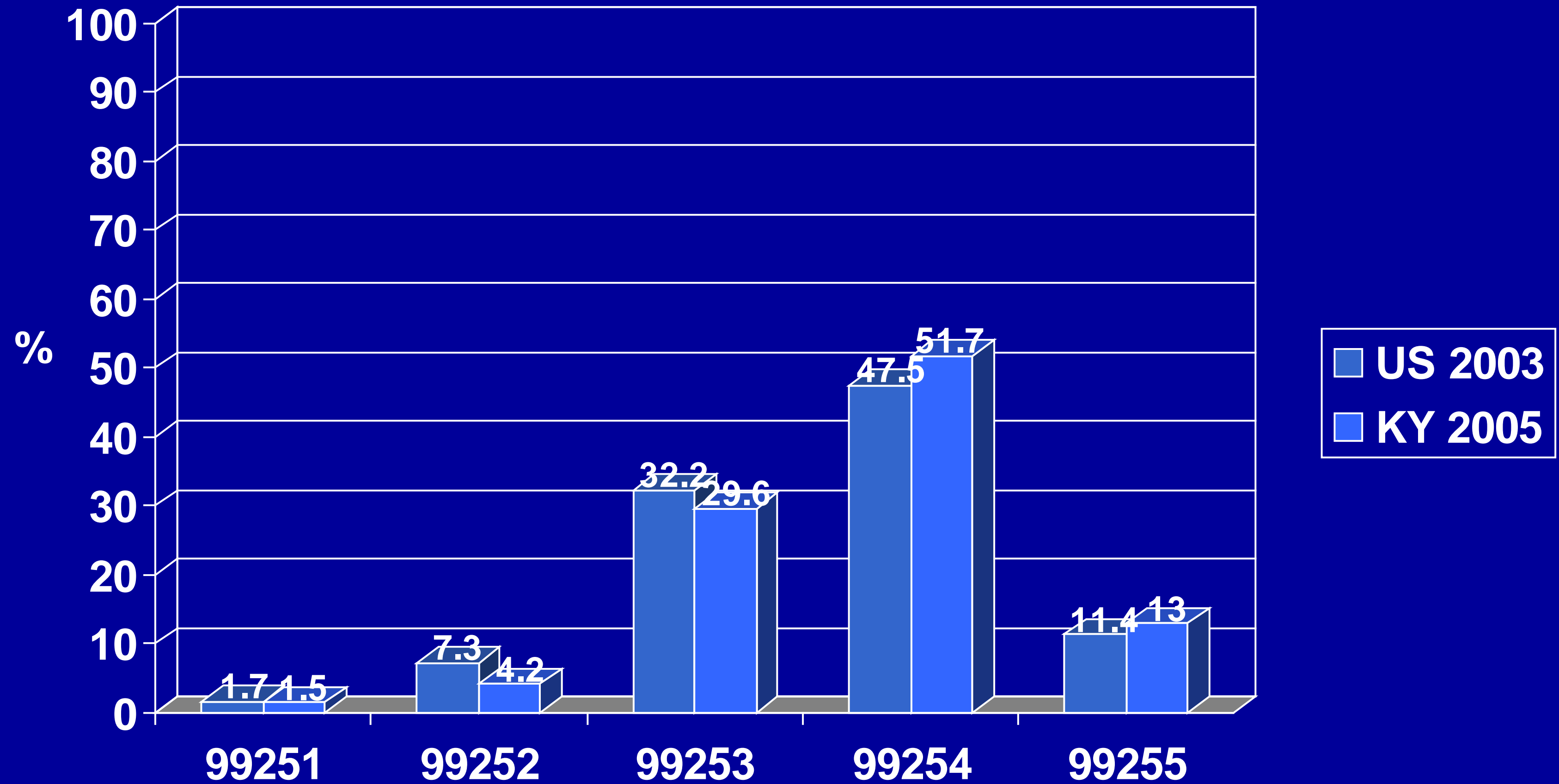
New Outpatient (2%)
GI National Medicare 2003



Initial Hospital Care (2%) GI National Medicare 2003



Inpatient Consult (10%) GI National Medicare 2003



Established Patient Subsequent Hospital Care

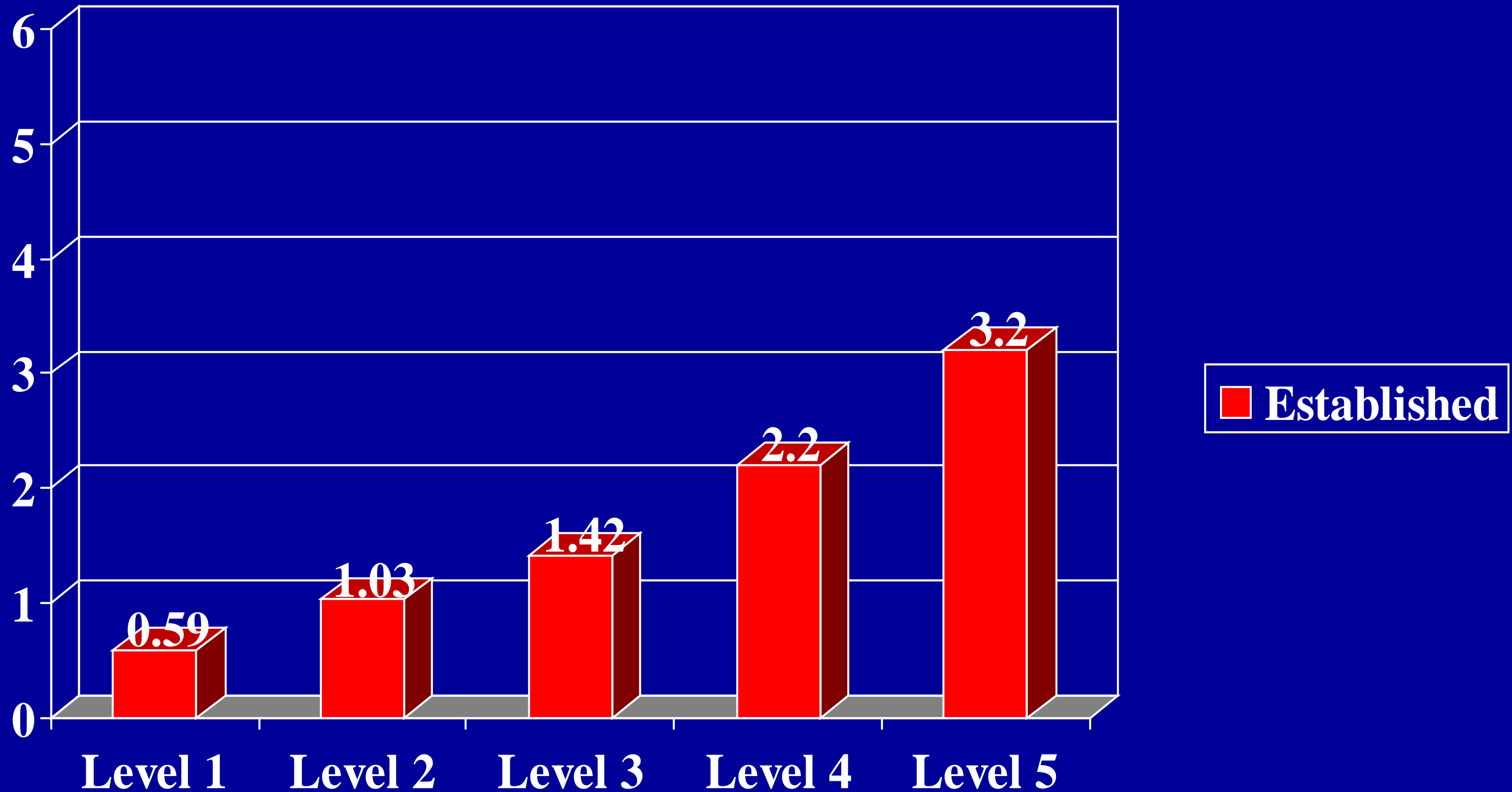
ONLY 2 COMPONENTS ARE REQUIRED

LEVEL = {lower of the TWO HIGHER components}

(History, Physical Exam, Decision Making)

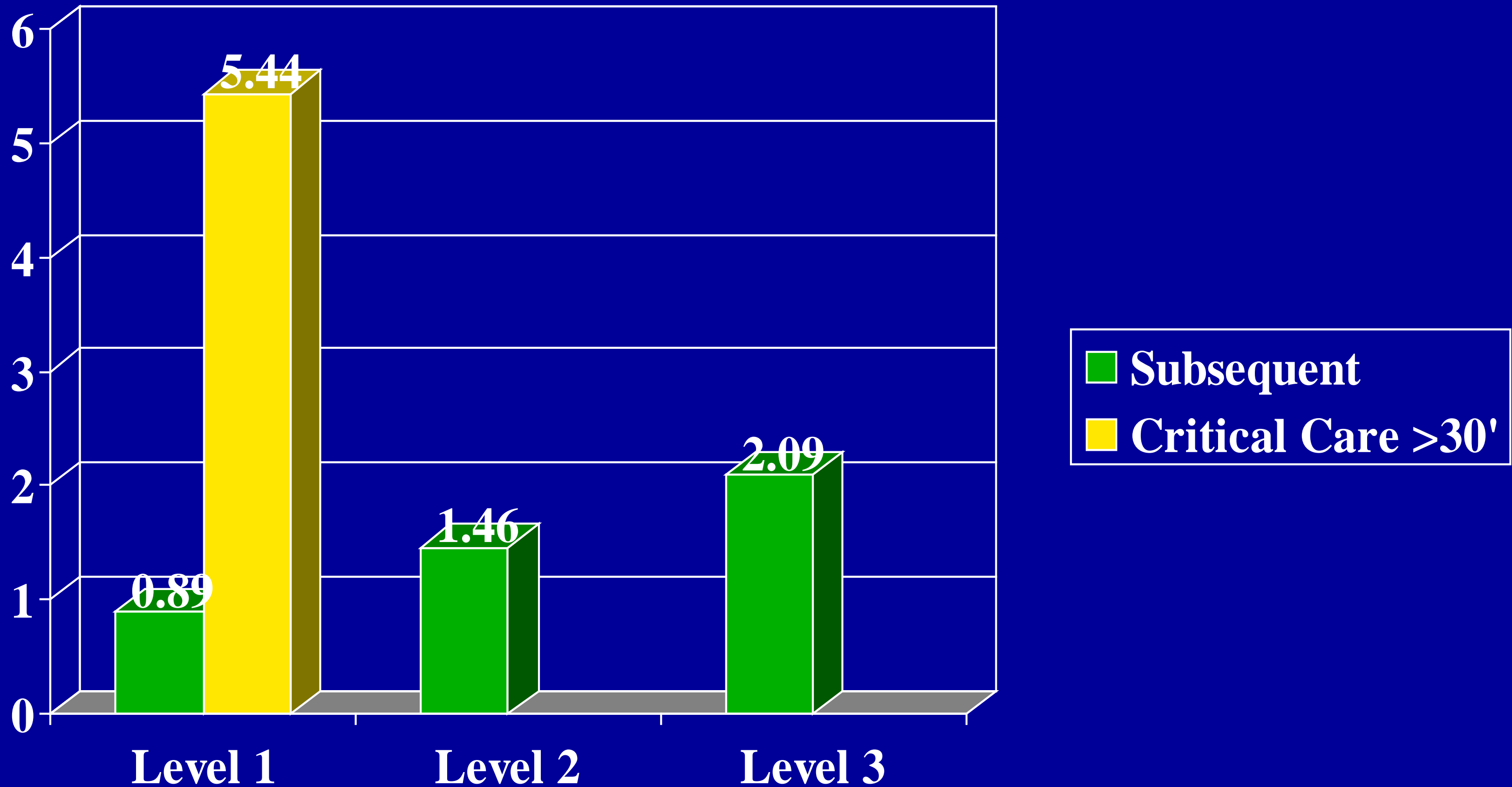
Established Clinic Patients

Out-Patient RVU



Subsequent Hospital Care vs Critical Care > 30 min

In-patient RVU



	Established Level 5	Subsequent Level 3
History (All)	Chief Complaint 4 descriptors or 3 status ROS = 10 Past M,S,F = all 3	Chief Complaint 4 descriptors or 3 status ROS = 2 - 9 Past M,S,F = 1
PE (All)	2 elements in 9 systems	12 elements
Decision (2 of 3)	Dx/Management options = 4 pts Data Complexity = 4pts Risk (Dz/Test/Rp) = HIGH	Dx/Management options = 4 pts Data Complexity = 4 pts Risk (Dz/Test/Rp) = HIGH

Limiting Factor

ONLY 2 of 3 COMPONENTS ARE REQUIRED

High Risk

of Disease/Treatment/ Management **(only one)** (4 points)

- **Ac/Ch illness w threat to life/body function**
- Drug with risk & monitoring
- Elective major surgery
- Chronic illness with severe exacerbation
- Abrupt neuro change
- Severe side effect
- Dx Endoscopy / cardiac cath. with risk
- DNR decision
- Emergency endoscopy surgery, angio, or Bx
- **Parenteral narcotic**

Likely to be Level 5 (Level 3 Hospital F/U)

Actualizing Past M,F&S Hx
Subsequent Hospital Care

- Daily changes in Family and/or Social Hx are extremely unlikely.
- You can describe changing events in Past Hx (which are not clinical hx nor physical exam):
  - **Fluid input/output**
  - **Weight change**
  - **Number of bowel movements**
  - **Day # post-op, or day # of X-drug**
  - **New allergic reaction/ adverse drug event**
  - **Medication Changes /medchanges**

CERNER & EPIC GI Subsequent Care Template

- History: (1/1/4)
  - *Unable to obtain Complete H.P.I., R.O.S., Past Medical, Social, nor Family History due to inability of the patient to give the information (due to medical condition: _) and because other reliable source is not available at this time: _ ; (when appropriate, write YES and describe condition, to request* Credit as Comprehensive History)
- ROS: (0/1/2)
- Constitutional: No fever; No anorexia
- Respiratory: No dyspnea; No cough
- Cardiovascular: No palpations; No edema
- GI: No nausea; No diarrhea
- PMFS Hx: (0/0/1)
- /medchanges (CERNER); I/O's (EPIC)

All Abnormal ROS or PE findings should prompt deletion of "normal" descriptor + description of abnormality

CERNER & EPIC GI Subsequent Care Template

- Physical Exam: (1/6/12)
- Constitutional: No distress
- Skin: Normal Inspection; Normal Palpitation
- Respiratory: Normal Effort; Normal Palpation; Normal Percussion; Normal Auscultation
- Cardiovascular: Normal palpation; Normal auscultation; No varices or edema
- Abdomen: Normal general palpation/auscultation; Normal liver and spleen
- Lymphatic: Normal neck lymph nodes; Normal axillae lymph nodes
- Psychiatric: Normal judgment/insight; Normal orientation; Normal memory; Normal mood/affect
- Data: (2/3/4)
- IMPRESSION/DX: (2/3/4) [(New + W/U (4), New (3), Worsened (2), Stable (1), Improved (1), Self-Limited (1)]
- RISK STATEMENT: (Minimal/Moderate/High)
- CRITICAL CARE STATEMENT:
- ATTENDING ATTESTATION:

P.E.: 12 most clinically valuable
Subsequent Hospital Care

- 3 vital signs (RN)
- General appearance
- Conjunctiva
- Respiration effort
- Lung auscultation
- Heart auscultation
- Edema
- Abdomen palpation
- Liver/spleen
- Orientation
- Insight/judgment
- Mood/affect

Subsequent L3 vs Critical Care L1

- Remember, some "Subsequent Hospital Care L3", may be "Critical Care L1" if :
  - The patient is "critically ill/injured with high probability of life threatening deterioration", **and**
  - The Attending expends 30 minutes or more taking care of the patient

- Subsequent Hospital Care L3 = 2.09 RVU,
- Critical Care L1 = 5.44 RVU

Concurrent “Subsequent Care”

http://www.cms.hhs.gov/Manuals/IOM/list.asp

(Rev. 2282, 08-26-11)

- If two physicians are each responsible for a different aspect of the patient’s care, Medicare will pay both visits if the physicians are:
  - in different specialties, **and**
  - the visits are billed with different diagnoses.
- There are circumstances where concurrent care may be billed by physicians of the same specialty.

	Established Level 4	Subsequent Level 2
History (All)	Chief Complaint 4 descriptors or 3 status ROS = 2-9 Past M,S,F = 1	Chief Complaint 1 descriptor ROS = 1
PE (All)	12 elements	6 elements
Decision (2 of 3)	Dx/Management options = 3 pts Data Complexity = 3 pts Risk (Dz/Test/Rp)= MODERATE	Dx/Management options = 3 pts Data Complexity = 3 pts Risk (Dz/Test/Rp)= MODERATE

ONLY 2 of 3 COMPONENTS ARE REQUIRED

Moderate Risk of Complication (3 points)

- **Prescription drug**
- 2 Chronic Stable illness
- Chronic illness w mild exacerbation
- Liver or kidney Bx
- Undiagnosed problem w. uncertain prognosis
- Elective major surgery
- Angiography with contrast
- Minor surgery w risk
- **Acute illness w systemic symptoms.**
- Obtain fluid from cavity
- Dx. Endoscopy/ cardiac cath w/o risk
- Cardiac Stress Test
- **IV fluids + additives (K, Mg, P, TPN, vitamins)**
- **Therapeutic Nuclear Medicine**

Likely to be Level 4 (Level 2 Hospital F/U)

	Established Level 3	Established Level 2 Subsequent Level 1	Established Level 1 (Done by RN when MD in premises)
History **(All)**	**Chief Complaint** **1 descriptor** **ROS = 1**	**Chief Complaint** **1 descriptor**	**Chief Complaint** **1 descriptor**
PE **(All)**	6 elements	1 element	1 element
Decision **(2 of 3)**	**Dx/Mgmt options = 2 pts** **Data Complexity = 2 pts** **Risk (Dz/Test/Rp) = LOW**	**Dx/Mgmt options = 1 pt** **Data Complexity = 1 pt** **Risk (Dz/Test/Rp) = MINIMAL**	**Dx/Mgmt options = 0-1 pt** **Data Complexity = 0-1 pt** **Risk (Dz/Test/Rp) = NONE or MINIMAL**

ONLY 2 of 3 COMPONENTS ARE REQUIRED

Low Risk of Complication (2 points)

- **OTC drugs**
- **Diet**
- **One stable Ch. Illness**
- Acute uncomplicated illness
- Two or more self-limited illness
- IV fluids w/o additives
- Pulmonary Function test
- Arterial puncture
- Radiographies w contrast
- Physical/Occupational therapy.

Likely to be Established Level 3

Minimal Risk of Complication (1 point)

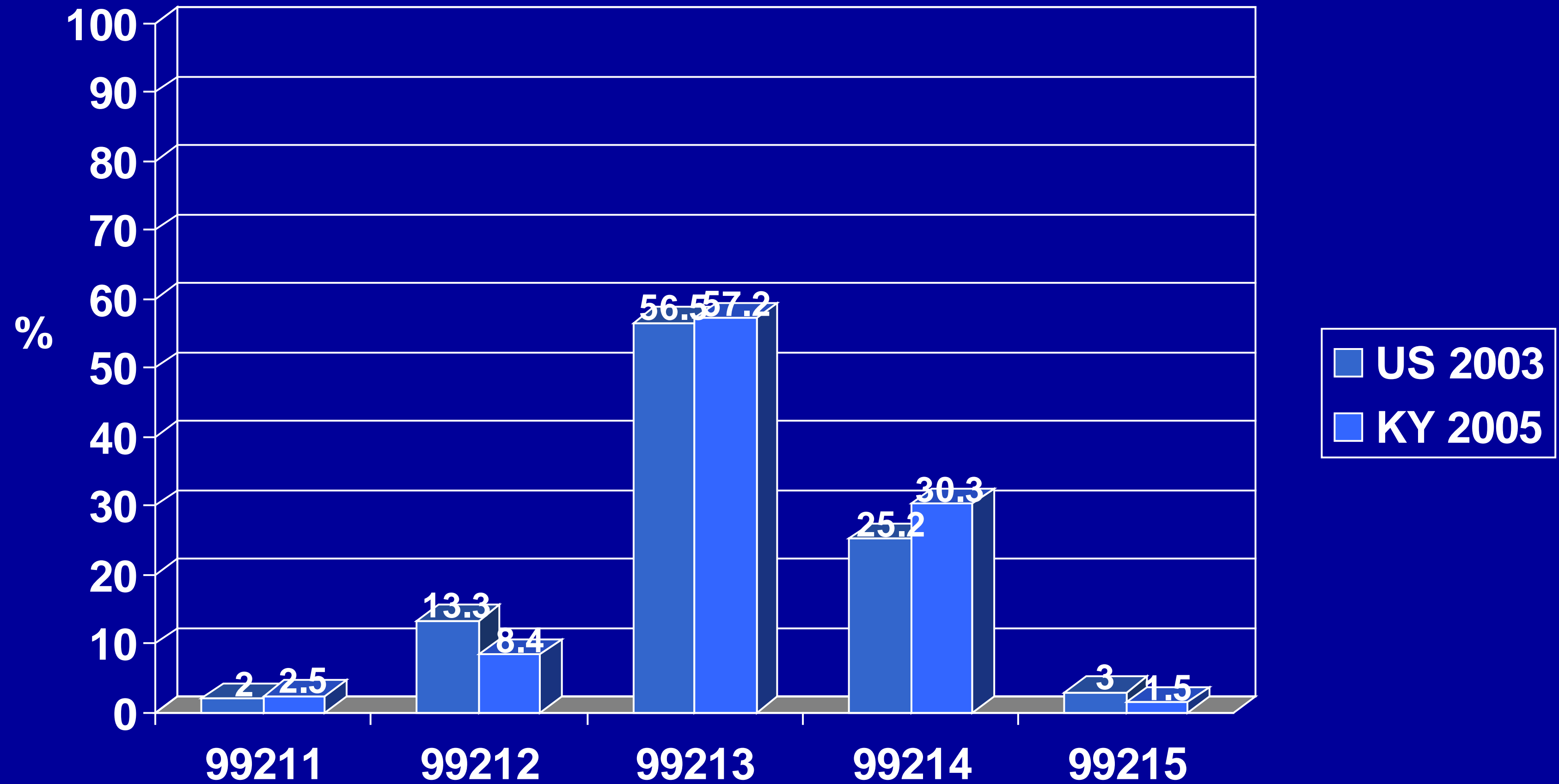
- **Venipuncture** (laboratory tests)
- **Rest**
- **Urine analysis**
- Self limited or minor problem
- X-Ray without contrast
- Ultrasound
- EKG, EEG, Gargle,dressing, …

Likely to be Level 2 (Level 1 Hospital F/U)

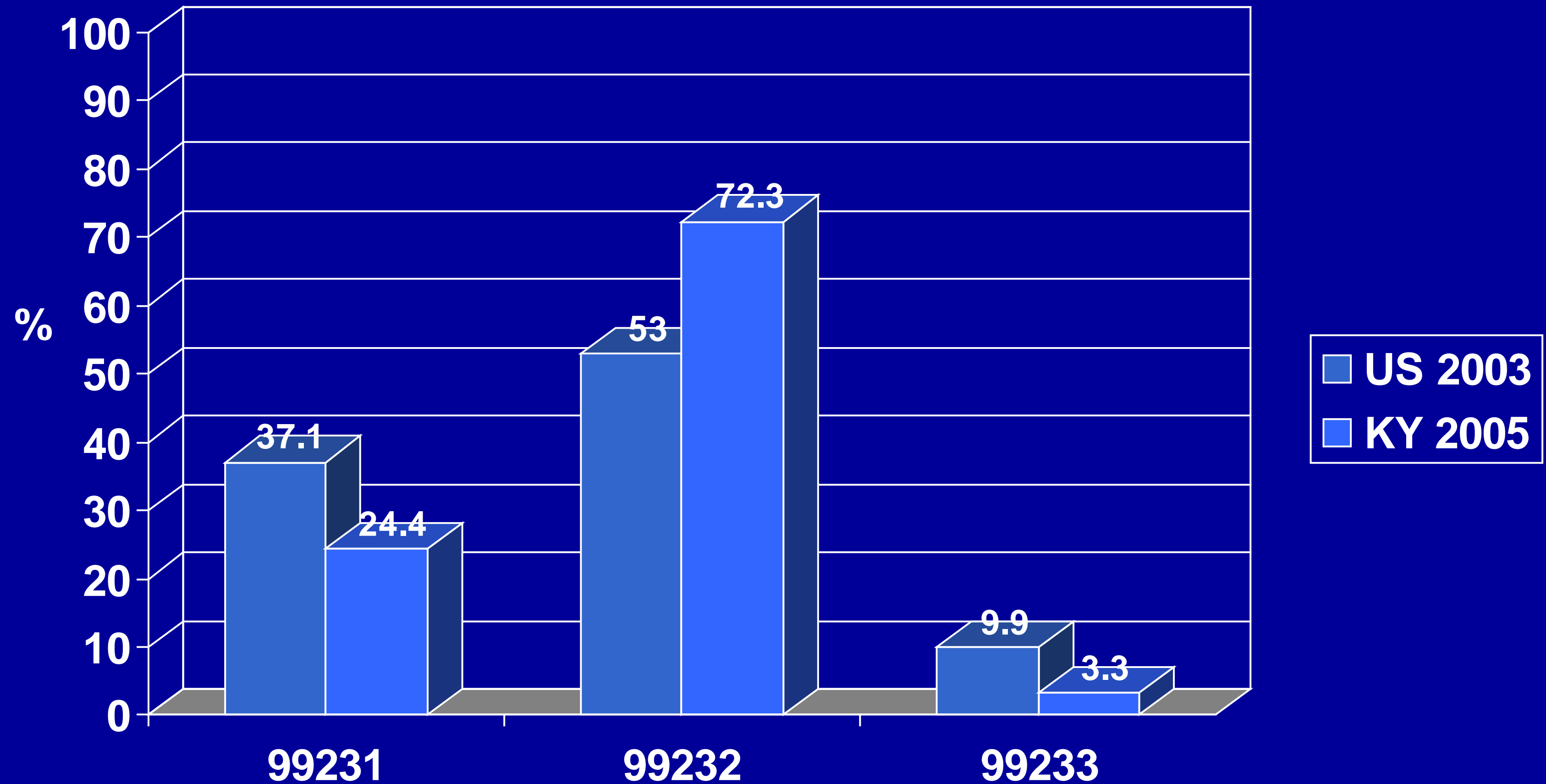
Established Office
Subsequent Hospital

	Established 5 (99215) (40 minutes)		**Established 4 (99214)** (25 minutes)		**Established 3 (99213)** (15 minutes)	**Established 2 (99212)** (10 minutes)	**Established 1 (99211)** (5 minutes)
		Subsequent 3 (99233) (35 minutes)		**Subsequent 2 (99232)** (25 minutes)		**Subsequent 1 (99231)** (15 minutes)	
History	Comprehensive (CC-4-10-3)	Detailed (CC-4-2-1)	Detailed (CC-4-2-1)	Expanded Focused (CC-1-1-0)	Expanded Focused (CC-1-1-0)	Focused (CC-1-0-0)	RN only 1
Physical Exam	Comprehensive (2x9)	Detailed (12)	Detailed (12)	Expanded Focused (6)	Expanded Focused (6)	Focused (1)	RN only 1
Decision Making	High (4-4)	High (4-4)	Moderate (3-3)	Moderate (3-3)	Low (2-2)	Straightforward (1-1)	

Established Outpatient (44%)
GI National Medicare 2003



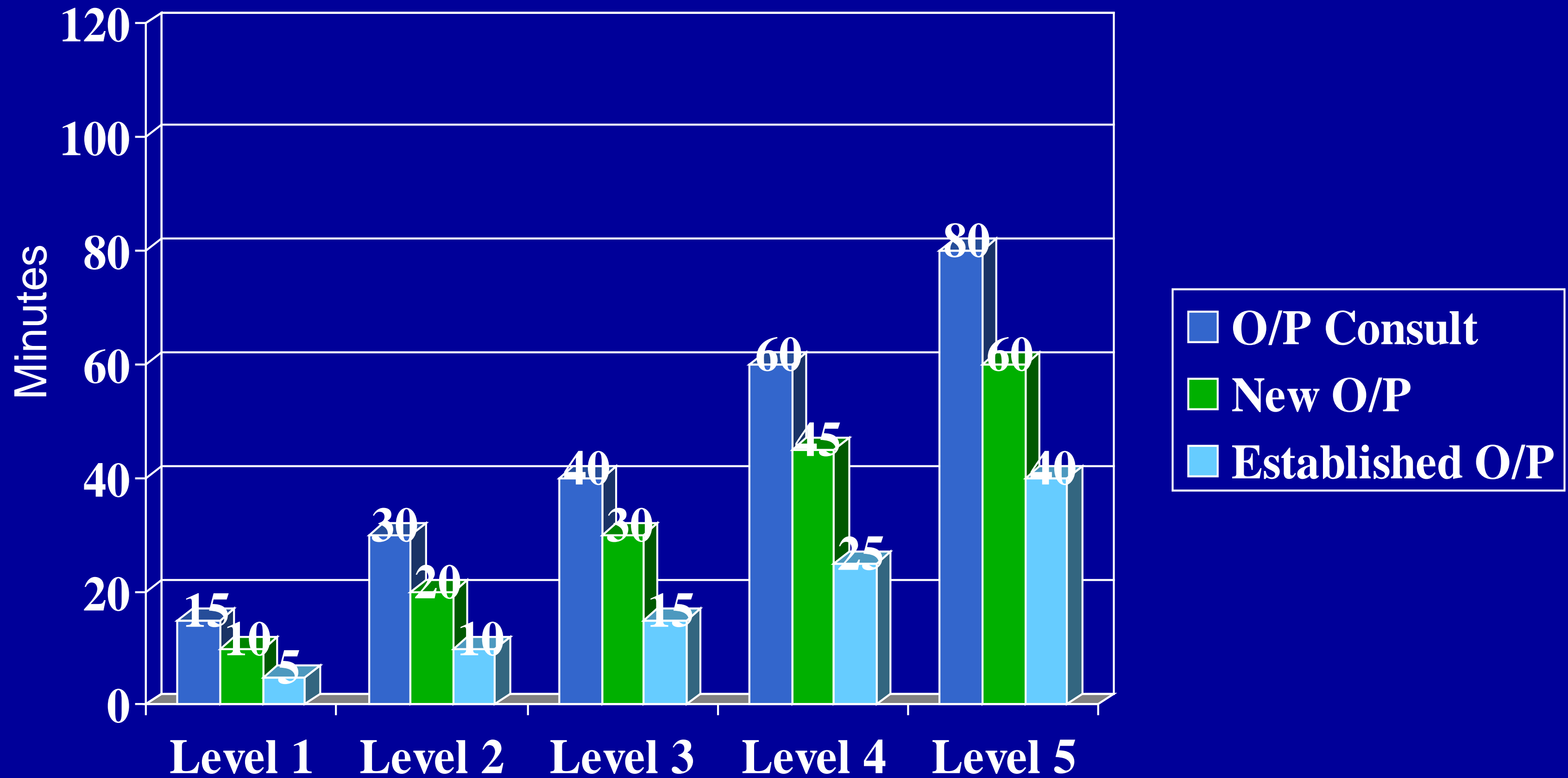
Subsequent Hospital (34%)
GI National Medicare 2003



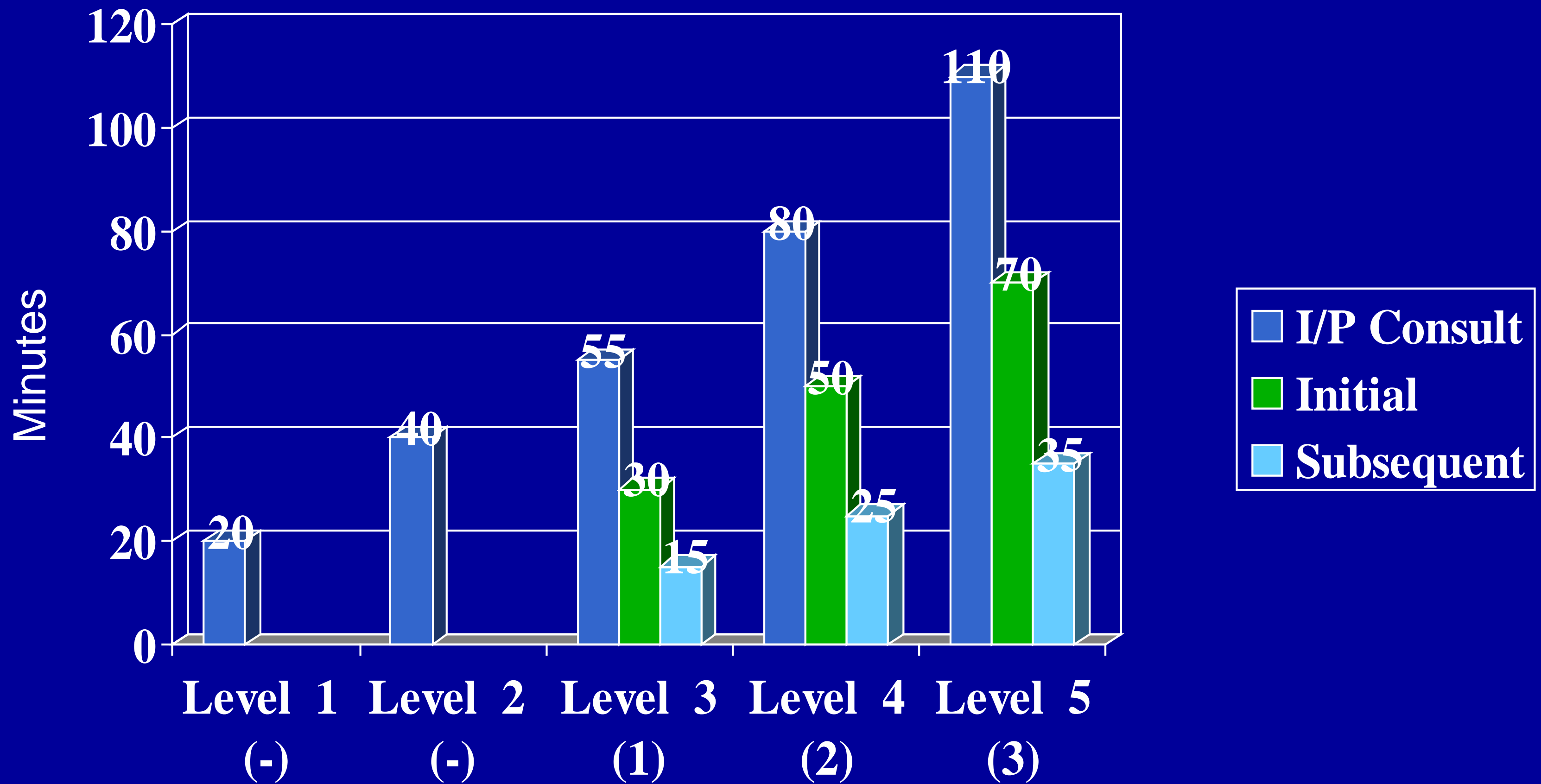
E&M with Counseling Predominance

- **If more than 50% of the "face-to-face" time was utilized for counseling**, you can bill by time.
- The "bill by time" scale is very low and, unless your documentation of other aspects of the encounter is limited, you should not bill by time.
- Only "ATTENDING PHYSICIAN" TIME can be counted (Fellow, Resident, Intern, P.A., A.R.N.P., or Student time does not count)
- Payment: a) Facility = 3.6 RVU/h ($134)
  b) Non-Facility = 5.1 RVU/h ($190)

Out-Patients
E&M Level by Time (minutes)



In-Patients
E&M Levels by Time (minutes)



Critical Care E&M

(critically ill/injured with high probability of life threatening deterioration)

- Independent of Location (ICU, vs ER, vs Ward)
- Defined by TOTAL TIME OF "ATTENDING MD" FULL ATTENTION (if =/> 30 minutes)
- **TIME**:
  - **A)** Continuous or not (add all of them),
  - **B)** At bedside or elsewhere in the floor, ***but*** immediately available,
  - **C)** Time for "Separately Billable Procedure" can not be counted.
- **99291**: First 30 to 74 min (5.44 RVU vs 4.12 for Initial Care-L3, and vs 2.09 for Subsequent Care-L3)
- **99292**: Each additional 30 min or fraction (1-30 minutes) over the initial 74 minutes (2.71 RVU, each)

For 78 min critical care you bill: 99291 + 99292 = 9.56 RVU

Procedures Included in Critical Care Service
(do not bill separately)

- Cardiac output by dilution (93561-2)
- Chest X-Ray interpretation
- Pulse Oxymetry
- Interpretation of Data Stored in Computer (EKG, BP, CBC,…)
- Temporary transcutaneous pacing
- Management of Ventilation (94656-62)
- Peripheral IV access, venipuncture, arterial puncture.
- Naso-gastric / oro-gastric tube placement.

No Consult Services For Medicare since 2010

- You cannot bill for consult in Medicare patients starting in 2010.
- Inpatient consults are billed under “Initial Hospital Care” codes.
- Outpatient Consults are billed depending if patient is:
  - “New” to the practice (no “face to face” service by anyone in the practice over the last 3 years) or
  - “Established” to the practice (any “face to face” service over the last 3 years)

Equivalency Table for In-Patient “No Medicare Consult” Services

Original	**IP Consult-5 (99255)** (110 minutes)	**IP Consult-4 (99254)** (80 minutes)	**IP Consult-3 (99253)** (55 minutes)
Changed to…	**Initial Hosp-3 (99223)** (70 minutes)	**Initial Hosp-2 (99222)** (50 minutes)	**Initial Hosp-1 (99221)** (30 minutes)
History	Comprehensive (CC-4-10-3)	Comprehensive (CC-4-10-3)	Detailed (CC-4-2-1)
Physical Exam	Comprehensive (2x9)	Comprehensive (2x9)	Detailed (12)
Decision Making	High (4-4)	Moderate (3-3)	Low (2-2)

Consult L-2 is equivalent to “Subsequent L-2” if NOT using Decision Making, or “Subsequent L-1” if using Decision Making

Consult L-1 is equivalent to “Subsequent L-1”

Equivalency Table for Out-Patient "No Medicare Consult" Services

Changed to…	**OP New-5 (99205)** (60 minutes)	**OP New-4 (99244)** (45 minutes)	**OP New-3 (99243)** (30 minutes)	**OP New-2 (99242)** (20 minutes)	**OP New-1 (99241)** (10 minutes)
Original	**OP Consult-5 (99245)** (80 minutes)	**OP Consult-4 (99244)** (60 minutes)	**OP Consult-3 (99243)** (40 minutes)	**OP Consult-2 (99242)** (30 minutes)	**OP Consult-1 (99241)** (15 minutes)
Changed to…	Established 5 (99215) (40 minutes)	Established 4 (99214) (25 minutes) (if using Decision Making 3-3)	Established 4 (99214) (25 minutes) (If NOT using Decision Making)	Established 3 (99213) (15 minutes) (If NOT using Decision Making)	Established 2 (99212) (10 minutes)
History	Comprehensive (CC-4-10-3)	Comprehensive (CC-4-10-3)	Detailed (CC-4-2-1)	Expanded Focused (CC-1-1-0)	Focused (CC-1-0-0)
Physical Exam	Comprehensive (2x9)	Comprehensive (2x9)	Detailed (12)	Expanded Focused (6)	Focused (1)
Decision Making	High (4-4)	Moderate (3-3)	Low (2-2)	Straightforward (1-1)	Straightforward (1-1)

Emergency Department Visits
(New or Established)

	99281	99282	99283	99284	99285
History	Problem Focused (CC-1-0-0)	Expanded Focused (CC-1-1-0)	Expanded Focused (CC-1-1-0)	Detailed (CC-4-2-1)	Comprehensive (CC-4-10-3)
Physical Exam	Problem Focused (1)	Expanded Focused (6)	Expanded Focused (6)	Detailed (12)	Comprehensive (2x9)
Decision Making	Straightforward (1-1)	Low (2-2)	Moderate (3-3)	Moderate (3-3)	High (4-4)

ED Visits can not be billed by time
(Unless billed as Critical Care)

Transitional Care Management

Patients being discharged from acute, rehabilitation or long-term acute hospital stays, into the community

- 99495 Transitional care management with the following required elements:
  - Communication (direct contact, telephone, electronic with the patient and/or caregiver within two business days of discharge)
  - Medical decision making of at least moderate complexity in the service period
  - Face-to-face visit within 14 days of discharge
- Value: 2.11 Facility RVU or 4.82 Non-Facility RVU

Transitional Care Management

Patients being discharged from acute, rehabilitation or long-term acute hospital stays, into the community

- 99496 Transitional care management with the following required elements:
  - Communication (direct contact, telephone, electronic with the patient and/or caregiver within two business days of discharge)
  - Medical decision making of high complexity in the service period
  - Face-to-face visit within seven days of discharge
- Value: 3.05 Facility RVU or 6.79 Non-Facility RVU

Procedure + E/M on same day,

Billing with PA-ARNP /Trainee/Student,

Billing Diagnosis

E&M Service in the same day of a Procedure

Modifier - 25

Significant E&M on "Global Procedure Period": MODIFIER 25

- E&M in day of procedure is for ***"significant, separately identifiable E&M beyond the pre-operative and post-operative work of the procedure"***

MODIFIER - 25

- The E&M service may be prompted by the same symptom or condition that prompted the procedure. (e.g.: melena for Consult level 4 and for EGD on same day)
- The same diagnosis can be used for both, E&M and Procedure on the same date.
- The “25 – modifier” is added to the E&M code to “protect it”. (e.g.: 99254-25)

MODIFIER - 25

- E&M visit on the same day of endoscopy or minor surgery (e.g.: cardiac cath) is payable if “significant, and separately identifiable” (separate notes are needed).
- Example: Patient admitted for “Unstable angina”; next day has normal cardiac cath; patient is discharged in view of cath findings: ***Bill for “cardiac cath” and “E&M discharge service” on same day (with 25- modifier for E&M).***

Billing with Trainee (Resident/Fellow), or Medical Student

Billing with Resident/Fellow

www.cms.gov/MLNProducts/downloads/gdelinesteachgresfctsht.pdf

- Attending physician must see & examine the patient, and confirm main finding of history **and** physical exam.
- Attending documents his/her participation in the management of the patient writing a brief note; "patient seen and examined by me **(attest)** with/after Dr. …….. **(tie)** ; assessment and plan was reached jointly **(manage)** " is adequate.
- Bill using the combined documentation of attending + trainee, under attending number, at 100% rate.

Teaching Attending Attestation

- “I performed a history and physical examination of the patient and discussed the management with the Resident/Fellow. I reviewed the Resident's/Fellow’s note and agree with the documented findings and plan of care.”
-
- “I was present with the Resident/Fellow during the history and exam. I discussed the case with the Resident/Fellow and agree with the findings and plan as documented in the Resident's/Fellow’s note.”
-
- “I saw and evaluated the patient. I reviewed the Resident's/Fellow’s note and agree, except that ….”
-
- "See Resident's/Fellow’s note for details. I saw and evaluated the patient and agree with the Resident's/Fellow’s finding and plans as written."

Billing with Medical Student/ Acting-Intern

- Attending **obtains own "history of present illness (HPI)"**, performs physical exam, and writes his/her assessment and plan.
- The attending can use ONLY THE STUDENT'S R.O.S., & Past M,S & F History) to supplement his/her billing documentation;
- **Attending must do his/her own HPI, physical exam, assessment, and plan.**
- Bill under attending number at 100% rate.

Billing with PA-ARNP

Billing with PA or ARNP

- **A physician can use documentation of service done by a PA or ARNP in order to enhance his/her own billing, only if his/her practice pays the PA/ARNP salary.**
- If patient is seen only by PA/ARNP without presence of supervising physician in the clinic:
  - **Bill under PA/ARNP billing number, at 85% of rate.**

Billing with PA or ARNP

- **“Incident to”**
- Physician’s practice pays PA/ARNP salary and pays clinic overhead (CAN NOT BILL IN “FACILITY”)
- Patient is seen **only** by PA or ARNP, in the physician’s office
- Plan of treatment was previously established by a physician in the group.
- Billing physician is present in clinic during the encounter
- No “New Diagnosis” is done.
- **Bill under “physician’s number” at 100%**

- **Split/Shared Service**
- Can NOT be used in Medicare “Consult” nor in ANY Passport E&M service.
- Physician’s practice pays PA/ARNP salary
- Both, physician and PA/ARNP, see the patient.
- **Bill “under physician’s number” at 100% rate**, adding the documentation of physician + PA/ARNP (if billing by time, use only physician’s face-to-face time)

ULP on Notes by MD + NP/PA

- There is an important distinction between notes created by residents/fellows versus notes by NPs or PAs:
- Unlike notes by residents or fellows, notes produced by NPs and PAs cannot be used to supplement the documentation by a physician to support an increased level of E&M complexity.
- The physician's documentation stands on its own in support of the E&M CPT charges submitted by the physician.
- Even if there is a highly detailed note from the NP/PA associated with the same visit, auditors will simply ignore it.

NP to supervising physician for charge submission

- After completing the visit note, the NP completes the “Incident to” Attestation Form (which includes the name of the supervising physician) and signs the note
- The NP assigns the charges (CPT code, diagnosis codes) in the charge module
- The NP changes the name of the billing provider from that of the NP to that of the supervising (attending) physician, and forwards the note to the supervising physician
- The supervising physician will receive a task regarding the need to submit the charges
- The supervising physician submits the charges
- The supervising physician may review and amend the note but is not required to do so for “incident to” billing

NP selects “incident to” in the Allscripts drop down menu option

- After completing the visit note, the NP completes the “Incident to” Attestation Form (which includes the name of the supervising physician) and signs the note
- The NP assigns the charges (CPT code, diagnosis codes) in the charge module
- The NP selects “incident to” in the drop-down menu labeled Special Billing at the bottom of the Encounter Form view in the Charge Module (see Figures below)and submits the charge
- The billing coder reviewing the charge data to submit the claim sees the “incident to” notification in the charge module, changes the billing provider name to the supervising physician (the billing coder must review the attestation form in the visit note in Allscripts to determine the correct provider), and submits the claim

“Incident to” Billing by PA in Allscripts

- After completing the visit note, the PA completes the Attestation Form (which includes the name of the supervising physician), including the “incident to” portion of the form, signs the note, and forwards the note to the supervising physician
- The supervising physician will receive a task regarding the need to sign the note and submit the charges
- The PA may assign the charges (CPT code, diagnosis codes) in the charge module prior to , or leave this to the supervising physician, depending on the desired workflow for the clinic
- The PA or supervising physician completing the charge module should select “incident to” in the drop down menu in the data field labeled Special Billing at the bottom of the Encounter Form view in the Charge Module
- The supervising physician submits the charges (after reviewing the completed charge data or completing the charge data as above)
- The billing coder reviewing the charge data to submit the claim sees the “incident to” notification in the charge module and submits the claim so it can be paid at the physician rate if the payor permits this to be done

Billing with PA or ARNP

- If Medicare "consult" or any Passport patient is seen by both, physician & PA/ARNP (were split service is not allowed):
  - **a) Bill under physician's number using ONLY the physician's documentation, at 100% rate, or**
  - **b) Bill under PA/ARNP number using only the PA/ARNP documentation, at 85% (100% in Passport) rate, or**
  - **c) For Medicare, bill it as a NEW PATIENT (NOT Consult), using documentation of both PA/ARNP + Physician, under physician's number, at 100% rate.**

Billing Diagnosis

NEEDED BOOKS

- Federal Register
  - RVU table
  - Medicare Conversion Factor
- Diagnosis: ICD-9 CM (1975) and ICD-10 CM (1990)
  - Regular Codes
  - V-Codes: Factors influencing health status and contact with health services (paid only if mandated by law)
  - E-Codes: External causes of injury and poisoning
- Procedures: CPT; after 10/2015 inpatients under ICD-10 PCS
  - E&M
  - Anesthesia
  - Surgical Procedure
  - Radiology
  - Pathology & Laboratory
  - Medical Procedure

Billing Diagnosis

Outpatient Visits	Hospital care	Diagnostic study or surgery
-Bill under reason that prompted the visit: Sign, symptom, or diagnosis	-Bill under Final diagnosis; -If final diagnosis is not known, then use the reason of the admission (sign or symptom)	-Requires valid indication/reason **(necessity)** -Bill under Final diagnosis related to indication; -If exam is normal, then bill under: Sign, symptom, or diagnosis that prompted the study or surgery.

Billing Diagnosis Code ICD-9

Starting Oct 1st 2015: ICD-10

- Do not code "rule out", "suspected", "probable", "questionable".
- Must be at the highest level of specificity (XYZ.**AB**)

- Hepatitis X: a) Acute, b) Chronic, c) With hepatic coma
- Ulcerative Colitis: a) Proctitis, b) Proctosigmoiditis, c) Left sided, d) Universal
- Crohn's: a) Colitis, b) Ileitis, c) Ileo-colitis
- Varices: a) Esophagus, b) Stomach;
  - i)w. bleed ii)w/o bleed
- Ulcer: a) Duodenal, b) Gastric, c) Gastro-jejunal;
  - i) Acute, ii) Chronic
    - j) w. hemorrhage, jj) w. hemorrhage & perforation,
      - k) w/o obstruction, kk) w. obstruction

Billing Diagnosis Code

- Ulcer = has no code
- Duodenal ulcer = XYZ = not specific enough = inadequate for billing
- Chronic duodenal ulcer = XYZ.A = adequate for billing but imperfect
- Chronic duodenal ulcer with hemorrhage = XYZ.B = adequate for billing but imperfect
- Chronic duodenal ulcer with hemorrhage, without obstruction = XYZ.**BC** = 532.**40** = **PERFECT!**

ICD-10 vs ICD-9

- ICD-10 uses codes that are longer (in some cases) than those of ICD-9, following a basic structure.
- There are 68000 ICD-10 codes (vs 13000 ICD-9 codes); Digestive disease codes range is K00-K95
- ICD-10 structure:
  - Digits 1-3 will now refer to the category
    - Digit 1 is always alphabetic (K = digestive disease)
    - Digits 2-3 are always numeric
  - Digits 4-6 will cover clinical details such as severity, etiology, and anatomic site (among others),
    - are either alphabetic or numeric
  - Digit 7 will serve as an extension when necessary,
    - is either alphabetic or numeric

Billing Diagnosis

- **Outpatient Visits**: The reason that prompted the visit (sign/symptom/diagnosis)
- **Hospital care**: The final diagnosis; if final diagnosis is not known, then use the reason of the admission (sign/symptom)
- **Diagnostic study/surgery**:
  1) Requires valid indication/reason **(necessity)**
  2) Is billed under the final diagnosis;
  - If exam is normal, then use the sign or symptom/reason that prompted the study/surgery.

Billing Diagnosis Code

- Do not code “rule out”, “suspected”, “probable”, “questionable”.
- Must be at the highest level of specificity (XYZ.**AB**)
- Ulcerative Colitis: a) Proctitis, b) Proctosigmoiditis, c) Left sided, d) Universal
- Crohn’s: a) Colitis, b) Ileitis, c) Ileo-colitis
- Varices: a) Esophagus, b) Stomach;
  - i)w. bleed ii)w/o bleed
- Ulcer: a) Duodenum, b) Gastric, c) Gastro-jejunal;
  - i) Acute, ii) Chronic
    - j) w. hemorrhage, jj) w. hemorrhage & perforation,
      - **k) w/o obstruction, kk) w. obstruction**

National Hepatology RVU Expectations (04-08-2014)

- As a service to the transplant community, the United Network for the Recruitment of Transplantation Professionals (UNRTP) is conducting a brief survey of transplant hepatologists in hopes of better understanding how relative value units (RVUs) are currently being deployed.
- Thus far, 97% of the respondents indicate that their institution/employer uses RVUs as a measure of physician productivity. They report an unadjusted target RVU of 5,536. In turn, 73% note that this target is adjusted for various activities, such as research and administration.

QUESTIONS ?

Teaching Physician Consults and other E&M

- The "Teaching Physician" can use, as part of his own, all the documentation done by a Resident or Fellow if:
  - The attending:
    - documents his/her participation in the management of the patient, and
    - confirms the main finding of history and physical exam.
- He/she can bill only for the work done by the trainee the day that the trainee wrote the note

(Consult note by the trainee should have the same date that the attending note).

UofL Health Care
Digestive Health Center

HISTORY/PHYSICAL/PROGRESS NOTES

Louisville, KY 40202

Medical Record No

Name

Unit/Bed

X CONSULT ☐ NEW ☐ **critically ill/injured**

Date	Time	Date of Birth	Requested By	Attending
			Dr. Oldfriend	

INITIAL GASTROENTEROLOGY CLINIC NOTE

Information From

X PATIENT ☐ FAMILY ☐ CAREGIVER

REASON:

PRESENT ILLNESS: *Main sign/symptom (1/1/4/4/4): (location, quality, severity, duration, timing, context, modifiers, associated signs/symptoms)*

Level 1 & 2 need 1 descriptor

Levels 3, 4, & 5 need 4 descriptors

Aids to Document History

- **Reason or Chief Complaint:**
- **History of Present Illness:** Main sign/symptom (1/1/4/4/4) location, quality, severity, duration, timing, context, modifiers, associated signs/symptoms.
- **Review of Systems:** (0/1/2/10/10)
- **Past Medical, Social and Family History:** (0/0/1/3/3)

ROS and Past M,F&S Hx

MEDS - vitamins

All "positives" indicated by a number

All negatives indicated by "check" mark

ROS *Checked areas (√) were explored, but negative; areas numbered (#) were positive as described* (0/s.d./2/10/10)
Constitutional ①, Skin ✓, Eyes ✓, ENMT ✓, Resp ✓, CV ✓, GI ✓, GU ✓, Musculoskeletal ②, Lymph ____,
Neuro ____, Psych ✓, Endocrine ③, Immune ✓

Positives: ① Fatigue, anorexia ② Arthralgia in knees ③ Polydipsia + polyuria

Requirement by "level"

History (0/0/1/3/3) DRUG ALLERGIES: Sulpha → rash

PATIENT - s/p appendectomy - DM x 5 y; on diet - Depression - Serve 95

SOCIAL - IVDA twice in college 74 - No EtOH / Tobacco - Divorced - Realtor

FAMILY - F: CAD - M: HBP - No sibs - child: healthy 15 y/o

Actualizing Past M,F&S history

ROS *Checked areas (√) were explored, but negative; areas numbered (#) were positive as described (0/0/s.d./2/10)*
Constitutional _____, Skin _____, Eyes _____, ENMT _____, Resp. _____, CV _____, GI _____, GU _____, Musculoskeletal _____, Lymph _____,
Neuro _____, Psych _____, Endocrine _____, Immune _____

Positives (negatives optional):

"Passive" actualization.
Cross-reference to previous visit

Requirement by "level"

History (0/0/0/1/3) Past ***x*** , Family ***x*** , and Social ***x*** was unchanged from ***01/24/05*** when checked (√)

PAST	Meds ☐ None ☐ Listed	NEW Allergy ☒ None ☐ Listed	NEW Dx/Surg ☐ None ☐ Listed	NEW Vaccine ☐ None ☐ Listed	☐ Other
SOCIAL	ETOH ☒ No ☐ Listed	Tobacco ☐ None ☐ Listed	Rec. Drug ☐ None ☐ Listed	Abuse ☐ None ☐ Listed	☐ Other
FAMILY	New Dx in Family ☒ No ☐ Listed	☐ Other			

LIST:

"active" actualization

ULH/723-006(10/04)F

Physical Exam
General Multi-System Exam

PHYSICAL: BP 116/75 Pulse 68 Resps Height 5' 6" Weight 145 Temp

PHYSICAL EXAM (1/6/12/9x2/9x2) At minimum, checked areas (√) were examined but non-contributory; areas crossed (X) were relevant as described #

1. Appearance; > 3 V.S.
2. Skin/SQ inspec; Palp
3. Conj/lids; Pupils/iris; Fundus
4. Ext ear/nose; Otoscopy; Hearing; Rhynoscopy; Lips/teeth/gum; Oropharynx
5. Breast insp; B. palp
6. Neck; Thyroid
7. Resp effort; Chest percu; Ch. palp; Lung auscul
8. Heart palp; H. auscul; Carotid P; Femoral P; Pedal P; Abd Ao; Edema/varices
9. Abd palp; Liver/spleen; Hernias; Ano-rectal; Guaiac (if indicated)
10. Scrotum/testes; Penis; Prostate
11. Ext/vagina; Urethra; Bladder; Cervix; Uterus; Adnexa
12. Gait/station; Digits/nails; Insp/palp; ROM; Stability; Musc. strength/tone
13. Neck LN; Axillae LN; Groin LN; LN
14. CN; DTR/Babinski; Sensation
15. Judgement/insight; Orientation; Memory; Mood/affect

⑨ Umbilical hernia

Requirements by "level"

All "negative" documented with a "check"

All "positive" marked with an "X" and documented under the number of the item

Data Complexity

Requirements per level

DATA: Diagnostic studies evaluated by type; comments are given if needed (O=ordered; R=reviewed; D=discussed; V=visualized) Circle or check (√) indicates work done ; only very relevant data was written below **(1/1/2/3/4 points)**:

Labs/Path: O/R; Radiol: O/R, D, V (2); Med test/Endo: O/R D,V (2); Path: D,V (2); Old Records Reviewed (2) X Requested __	Da=

The circle indicates activity done; some have a "2 point" value

IMPRESSION/DX: (1/1/2/3/4) [New+W/U (4); New (3), Worsened (2), Stable (1), Improved (1), Self-Limited (1)] ∑ Dx 6

1. Cirrhosis: stable
2. Chronic HCV: on therapy
3. Leukopenia: worse/ due to interferon
4. Esophageal varices (s/p banding) stable
5. PSE: controlled

Item "3" had a value =2; all other items had a value of 1 each (4 of them). Total = 6 points

Assessment/Plan:

1. Continue Peg-IFN/RBV
2. Continue Neupogen for neutropenia
3. Check HCV-RNA
4. CBC + diff q 2 weeks
5. Continue Lactulose
6. On liver Transplant list.

Time Scale

Required points per "level"

Single "highest" risk = 4 points

Risk (1/1/2/3/4)

①		②		③		④	
☐ Venous lab	☐ Urine test	☐ OTC drug	☐ Diet	☐ Prescrip. drug	☐ Proc. Avg. Risk	☐ Dz threat function/life	X Rx w/risk/monitoring
☐ EKG, EEG	☐ U/S, Plain X-ray	☐ Contrast X-ray	☐ Arterial puncture	☐ Elective surg./Bx	☐ Acute systemic dz	☐ Emergency procedure	☐ Procedure w/risk
☐ Rest				☐ Mild exac. ch. dz	☐ 2 stable ch. dz	☐ Severe exac. ch. dz	☐ Parenteral narcotic

☐ COUNSELING > 50% OF (C: 15:30:40:60:80, N: 10:20:30:45:60) ______________ MIN SESSION.
☐ letter and/or ☐ fax with recommendations sent to requesting physician.

Old records requested: ________
Obtain Hx from family: ________

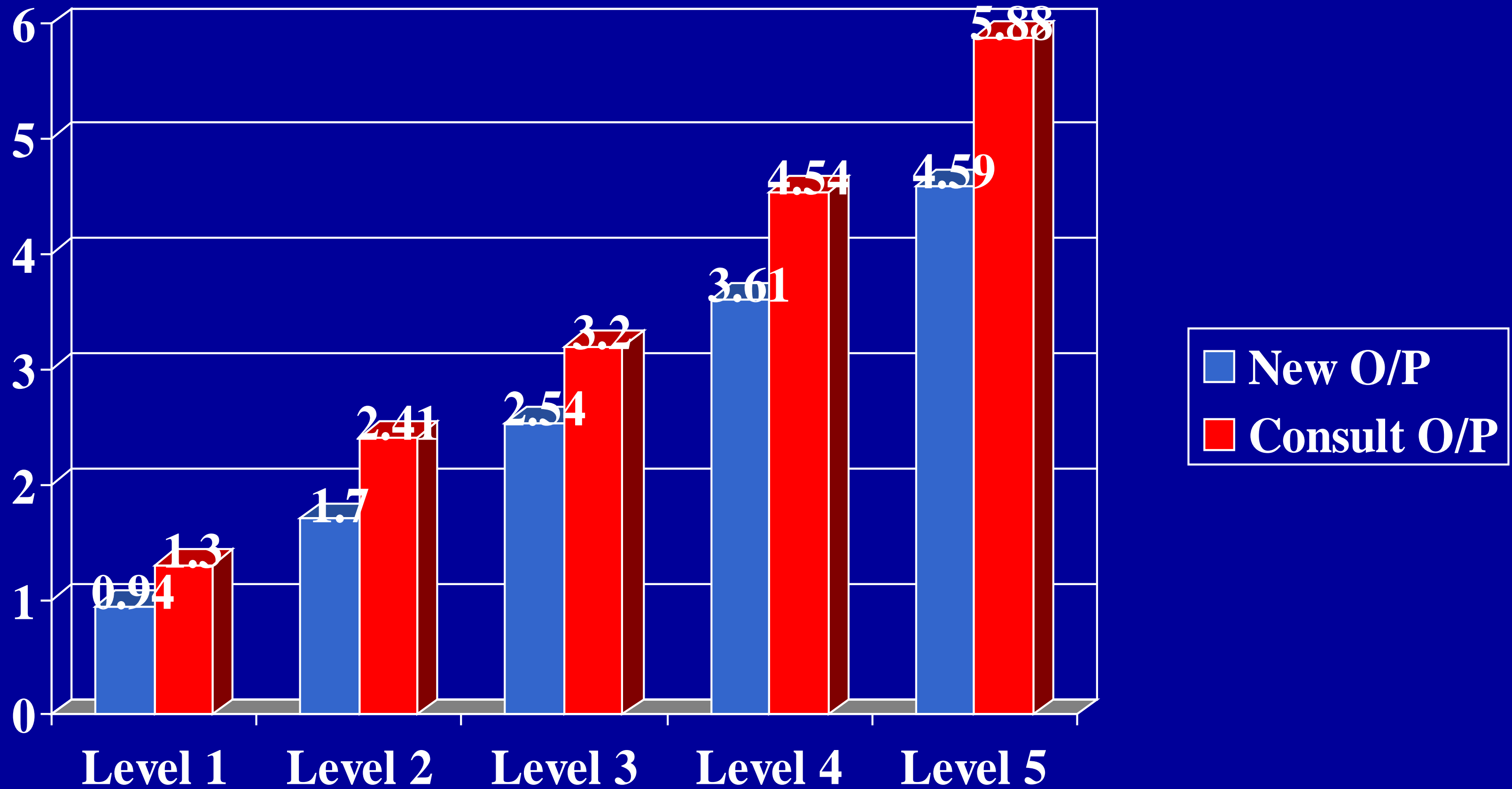
Physician Signature

M.D.

HISTORY/PHYSICAL/PROGRESS NOTES

Out-Patient RVU

New-Patient vs Clinic Consult



New = 78% of a Consult RVU

Medicare Conversion Factor

- 1998 36.69
- 2001 37.27
- 2003 36.79
- 2004 37.33
- *2005 37.89*
- *2006* ***37.89***
- *2007 37.89*
- *2008 38.08 (peak value)*
- *2009 36.06*
- *2010 36.87*
- *2011 33.97*
- 2012 34.03
- 2013 34.02

2014 35.82

2015 35.80

2016 36.10