Accurate Documentation and Billing ***Evaluation & Management***

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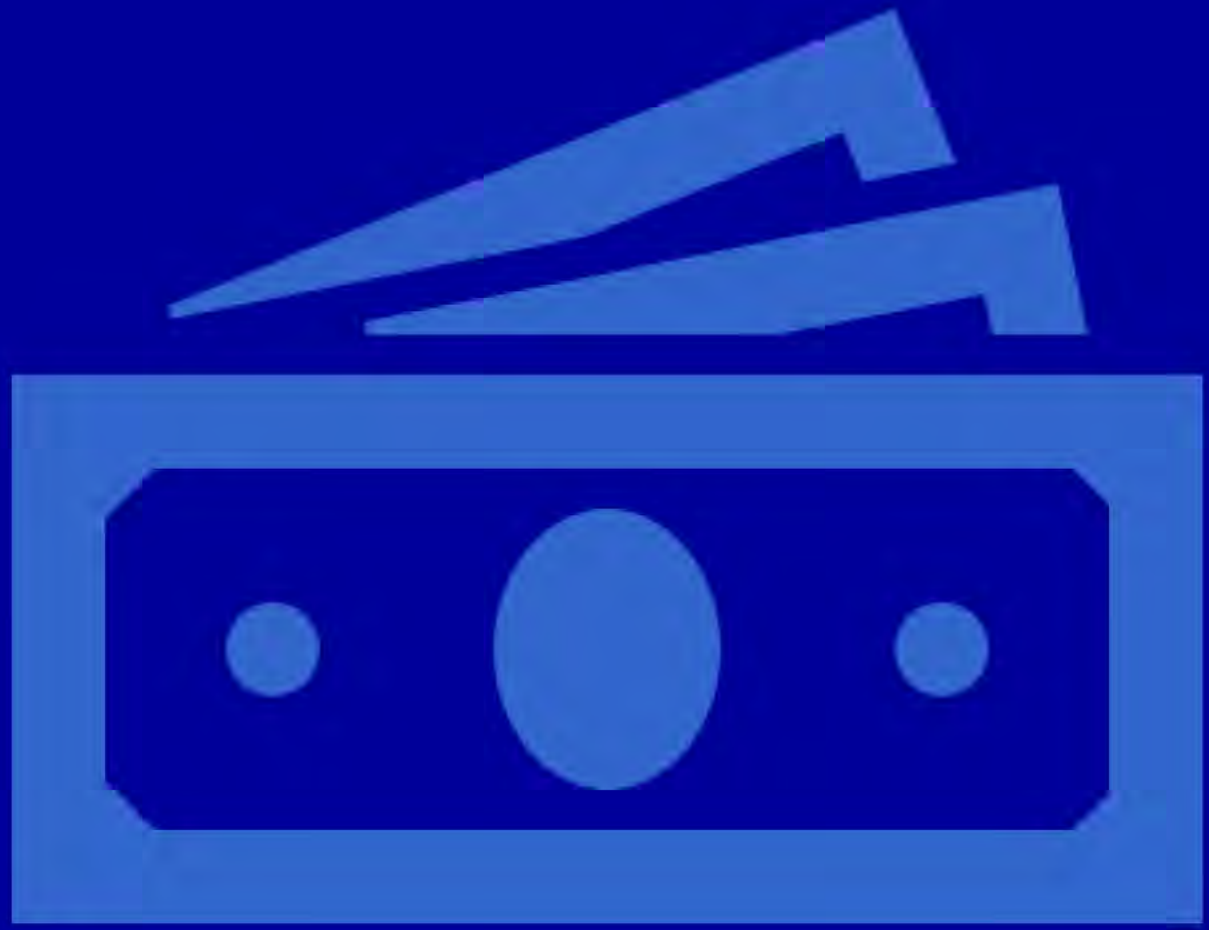
Documentation Requirements for E&M levels

- 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*

How are you paid for E&M



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 2022 = $34.60)

Examples:

- Level 5 O/P New = 4.6 RVU x 34.60= $ 159.16
- Level 3 O/P New = 2.6 RVU x 34.60= $ 89.96
- Level 5 Established = 3.2 RVU x 34.60= $ 110.72
- Level 3 Established = 1.4 RVU x 34.60= $ 48.44
- Level 1 Established = 0.6 RVU x 34.60= $ 20.76

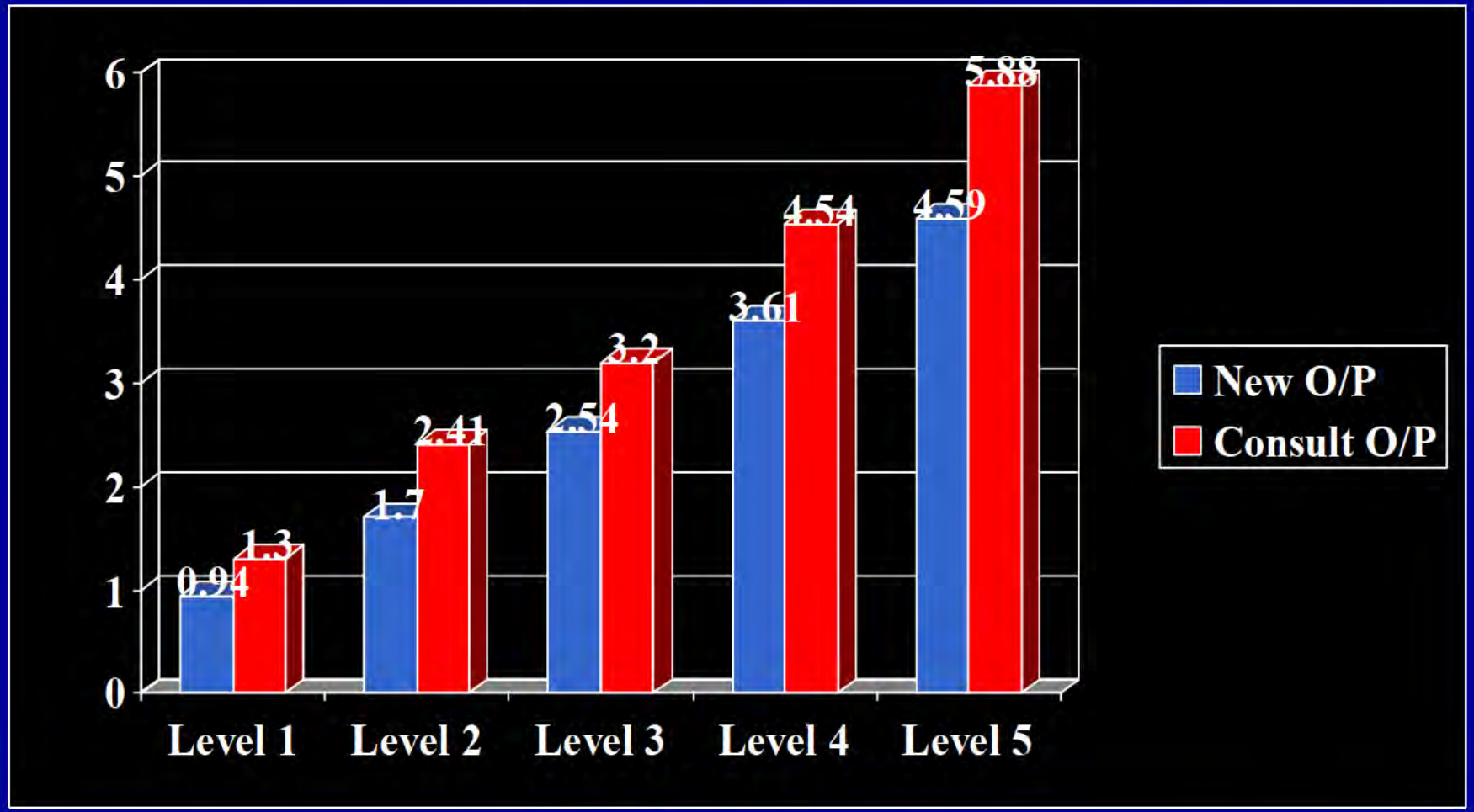
Medicare Conversion Factor

1994	**32.90**
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
2020	36.08
2021	34.89
2022	34.60
2023	**33.88 *(trough)***

Out-Patient RVU

New-Patient vs Clinic Consult (CMS does NOT pay Consults)

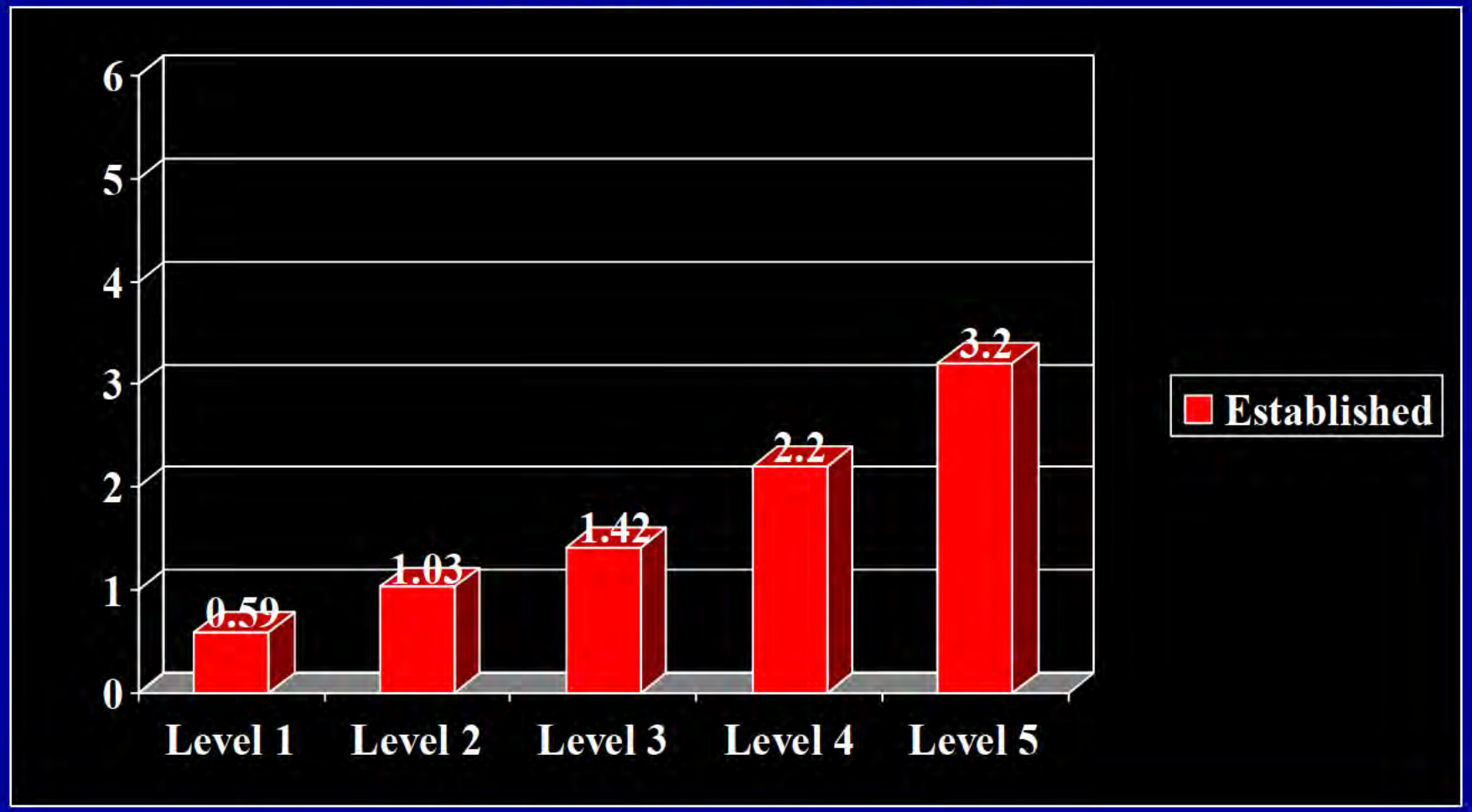


New = 78% of a Consult RVU

Only Some Private Insurance pay Consults

Established Clinic Patients

Out-Patient RVU

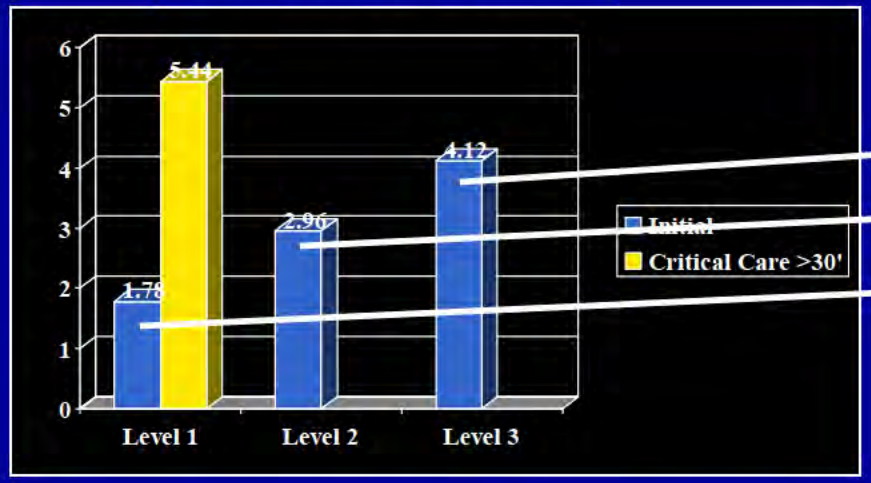


In-Patient RVU

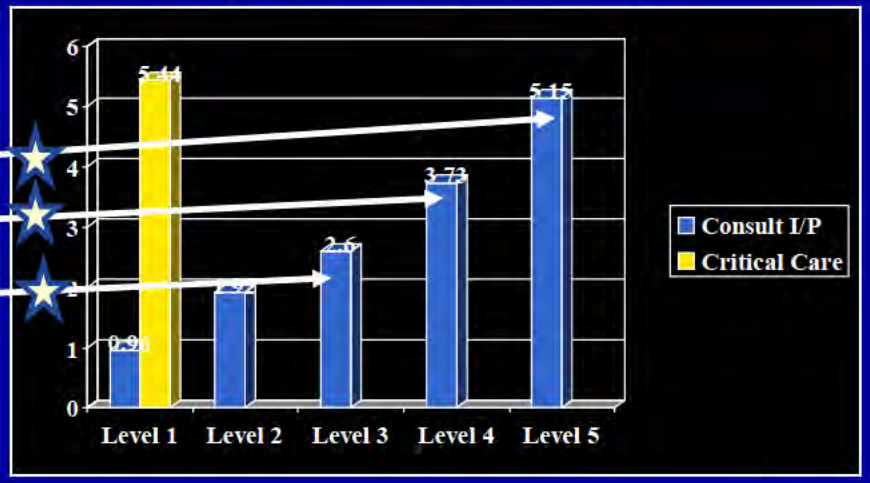
Initial Hospital Care, vs Consult, vs Critical Care >30'

★ Equal documentation

Initial Hospital Care



In-patient Consult



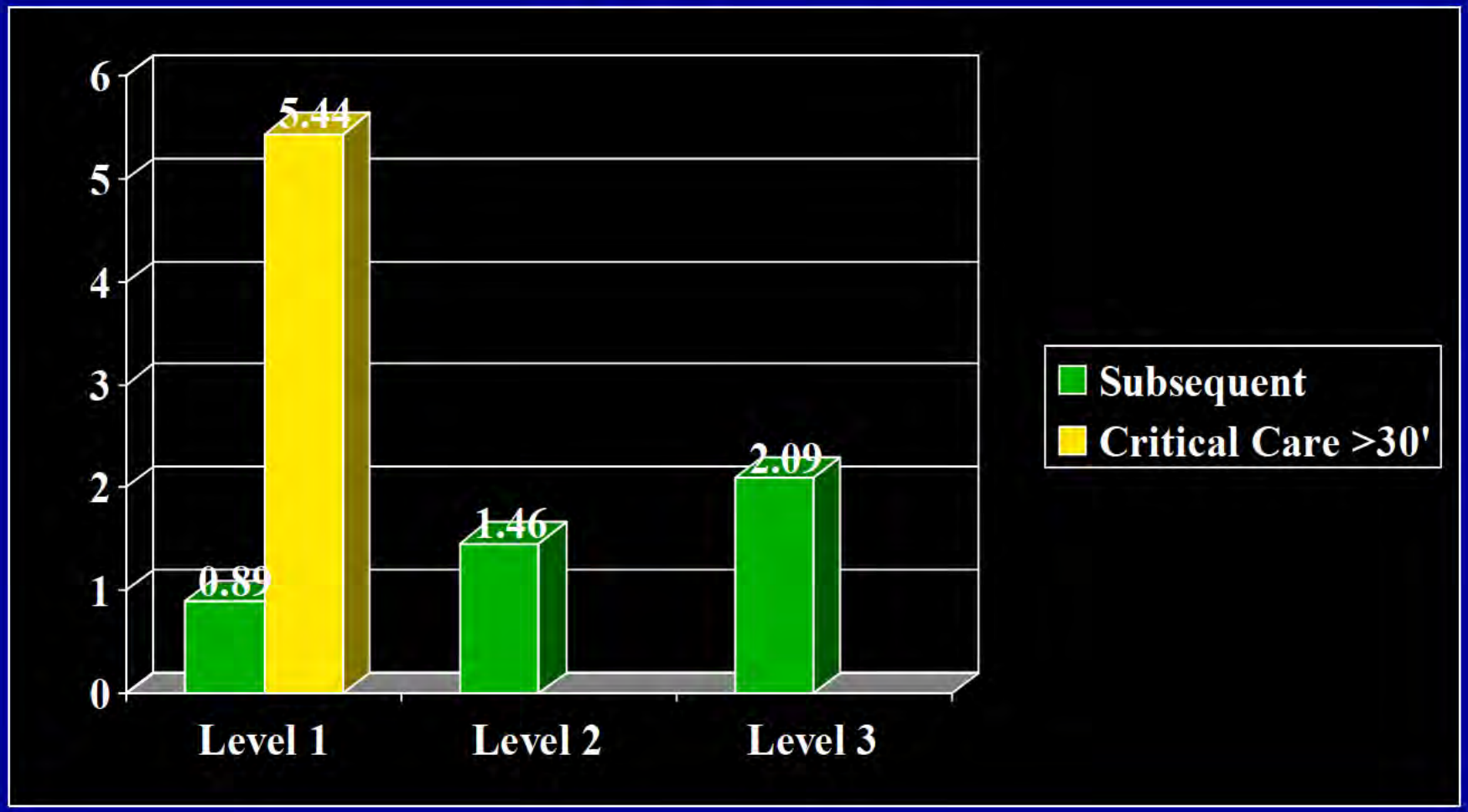
Critical Care RVU is more than the highest Initial Hospital Care or Consult

"critically ill, or injured with high probability of life-threatening deterioration and attending expends 30 or more minutes taking care of the patient"

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

Subsequent Hospital Care vs Critical Care > 30 min

In-patient RVU



Doing It Right!

1. Understand Documentation Guidelines
2. Perform the Medical Service
3. Document what you did (according to the guidelines)
4. Bill what you documented
5. Collect what you billed

Definition of Terms in E&M Billing

Evaluation and Management Basic, Common Types

Initial Hospital care:

- Admission work.

Subsequent Hospital care:

- Daily hospital care (if not billing Critical Care).

Critical Hospital Care:

- 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
  - Requires “time spent” documentation.

Evaluation and Management Basic, Common Types

New Outpatient: is one who has **NOT** "been seen" or received any professional services from a physician or qualified health professional of

- the **exact same specialty and subspecialty**
- who belongs to **the same group** practice,
- within the **past three years**.

Established Outpatient: 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

Consult:

- May be In-Patient or Out-Patient

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

No Consult Services For **Medicare** since 2010

You cannot bill for consult in Medicare patients since 2010.

Inpatient consults are billed under “Initial Hospital Care” codes.

Outpatient Consults Billed as “New Patient” or “Established Patient” as appropriate.

Definition of Terms for Coding

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Consult: Only with some Private Insurances.

- CMS eliminated Consults in 2010.
- Anthem and United Healthcare do not pay for Consults.
- Billing level Based on “Decision Making” or “Time”.
- If “consultation” is not accepted, then it is billed following Out-Patient “New patient” or “Established patient” as appropriate.

Definition of Terms for Coding

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

External Source Note: Note from a physician or healthcare professional from:

- a different group (even if from same specialty) or
- from a different specialty or subspecialty.
- Examples: Discharge summary, In-patient Renal notes, out-patient Endocrine note, requesting Primary Care note, Operative report, Dietitian note, PharmD note, etc.

Definition of Terms for Coding

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

- **Test** (ordered or reviewed):
  - **Out-Patients and In-Patients:**
    - Each item of Imaging, Laboratory, Pathology, Medical Test, Psychometric or Physiologic test.
    - Examples: CBC, CMP, Mg, Urine Na, ECG, Chest Xray, KUB, CAGE questionnaire, ACTH Stim Test, Path report, EKG, EGD, etc. each count as 1 test.

Definition of Terms for Coding

Independent historian: An individual (parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history

- Example: due to developmental stage, encephalopathy, dementia, poor insight, memory loss, or psychosis)

Independent Interpretation: The interpretation of a test for which there is:

- a CPT code, and
- in which an interpretation or report is customary (but is not done by you).
- Some form of interpretation should be written by you. Example: review of ECG shows: ……, or CXR shows: …..

Definition of Terms for Coding

Social determinants of health:

- Economic and social conditions that influence the health of people and communities.
- Examples: food or housing insecurity, high medication cost (Donut hole), history poor compliance, substance abuse, transportation problems.

Prescription drug management:

- Decision to maintain, increase, decrease dose or to add or discontinue medication.
- Continue current medications satisfies requirement.

Drug Therapy Requiring Intense Monitoring

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Type of drug: therapeutic agent that has the **potential** to cause **serious morbidity** or death.

Purpose of Monitoring: assessment of **adverse effects** and not of therapeutic efficacy.

What defines "intensive": not less than quarterly.

How long can it be: long-term or short-term

How should be done: what is generally accepted practice for the agent but may be patient specific in some cases.

What test can it be: a lab test, a physiologic test or imaging.

- Monitoring by history or examination does not qualify

Services Reported Separately

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be Reported and Billed separately by using Modifier 26.

- We can do and Report FibroScan or VideoCapsule on same day of E&M
  - use modifier 25 to protect E&M, and
  - use modifier 26 to protect the Procedure
- If Reported and Billed separately, the actual performance and/or interpretation of diagnostic tests/studies during a patient encounter should not be included in determining the levels of E/M services.

If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is NOT separately Reported and Billed, it is part of Medical Decision Making.

Number and Complexity of Problems/Diagnosis

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

Comorbidities/underlying diseases ONLY affect the E/M level **if they <u>are addressed</u>**, and **their presence <u>increases</u>:**

- **the amount and/or complexity of data** reviewed and analyzed, **or**
- **the risk** of complications and/or morbidity or mortality of patient management.

The final diagnosis does not in itself determine the complexity or risk, as **extensive evaluation may be required to reach the conclusion** that the signs or symptoms **do not represent a highly morbid condition**.

Multiple problems of a lower severity may, in the aggregate, create higher risk due to their interaction.

Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment, does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

Components of the Evaluation and Management Note

The 3 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 Billing

Component	Need	Level of Care
Chief Complaint/ Reason of Visit (medical necessity)	**Needed**	**Always Required**
History -HPI -ROS -Past Medical, Social, Family	What you feel is pertinent	Does NOT count
Physical Exam	What you feel is pertinent	Does NOT count
Decision-Making -Diagnosis Complexity -Data Complexity -Risk	**Needed**	**Counts** -Level of the "Elements"
Level of Care Billed		**The lower of the 2 highest Decision-Making Elements**

History

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)
Med Necessity	Chief Complaint	Chief Complaint	Chief Complaint	Chief Complaint
History of Present Illness	1-3 descriptors	1-3 descriptors	4 descriptors or status of 3 diseases	4 descriptors or status of 3 diseases
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"

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)}

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)
  - .

Requirements for levels 1,2,3,4 & 5

  - *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:

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

CERNER & EPIC GI Consult Template
History

- R.O.S. Admission: (**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

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 from …" **only if you describe the "date and location of previous ROS / Past M,S&F history note"**

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:

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** Part of EPIC Template
  - **Weight change**
  - **Number of bowel movements**
  - **Day # post-op, or day # of X-drug**
  - **New allergic reaction/ adverse drug event**
  - **Medication Changes** **/medchanges** Part of CERNER Template

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 P.E. 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** systems
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

Physical Exam Rules

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

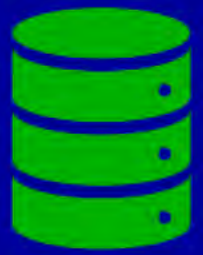
CERNER & EPIC GI Consult P.E. Template

- **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 cranial 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.

DECISION MAKING

Elements of Decision Making
(need only two)



Data Complexity

Diagnosis Complexity

Risk (Testing/ Treatment)

Data Complexity

DATA COMPLEXITY Has 3 Elements		
1	Needs **3 points** on this section	**Unique-source External-note(s) review # =**
		Unique Test(s) Ordered # =
		Unique Test(s) Reviewed # =
		Independent historian(s) # =
2	**Interpretation of Test done by other Healthcare provider (not separately reported): *Describe your interpretation …***	
3	**Discussion of Management, or of Test-Interpretation with different specialist/sub-specialist (not separately reported): *"Discussed with…"***	

By Counting number of Elements

Level 5 (Extensive) = 2 of 3 Elements

Level 4 (Moderate) = 1 of 3 Elements

Level 3 (Limited) = Independent historian or 2 Tests / External Notes

Data Complexity Attestation In CERNER and EPIC

The DATA COMPLEXITY of this Encounter, based on the number of elements fulfilled, is (-/Minimal/Limited/Moderate/Extensive)**:** *** (choose one with an "X")

- _ **EXTENSIVE:** I completed **2 of these 3** items: a) ordered or reviewed ≥ 3 of the following: unique lab(s)/test(s), unique source external note(s), obtained history from unique independent historian(s) **AND/OR** b) independently interpreted a test not performed by me **AND/OR** c) discussed management/test interpretation with a specialist
- _ **MODERATE:** I ordered or reviewed ≥ 3 of the following: unique lab(s)/test(s), unique source external note(s), obtained history from unique independent historian(s) **OR** independently interpreted a test not performed by me **OR** discussed management/test interpretation with a specialist
- _ **LIMITED:** I ordered or reviewed ≥ 2 of the following: unique lab(s)/test(s), unique source external note(s) **OR** obtained history from an independent historian
- _ **MINIMAL:** Minimal or None

Diagnosis Complexity Table

Single Highest Item	Level
-1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or -1 acute or chronic illness or injury that poses a threat to life or bodily function	5 Extensive
-1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or -2 or more stable chronic illnesses; or -1 undiagnosed new problem with uncertain prognosis; or -1 acute illness with systemic symptoms; or -1 acute complicated injury	4 Moderate
-2 or more self-limited or minor problems; or -1 stable chronic illness; or -1 acute, uncomplicated illness or injury	3 Limited
-1 self-limited or minor problem	2 Minimal

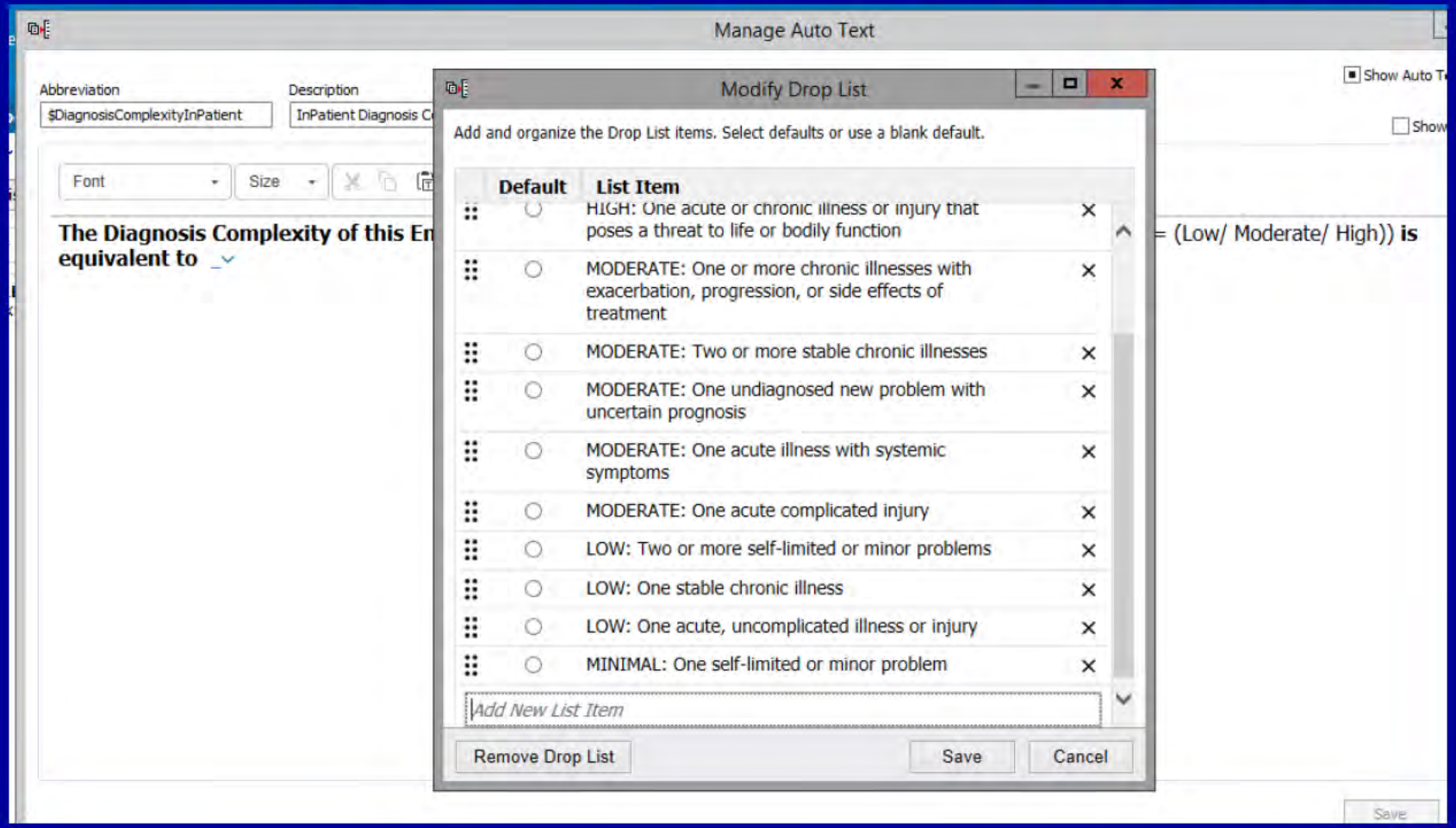
Attestation of Diagnosis Complexity CERNER PowerNote

DIAGNOSIS COMPLEXITY: The DIAGNOSIS COMPLEXITY of this patient is AS MARKED WITH "X" (Limited/ Moderate/ Extensive)

- _ **EXTENSIVE**: 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; OR 1 acute or chronic illness or injury that poses a threat to life or bodily function
- _ **MODERATE**: 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; OR 2 or more stable chronic illnesses; OR 1 undiagnosed new problem with uncertain prognosis; OR 1 acute illness with systemic symptoms; OR 1 acute complicated injury
- _ **LIMITED**: 2 or more self-limited or minor problems; OR 1 stable chronic illness; OR 1 acute, uncomplicated illness or injury
- _ **MINIMAL**: 1 self-limited or minor problem

Attestation Diagnosis Complexity

EPIC and CERNER Dynamic Documentation



RISK

of Complication, Morbidity or Mortality
from Testing, or Management

- Points given by the ***single highest risk*** *(non-additive).*

From Risk Table
High
Moderate
Low
Minimal

High Risk

Likely Level 5 New, Consult or Established, or Level 3 Admission or Subsequent Care

- **Decision regarding hospitalization**
- **Diagnostic endoscopies with identified risk factors**
- **Drug therapy requiring intensive monitoring for toxicity (>/= quarterly)** (immunosuppression, diuretics).
- An abrupt change in neurologic status
- **Cardiovascular imaging studies with contrast with identified risk factors** (TIPS)
- Cardiac electrophysiological tests
- Discography
- Elective major surgery (open, percutaneous or endoscopic) with identified risk factors
- Emergency major surgery (open, percutaneous or endoscopic)
- Parenteral controlled substances
- Decision not to resuscitate or to de-escalate care because of poor prognosis

Moderate Risk

Likely Level 4 New, Consult or Established, or Level 2 Admission or Subsequent Care

- **Diagnosis or treatment significantly limited by social determinants of health**
- **Prescription drug management**
- **Diagnostic endoscopies with no identified risk factors**
- **Obtain fluid from body cavity**
- **Deep needle or incisional biopsy** (Liver Bx)
- Physiologic tests under stress (cardiac stress test, ACTH Stim Test)
- Cardiovascular imaging studies with contrast and no identified risk factors
- Minor surgery with identified risk factors
- Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors
- Therapeutic nuclear medicine
- IV fluids with additives
- Closed treatment of fracture or dislocation without manipulation

Low Risk

Likely Level 3 New, Consult or Established, or Level 1 Admission or Subsequent Care

- Over-the-counter drugs
- IV fluids without additives
- Physiologic tests not under stress
- Non-cardiovascular imaging studies with contrast
- Superficial needle biopsies
- Clinical laboratory tests requiring arterial puncture
- Skin biopsies
- Minor surgery with no identified risk factors
- Physical therapy
- Occupational therapy

Minimal Risk

Likely Level 2 Established or Consult

- Laboratory tests requiring venipuncture
- Chest x-rays
- EKG/EEG
- Urinalysis
- Ultrasound
- KOH prep
- Rest
- Gargles
- Elastic bandages
- Superficial dressings

Aids to Document Decision Making and Critical Care

- **THE COMPLEXITY OF DATA I REVIEWED TODAY WAS:** (Minimal/Minimal/Limited/Moderate/Extensive)

DATA Complexity was _ **EXTENSIVE** (4 points) , _ **MODERATE** (3 points), _ **LIMITED** (2 points), _ **MINIMAL** (1 point) : (Total points from adding: Review/Order Labs/Path (1 point), Review/Order Radiology study (1 point), Review/Order Medical Test (1 point), Discussed X-Ray with Radiologist (1 point), Discussed Path with Pathologist (1 point), Requested Old Records (1 point), Summarized Old Record findings (2 points), Obtained history from additional source (2 points), Independently Interpreted Image, Tracing and/or Biopsy (2 points each type))

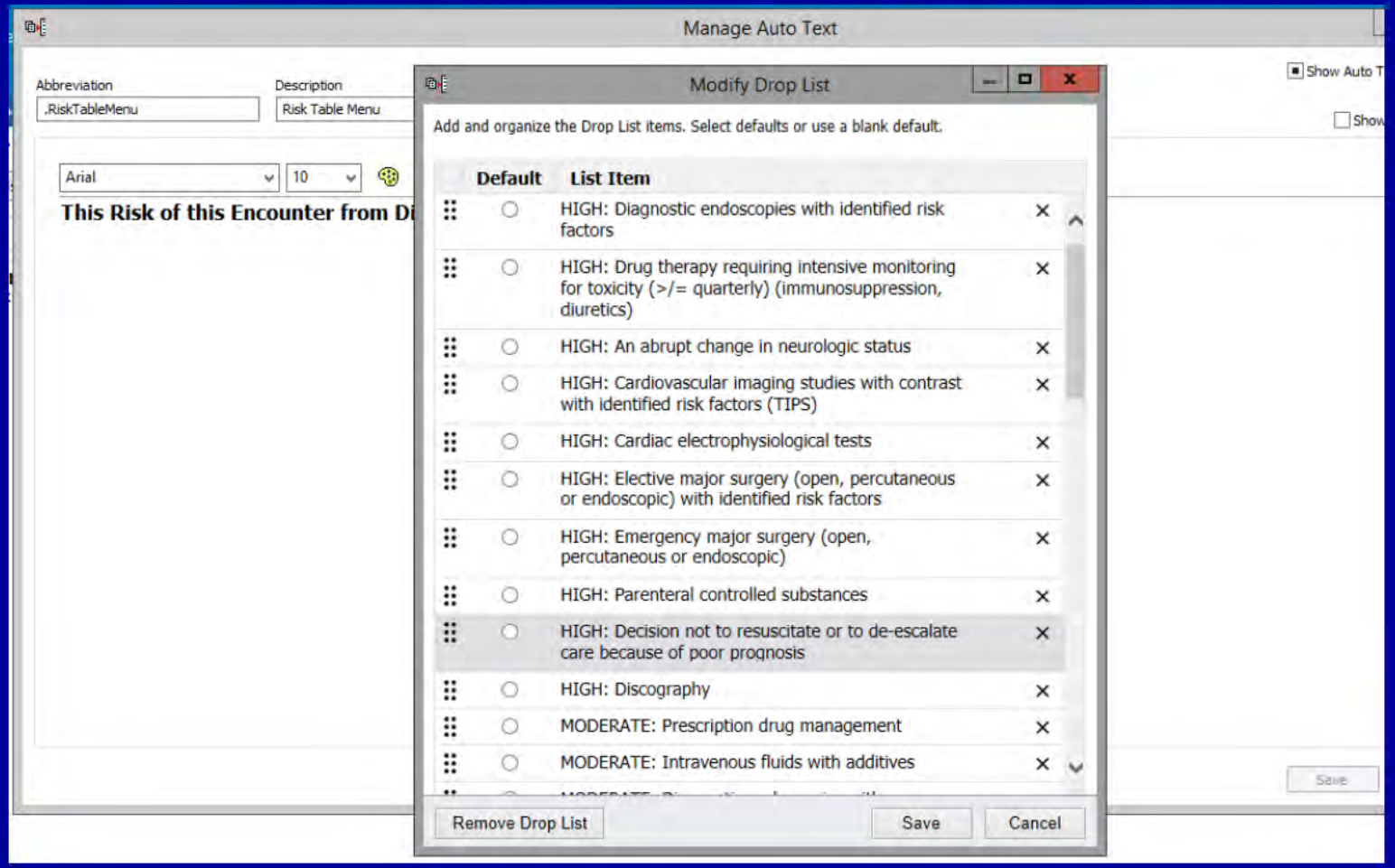
- **Impression/Diagnosis and Management**: (**1/1/2/3/4**)
  - [(New+W/U(4), New (3), Worsened (2), Stable (1), Improved (1), Self-Limited (1)]
  - *Hepatic Encephalopathy;* **NEW; will investigate cause (cultures, BMP,…)**

- **RISK** (**Minimal/Minimal/Low/Moderate/High**): (Dot phrases" (CERNER), or "Smart Phrases" (EPIC))

- **Critical Care**: ("Dot phrases" (CERNER), or "Smart Phrases" (EPIC))

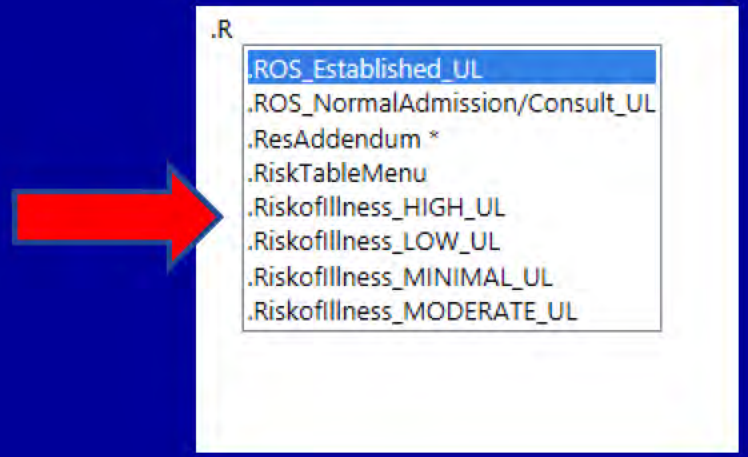
RISK Attestation

EPIC and CERNER Dynamic Documentation



RISK Attestation

CERNER PowerNote



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 equivalence to one or more of the following: 1. Diagnostic endoscopies with identified risk factors; OR 2. Drug therapy requiring intensive monitoring for toxicity (>/= quarterly) (immunosuppression, diuretics); OR 3. An abrupt change in neurologic status; OR 4. Cardiovascular imaging studies with contrast with identified risk factors (TIPS); OR 5. Cardiac electrophysiological tests; OR 6. Discography; OR 7. Elective major surgery (open, percutaneous or endoscopic) with identified risk factors; OR 8. Emergency major surgery (open, percutaneous or endoscopic); OR 9. Parenteral controlled substances; OR 10. Decision not to resuscitate or to de-escalate care because of poor prognosis

Level of Care 5 New, Consult, Established; Level 3 Admission, Subsequent

2 of 3 Elements needed (A, B, C)

A. DIAGNOSIS COMPLEXITY HIGH (One of the following)		B. DATA COMPLEXITY EXTENSIVE (2 of 3)		C. RISK HIGH (One of the following)
1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** **1** acute or chronic illness or injury that poses a threat to life or bodily function	**2 of 3**	Needs 3 points	Unique source External note(s) review # = Unique Test(s) Ordered # = Unique Test(s) Reviewed # = Independent historian(s) # =	☐ Drug therapy requiring intensive monitoring for toxicity (>/= quarterly) ☐ Decision regarding hospitalization ☐ Diagnostic endoscopies with identified risk factors ☐ An abrupt change in neurologic status ☐ Cardiovascular imaging studies with contrast with identified risk factors ☐ Cardiac electrophysiological tests ☐ Discography ☐ Elective major surgery (open, percutaneous or endoscopic) with identified risk factors ☐ Emergency major surgery (open, percutaneous or endoscopic) ☐ Parenteral controlled substances ☐ Decision not to resuscitate or to de-escalate care because of poor prognosis
		Interpretation of Test done by other Healthcare provider (not separately reported):		
		Discussion of Management, or of Test-Interpretation with different specialist/sub-specialist (not separately reported):		

External Note = From other institution(s) or other specialty(es)

Level of Care 4 New, Consult, Established
Level 2 Admission or Subsequent
2 of 3 Elements needed (A, B, C)

A. DIAGNOSIS COMPLEXITY MODERATE (One of the following)	**B. DATA COMPLEXITY MODERATE** (1 of 3)		**C. RISK MODERATE** (One of the following)
• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	**1 of 3**	Needs 3 points: Unique source External note(s) review # = Unique Test(s) Ordered # = Unique Test(s) Reviewed # = Independent historian(s) # =	☐ Prescription drug management ☐ Diagnosis or treatment significantly limited by social determinants of health ☐ Diagnostic endoscopies with no identified risk factors ☐ Obtain fluid from body cavity ☐ Deep needle or incisional biopsy ☐ Physiologic tests under stress (cardiac stress test) ☐ Cardiovascular imaging studies with contrast and no identified risk factors ☐ Minor surgery with identified risk factors ☐ Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors ☐ Therapeutic nuclear medicine ☐ IV fluids with additives ☐ Closed treatment of fracture or dislocation without manipulation
		Interpretation of Test done by other Healthcare provider (not separately reported):	
		Discussion of Management, or of Test-Interpretation with different specialist/sub-specialist (not separately reported):	

External Note = From other institution(s) or other specialty(es)

Level of Care 3 New, Consult, Established
Level 1 Admission or Subsequent
2 of 3 Elements needed (A, B, C)

A. DIAGNOSIS COMPLEXITY LOW (One of the following)	B. DATA COMPLEXITY LIMITED (1 of 2)		C. RISK LOW (One of the following)
• 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	**1 of 2**	Needs 2 points	Unique source External note(s) review # =	☐ Over-the-counter drugs ☐ Physiologic tests not under stress ☐ Non-cardiovascular imaging studies with contrast ☐ Superficial needle biopsies ☐ Clinical laboratory tests requiring arterial puncture ☐ Skin biopsies ☐ Minor surgery with no identified risk factors ☐ Physical therapy ☐ Occupational therapy ☐ IV fluids without additives
			Unique Test(s) Ordered # =	
			Unique Test(s) Reviewed # =	
		Independent historian		

External Note = From other institution(s) or other specialty(es)

Level of Care 2 New, Established or Consult

2 of 3 Elements needed (A, B, C)

A. DIAGNOSIS COMPLEXITY MINIMAL	B. DATA COMPLEXITY MINIMAL or NONE	C. RISK MINIMAL (One of the following)
• 1 self-limited or minor problem	• Minimal or None	☐ Laboratory tests requiring venipuncture ☐ Chest x-rays ☐ EKG/EEG ☐ Urinalysis ☐ Ultrasound ☐ KOH prep ☐ Rest ☐ Gargles

Conversion of Out-Patient Consult

If an Out-Patient Consult is rejected, it should be “converted” to “New patient” or “Established patient” depending on presence or previous “face-to-face” encounter in the last 3 years, by any member of the group.

The “Level of Care” will be determined by only the “Decision Making” elements of the encounter (the lower of the 2 highest).

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"

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

Critical Care Billing

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 Oximetry
- 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.

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

Billing By Time

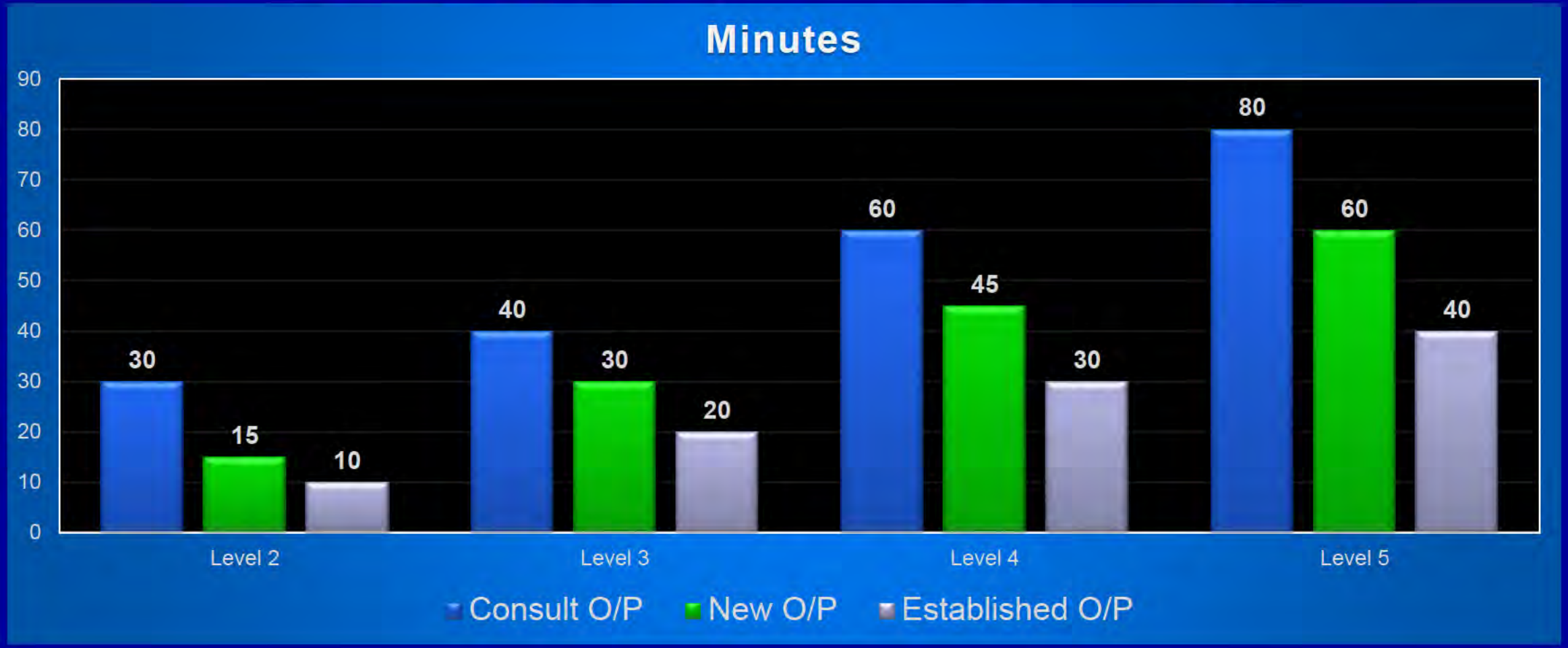
Measurement of Total Time Spent on day of Encounter

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

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

Out-Patients

E&M Level by Time (minutes)



E&M Billing by Time

Should use **total time**, which includes face-to-face and non-face-to-face time spent by the E/M provider. Does NOT include time spent on separately reported services or time spent on activities the clinical staff usually performs when you determine the total time.

- **New Out-patient codes:**
  - 99202: 15-29 minutes
  - 99203: 30-44 minutes
  - 99204: 45-59 minutes
  - 99205: 60-74 minutes

- **Established Out-patient codes:**
  - 99212: 10-19 minutes
  - 99213: 20-29 minutes
  - 99214: 30-39 minutes
  - 99215: 40-54 minutes

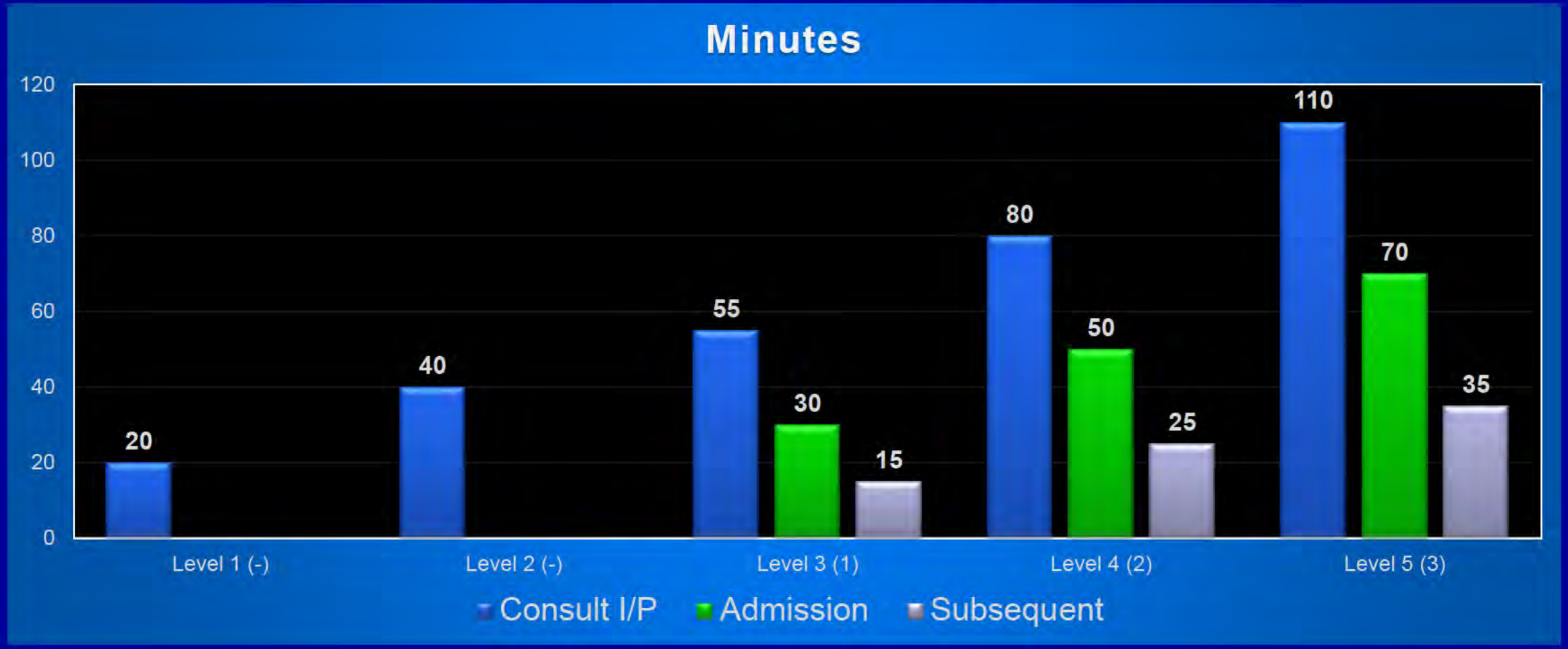
For Prolonged Services use 99XXX

Prolonged Outpatient Services

New Outpatient Prolonged Service	
Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	**Code(s)**
less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99XXX X 1
90-104 minutes	99205 X 1 and 99XXX X 2
105 minutes or more	99205 X 1 and 99XXX X 3 or more for each additional 15 minutes.

Established Outpatient Prolonged Service	
Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	**Code(s)**
less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99XXX X 1
70-84 minutes	99215 X 1 and 99XXX X 2
85 minutes or more	99215 X 1 and 99XXX X 3 or more for each additional 15 minutes

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



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 Billing

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

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

Clinic Telehealth COVID19 Times

Modifiers & POS for Medicare Telehealth

- Video visits and telephone E/M are deemed telehealth during the COVID-19 PHE
- Modifier -95 identifies the service as telehealth
- Report POS where the visit would have taken place in person
- Do not report POS 02; it will result in a lower payment if your practice is office-based

Service	Mod	POS 11 - office	POS 22 – hospital outpatient dept	POS 02 - telehealth
Video visit 99203	-95	$113.75 3.26 RVU	$84.44 2.42 RVU	$84.44 2.42 RVU
Video visit 99213	-95	$92.47 2.65 RVU	$68.04 1.95 RVU	$68.04 1.95 RVU
Phone E/M 99441	-95	$56.88 1.63 RVU	$36.29 1.04 RVU	$36.29 1.04 RVU

ACG
aga American Gastroenterological Association
ASGE American Society for Gastrointestinal Endoscopy

Telephone E/M Medicare Payment

Video Visit Established Patient E/M				Telephone E/M			
CPT	2021 Time	2021 Pmt	wRVU	CPT	Time	2021 PHE Pmt	2021 PHE wRVU
99211	NA	$23.03	0.18				
99212	10-19 min	$56.88	0.70	99441	5-10 min	$56.88	0.70
99213	20-29 min	$92.47	1.30	99442	11-20 min	$92.82	1.30
99214	30-39 min	$131.20	1.92	99443	21-30 min	$131.55	1.92
99215	40-54 min	$183.19	2.80				

POS 11 (if in person, would have been in the office);
Modifier 95 (Telehealth)

ACG aga American Gastroenterological Association ASGE American Society for Gastrointestinal Endoscopy

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).***

Common Services in Day-of-Visit

Require Modifier 25 in E&M

EPIC Counselling Statements

- **Smoking cessation Counselling:** I counselled the patient, about the importance of smoking cessation as risk factor reduction, for *** minutes (**3**-10 minutes = 99406, vs more than 10 minutes = 99407)
- **Alcohol avoidance in Chronic Liver Disease:** I counselled about alcohol avoidance as risk factor reduction for worsening liver disease and/or increased risk of Hepatocellular carcinoma, for *** minutes (**15**-29 minutes = 99401/GO443, vs 30-44 minutes = 99402)
- **Weight reduction counselling in NAFLD/NASH:** I counselled about diet and activity modification for weight reduction, as risk factor reduction of liver injury from NAFLD and NASH, for *** minutes (at least **15** minutes = 99401/GO447, vs 30-44 minutes = 99402)
- **Alcohol Abuse Screening and Brief Intervention:** I performed an Alcohol abuse structured screening (Single Question Prescreen, CAGE, AUDIT) and a brief intervention (SBI) service for *** minutes; (**15** to 30 minutes = 99408, vs greater than 30 minutes = 99409)
- **Drug Abuse Screening and Brief Intervention:** I performed a Drug Abuse structured screening by Drug Abuse Screening Test and brief intervention (SBI) service for *** minutes; (**15** to 30 minutes = 99408, vs greater than 30 minutes = 99409)

Documenting and Billing for Counselling in EPIC

The Diagnosis Complexity of this Encounter is equivalent to: {EM2021 Diagnosis Complexity:21033}.

Assessment, Management and Plan:
There are no diagnoses linked to this encounter.

No follow-ups on file.

Use “Control F2”

{COUNSELLING (Optional):28683}

{GIOTHERCOMMENTS (Optional):

{SMOKING:TXT,18353}
{ALCOHOL:TXT,18354}
{WEIGHT:TXT,18355}
{GI_INTERVENTION_ALCOHOL:TXT,18383}
{GI_INTERVENTION_DRUG:TXT,18384}

This Risk of this Encounter from **nt is equivalent to:** {EM2021 Encounter Risks:21032}

Based on DIAGNOSTIC COMPLEXITY, DATA and RISK, OR TOTAL TIME the Encounter Code of this visit is: {Encounter Code New:21634}

{Supervision Attestation (Optional):22061}

Single Question Alcohol Screening Tool

Up to once a year (CPT 96160/ G0442)

ALCOHOL PRESCREENING QUESTIONNAIRE

1. Do you sometimes drink beer, wine, or other alcoholic beverages?

☐ Yes ☐ No

If you answered "Yes," look at this card showing the size of standard drinks:

Beer 12 oz.
(5% alcohol)

Wine 5 oz.
(12% alcohol)

Liquor 1.5 oz.
(80-proof, 40% alcohol)

2. Women: How many times in the past 12 months have you had four (4) or more standard drinks in a day?

☐ Zero ☐ One or more times

Men: How many times in the past 12 months have you had five (5) or more standard drinks in a day?

☐ Zero ☐ One or more times

No Co-Insurance
No Deductible

If a patient's initial screening does not warrant a brief intervention, then use Medicare HCPCS code G0442, "Annual alcohol misuse screening, **15 minutes**" or, for commercial insurance, CPT code 96160 ($18.30)

Alcohol Screening and Intervention Codes

Payer	Code	Description	Fee schedule	RVU
Commercial insurance, Medicaid	99408	Alcohol and/or substance abuse structured screening and brief intervention services, 15-30 minutes.	$33.41	0.65
Commercial insurance, Medicaid	99409	Alcohol and/or substance abuse structured screening and brief intervention services, greater than 30 minutes.	$65.51	1.3
Medicare	G0396	Alcohol and/or substance abuse structured screening and brief intervention services, 15-30 minutes.	$36.25*	0.65
Medicare	G0397	Alcohol and/or substance abuse structured screening and brief intervention services, greater than 30 minutes.	$71.42*	1.3
Medicare	G0442	Screening for alcohol misuse in adults, 15 minutes. No coinsurance; no deductible for patient.	$18.30*	0.18
Medicare	G0443	Brief face-to-face behavioral counseling for alcohol abuse, 15 minutes. Up to four per year for individuals who screen positive for alcohol misuse. No coinsurance; no deductible for patient.	$26.20*	0.45
Medicaid	H0049	Alcohol and/or drug screening (code not widely used).	$24	
Medicaid	H0050	Alcohol and/or drug service, brief intervention, per 15 minutes (code not widely used).	$48	

No Co-Insurance
No Deductible

In EPIC use:
.AUDITALCOHOL or
.CAGEALCOHOL or
.SINGLEQUESTIONALCOHOL

KENTUCKY Living
Will Directive
Planning for Important Health Care Decisions

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

- 99498 - Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)

- https://www.caringinfo.org/wp-content/uploads/Kentucky.pdf

Billing with Resident or Fellow

(Rev. 4283, Issued: 04- 26-19, Effective: 01-01-19, 07-29-19)

Medical records must demonstrate:

That the Teaching Physician performed the service or **was physically present** during the key or critical portions of the service when performed by the resident; and

The Teaching Physician participated in the management of the patient.

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

History, physical exam and/or medical decision-making *must be* ***performed in the physical presence of a teaching physician or of a resident*** *in a service.*

Teaching Physician must personally perform (or re-perform) the physical exam and medical decision-making *(no need to re-document)*

Teaching Physician must verify *history, physical exam and/or medical decision-making.*

Physician Attestation with Medical Student

CMS 2019 Physician Fee Schedule Final Rule, page 572

- The history, medical exam and/or decision-making documented by the medical student was performed in the physical presence of (_ myself, _ Resident Physician/Fellow), and I verify them. I also personally performed the physical exam and decision-making and agree with the documentation.

Billing with PA-ARNP

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.

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 and uses "Incident-to" billing in Established Clinic patients or "Split/ Shared" Hospital care billing.**
- 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

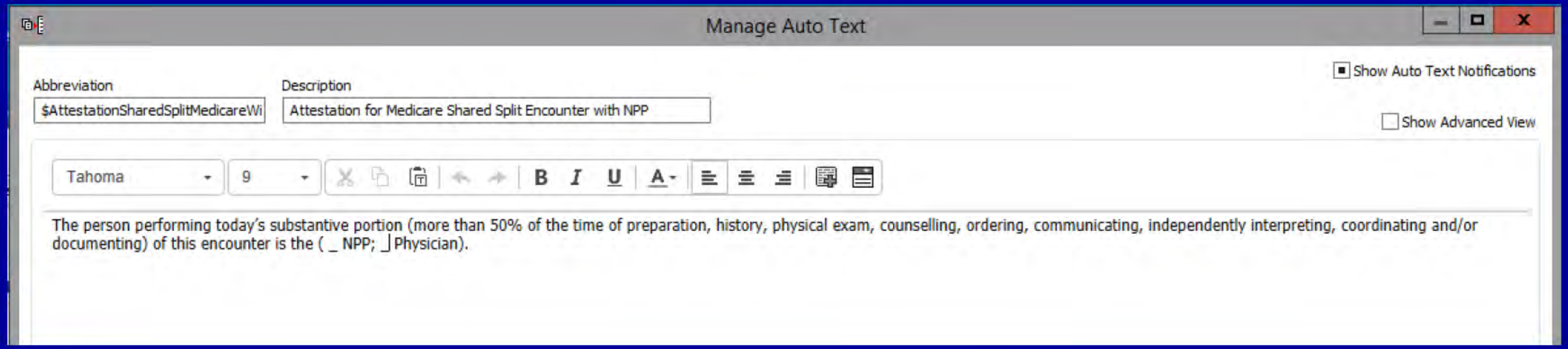
- **"Incident to"**

- 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 and immediately available 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
- Applies to Hospital and Hospital-Based Outpatient Clinic.
- Both, physician and PA/ARNP, see the patient.
- **Bill "under physician's number" at 100% rate if physician time was > 50% of the combined time.**
- **If PA/ARNP service was > 50% of total time, bill under ARNP/PA number at 85% rate.**

Attestation for Shared or Split Hospital Service



The person performing today's substantive portion (more than 50% of the time of preparation, history, physical exam, counselling, ordering, communicating, independently interpreting, coordinating and/or documenting) of this encounter is the (_ NPP; _ Physician).

2022 / 2023 CMS' New Rules for Split or Shared Facility E/M Visits

Medicare Claims Processing Manual, Chapter 12, 30.6.18

Status	2024	Comments
Documentation	2 providers PLUS **SUBSTANTIVE (more than 50%) of TOTAL TIME ONLY by the Billing Person**	In 2024 Billed by Provider with Substantive portion by time
Place of Service	Inpatient (21) Emergency (23) Outpatient (19, 22) SNF (31,32,54,56) New	Office POS removed. Skilled Nursing Facility added
Modifier	FS	New FS modifier identifies Split or Shared service

“Incident to” Billing by PA/NP (NPP) in EPIC

- Services must relate to an existing course of treatment; do not apply to a new patient or when treating an existing patient for a new illness or injury
- Physician must be present in the office suite and immediately available to furnish assistance and direction.
- After completing the visit note, the NPP 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 NPP 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 NPP 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 (where 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

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

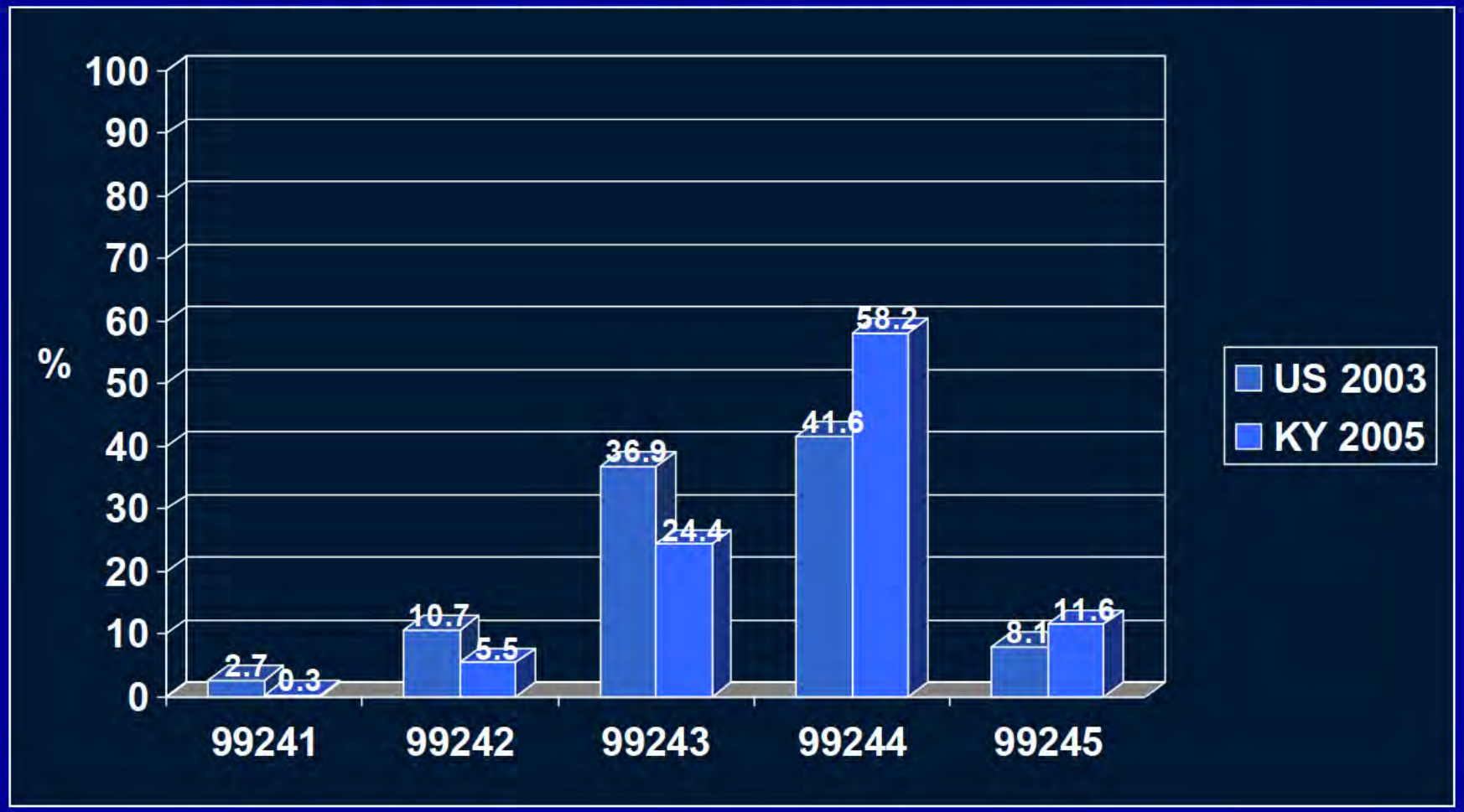
Billing Diagnosis Code

- 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!**

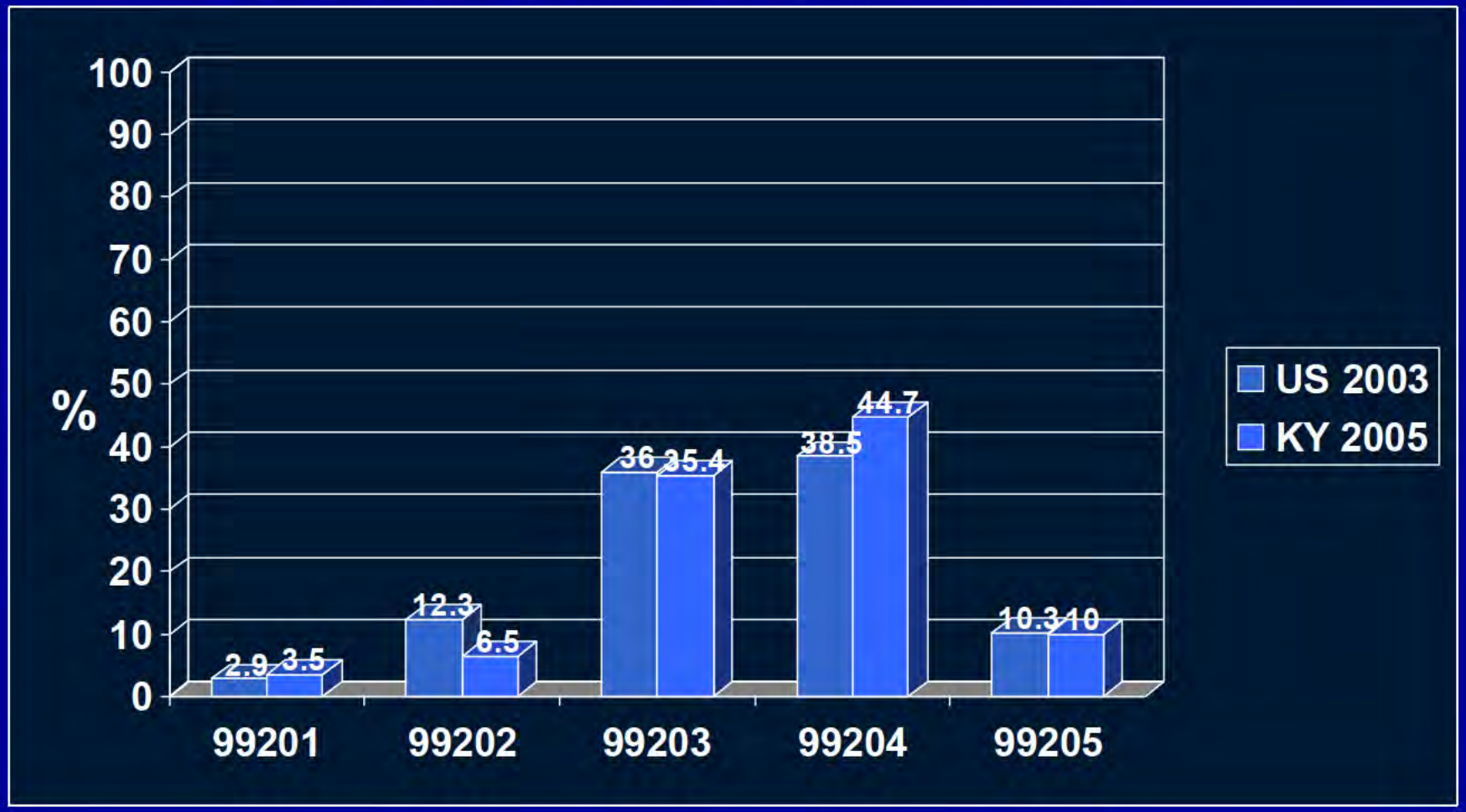
QUESTIONS ?

National GI Billing Patterns

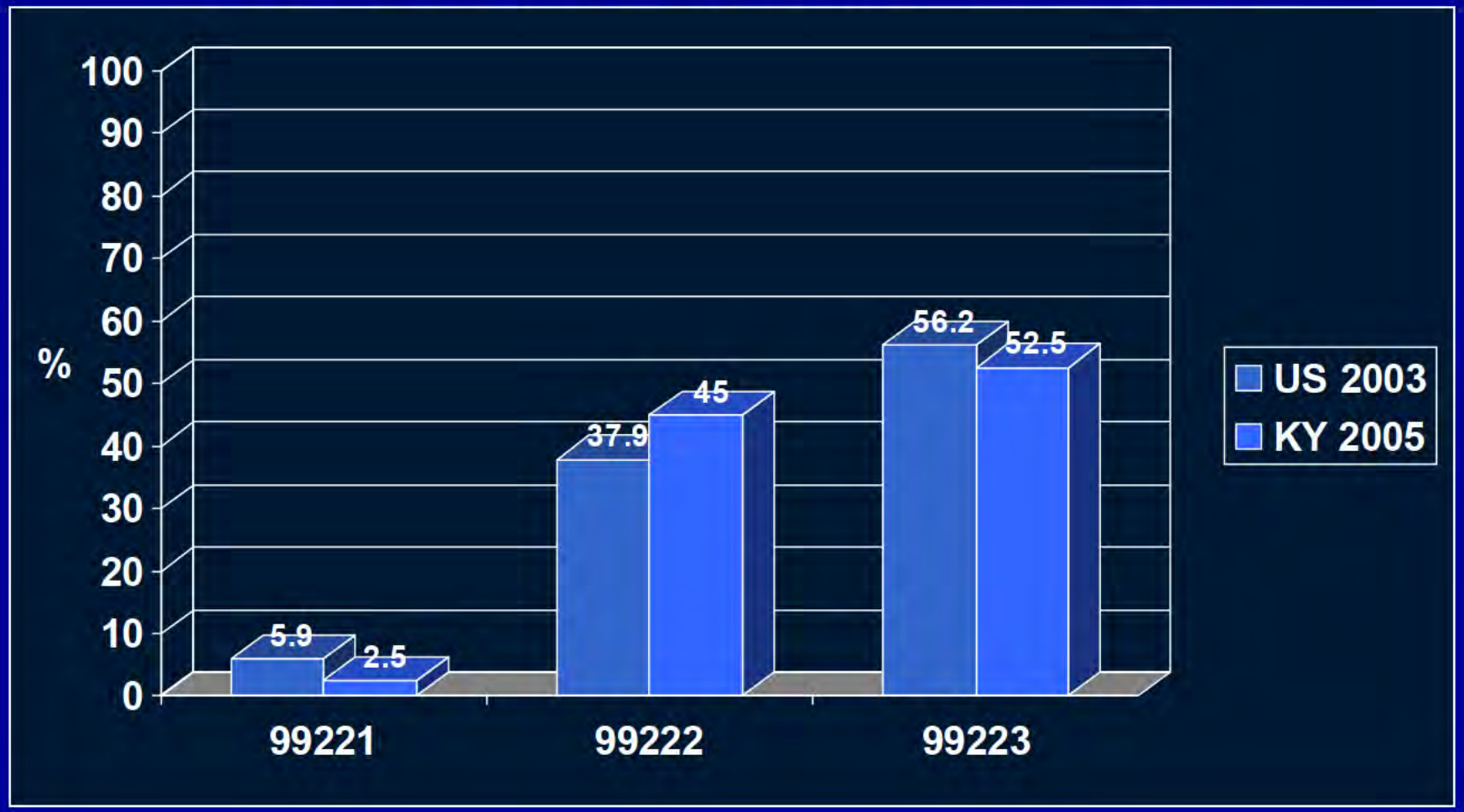
Office Consult (8%)
GI National Medicare 2003



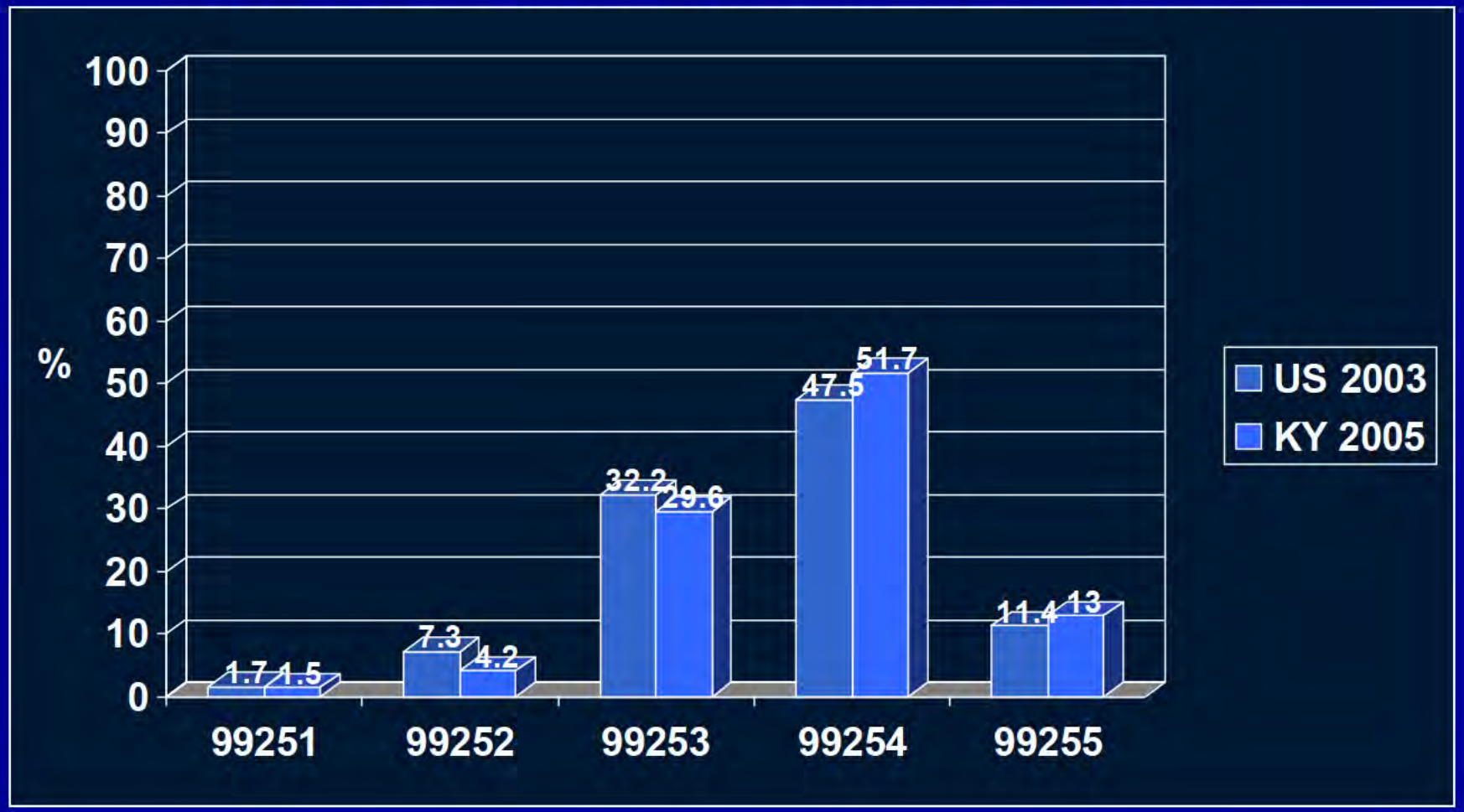
New Outpatient (2%)
GI National Medicare 2003



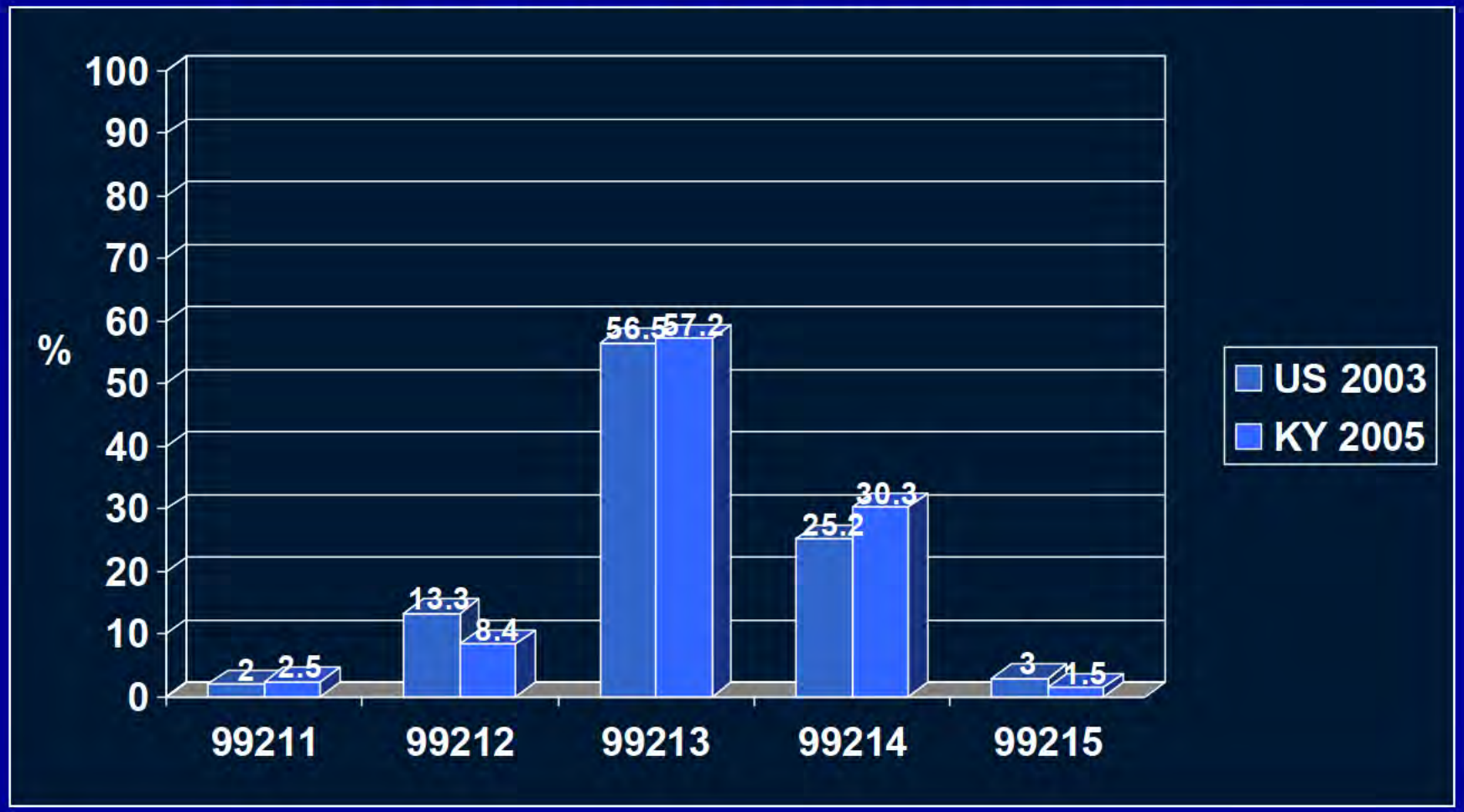
Initial Hospital Care (2%)
GI National Medicare 2003



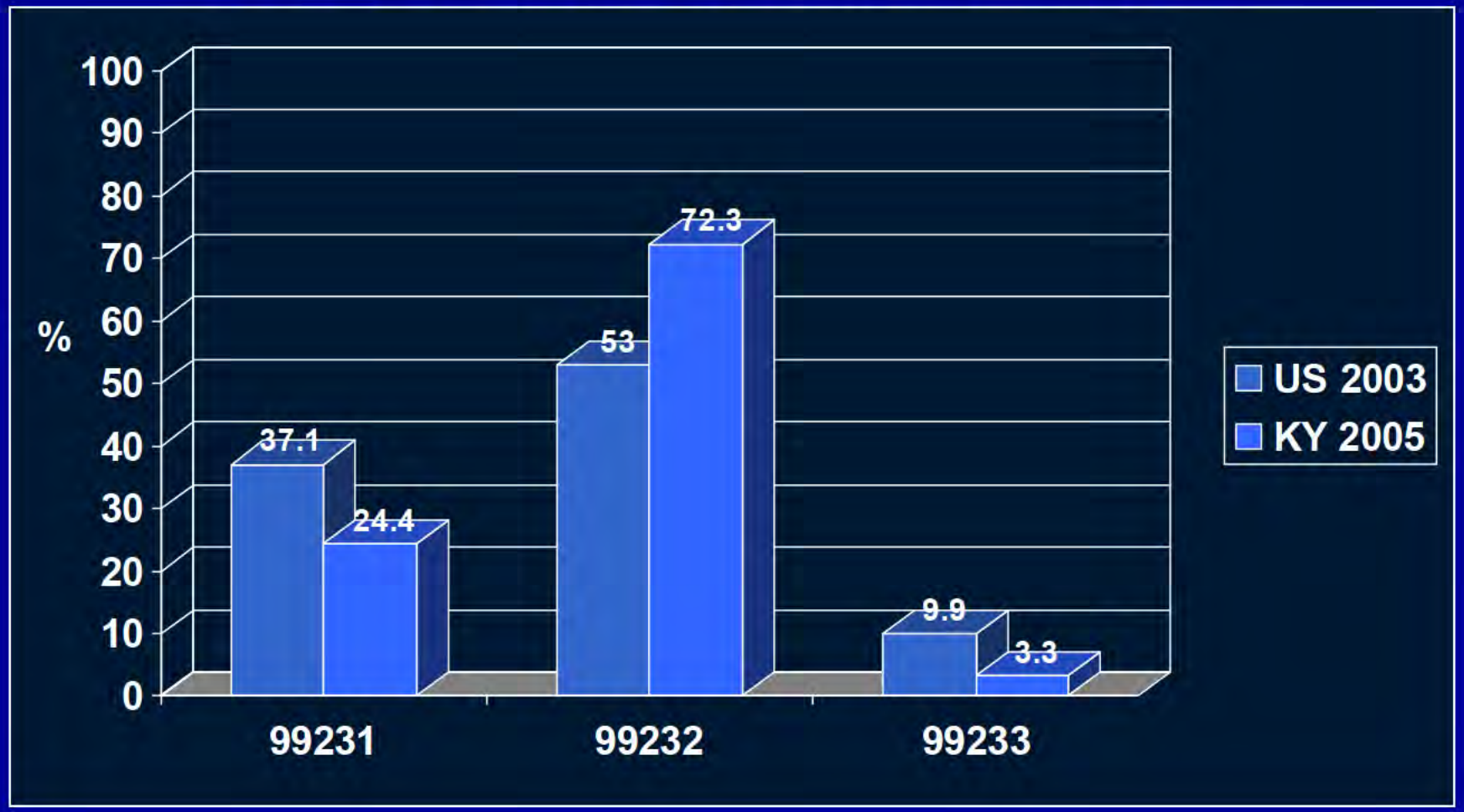
Inpatient Consult (10%)
GI National Medicare 2003



Established Outpatient (44%)
GI National Medicare 2003



Subsequent Hospital (34%)
GI National Medicare 2003



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

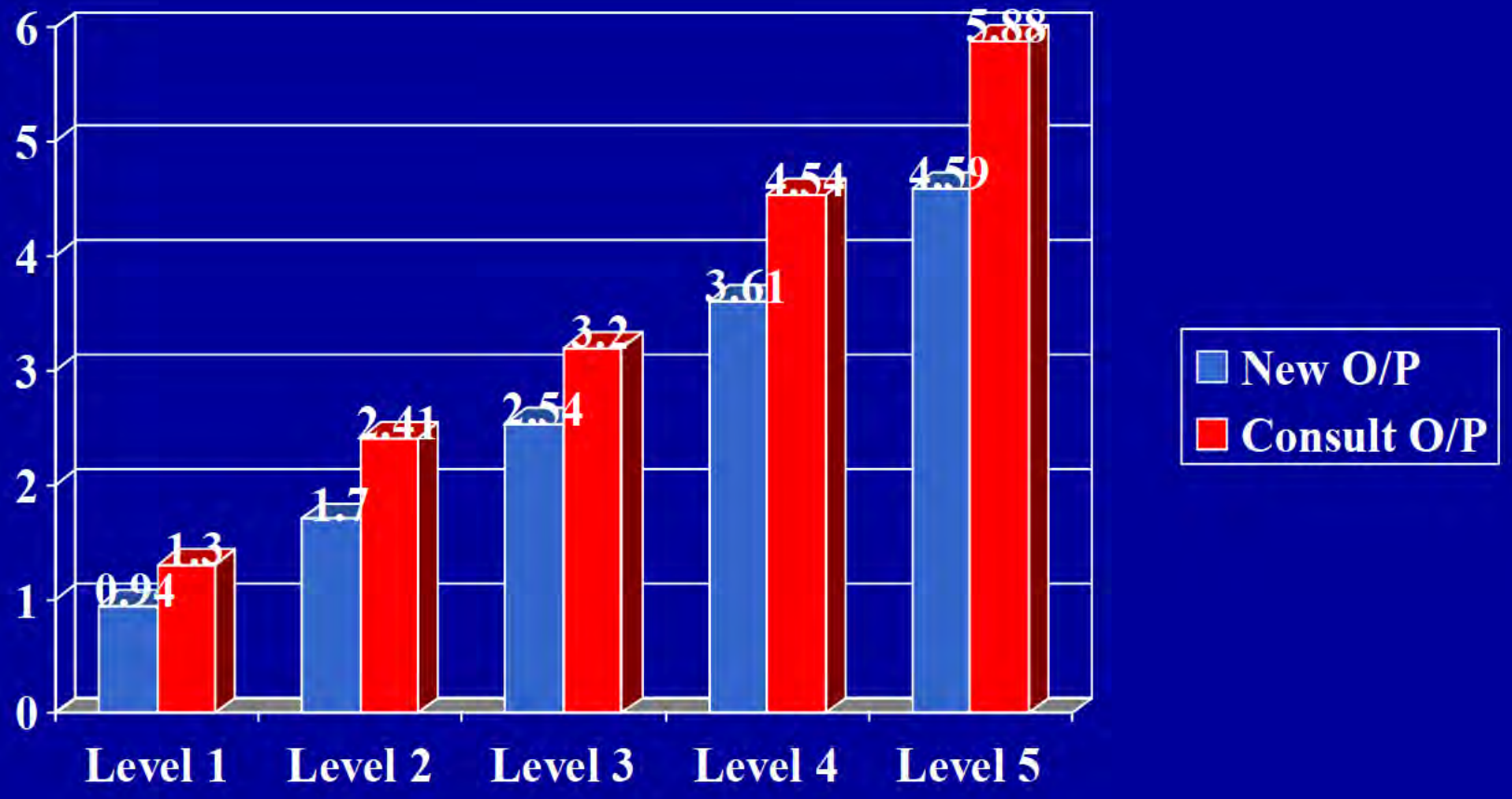
- E&M
- Anesthesia
- Surgical Procedure
- Radiology
- Pathology & Laboratory
- Medical Procedure

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

Out-Patient RVU

New-Patient vs Clinic Consult



New = 78% of a Consult RVU

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)

High Risk of Complication

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

(4 points)

- **Ac/Ch illness w threat to life/body function** (In-Patient only)
- Drug with risk & monitoring
- Elective major surgery
- Chronic illness with severe exacerbation, progression or treatment side effect (In-Patient only)
- 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)

Moderate Risk of Complication

Disease, Treatment or Management (3 points)

- **Prescription drug**
- 2 Chronic Stable illness (In-Patient only)
- Chronic illness w mild exacerbation (In-Patient only)
- Liver or kidney Bx
- Undiagnosed problem w. uncertain prognosis (In-Patient only)
- Elective major surgery
- Minor surgery w risk
- Acute illness w systemic symptoms(In-Patient only)
- 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)

Low Risk of Complication (2 points)

- **OTC drugs**
- **Diet**
- **One stable Ch. Illness** (In-Patient only)
- Acute uncomplicated illness (In-Patient only)
- Two or more self-limited illness (In-Patient only)

- 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)

Comparison of Risk Related to Diagnosis, Investigation or Treatment Out-Patient Vs In-Patient

Out-Patient

- Single Highest Item
- Lists are NOT identical

In-Patient

- Single Highest Item
- Lists are NOT identical

Risk Tables In-Patient vs Out-Patient

- They are very similar but not identical.
- In the Outpatient tables, all the Illness / Problem descriptions were removed and placed into “Out-Patient Diagnosis Complexity”

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)

Outpatient E&M Billing by Time on 2021

Should use **total time**, which includes face-to-face and non-face-to-face time spent by the E/M provider.

Does NOT include time spent on separately reported services or time spent on activities the clinical staff usually performs.

- **New Out-patient codes:**
  - 99202: 15-29 minutes
  - 99203: 30-44 minutes
  - 99204: 45-59 minutes
  - 99205: 60-74 minutes
- **Established Out-patient codes:**
  - 99212: 10-19 minutes
  - 99213: 20-29 minutes
  - 99214: 30-39 minutes
  - 99215: 40-54 minutes

For Prolonged Services use 99XXX

Prolonged Outpatient Services

New Outpatient Prolonged Service

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99XXX X 1
90-104 minutes	99205 X 1 and 99XXX X 2
105 minutes or more	99205 X 1 and 99XXX X 3 or more for each additional 15 minutes.

Established Outpatient Prolonged Service

Total Duration of Established Patient Office or Other Outpatient Services (use with 99215)	Code(s)
less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99XXX X 1
70-84 minutes	99215 X 1 and 99XXX X 2
85 minutes or more	99215 X 1 and 99XXX X 3 or more for each additional 15 minutes

Comparison of Diagnosis Complexity Rules

Out-Patient

Single Highest Item	Level
-1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or -1 acute or chronic illness or injury that poses a threat to life or bodily function	5 Extensive
-1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or -2 or more stable chronic illnesses; or -1 undiagnosed new problem with uncertain prognosis; or -1 acute illness with systemic symptoms; or -1 acute complicated injury	4 Moderate
-2 or more self-limited or minor problems; or -1 stable chronic illness; or -1 acute, uncomplicated illness or injury	3 Limited
-1 self-limited or minor problem	2 Minimal

In-Patient

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	

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

LEVEL OF CARE RULES FOR OUTPATIENTS
(EXCEPT CONSULT)

NEW AND ESTABLISHED PATIENTS

Determined only by
Decision Making

E&M Billing by Time

Out-Patient

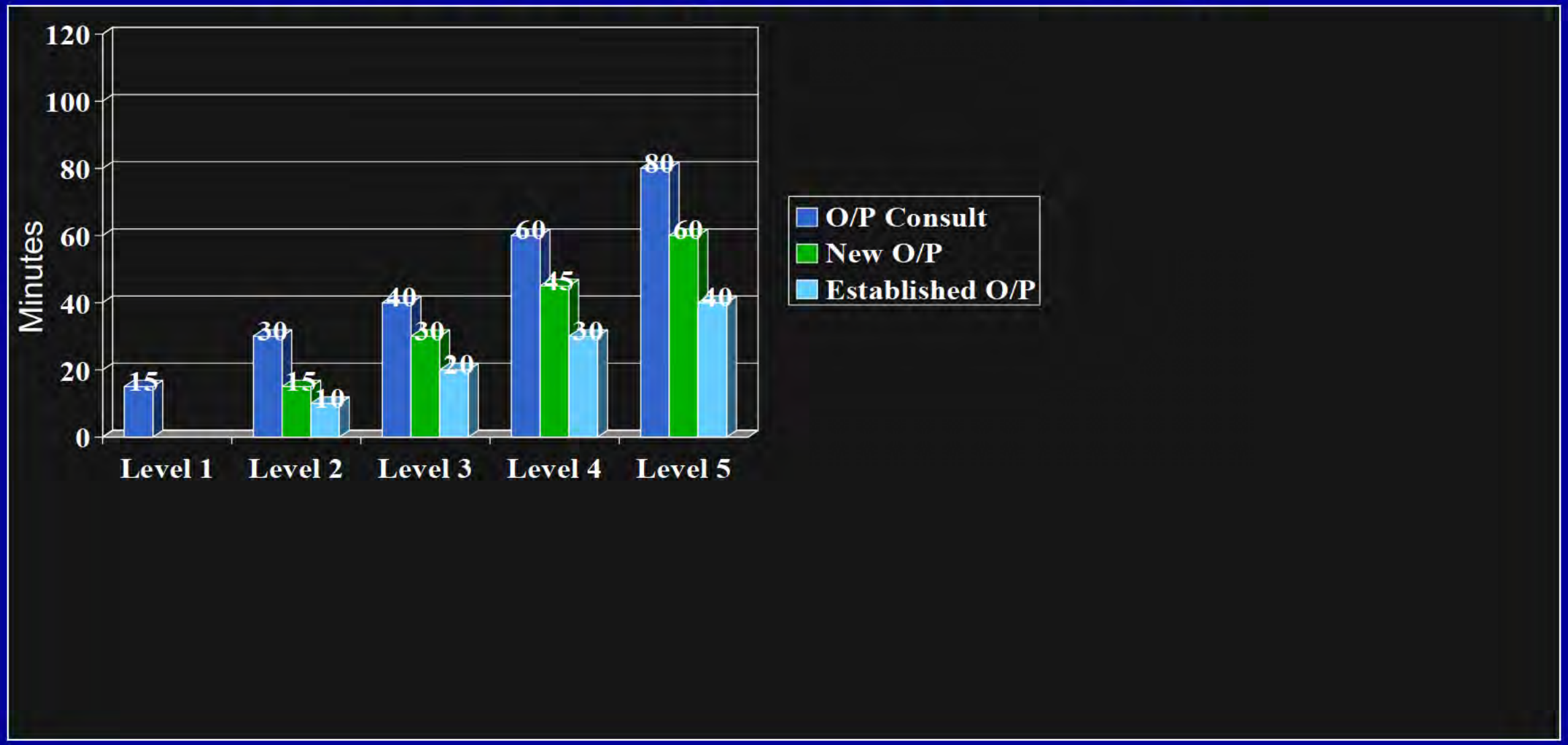
- Total Time Spent on that day
  - Preparing to see the patient (eg, review of tests)
  - Obtaining and/or reviewing separately obtained history
  - Performing a medically appropriate examination and/or evaluation
  - Counseling and educating the patient/family/caregiver
  - Ordering medications, tests, or procedures
  - Referring and communicating with other health care professionals (when not separately reported)
  - Documenting clinical information in the electronic or other health record
  - Independently interpreting results (not separately reported (and billed)) and communicating results to the patient/family/caregiver
  - Care coordination (not separately reported)

In-Patient

- **If more than 50% of the "face-to-face" time was utilized for counseling**, you can bill by time.
- The billable time is the "face-to-face" time only.
- 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)