Hospitalist Coding Compliance
sponsored by CHMB
CHMB Corporate Overview

• **Founded in 1995**
  - Privately Held, Profitable and P.E. Funded for Rapid Growth
  - Inc. 5000 Fastest Growing Private Companies 2008-2012
  - Dell Partner since 2003
  - Fully Integrated 4 Acquisitions 2008-2011

• **Partners w/ Allscripts since 2007**
  - Early Adopter - Star Reference Site for EHR/PM/Implementation
  - Deeply Connected Across Multiple Disciplines
    1) Enterprise EHR//PM
    2) Hosting and Software Implementation/Training
    3) RCM Services

• **4,000 + Providers**
  - 300+ staff in 24/7 work-cycle
  - Locations – San Diego, Irvine, Oakdale and Chicago
  - Customers Located Across 4 U.S. Time Zones
  - Remote Workforce – 15 Different States

• **Largest Install of Allscripts PM – End User Expertise**
  - 450 + PM Databases Built, Deployed and Supported
  - 7,500 + End-Users
  - 1,000 + physicians supported on EHR

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**Service**
- Customer Focused
- Completing “the last mile”

**Technology**
- Leading Technology
- Value Add Business Intelligence

**Results**
- End-to-End Solution
- Physician Hospital Alignment
CHMB Core Service Offerings

**HIT**
- PM/EHR Implementation
- Software Sales
- Hardware
- Application Support
- ASP/Hosting
- Software Development

**RCM**
- Billing Services
- Practice Management
- Reporting
- Credentialing
- Compliance & Auditing
- Coding
- Business Analytics
- Decision Support

**Consulting**
- Practice Formation
- Recruitment
- Practice Assessment
- Practice Valuations
- Payor Contracting
- PM Build, Implementation & Training
- Workflow
- Optimization
Putting Valuable Information Into The Hands That Matter

Performance Indicators

<table>
<thead>
<tr>
<th>Month</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>YTD</th>
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<tbody>
<tr>
<td>2013 Total Visits</td>
<td>633</td>
<td>537</td>
<td>532</td>
<td>539</td>
<td>466</td>
<td>467</td>
<td>525</td>
<td>537</td>
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Work RVU Analysis

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<tr>
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<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
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<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
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<tr>
<td>2013 RVUs</td>
<td>719</td>
<td>627</td>
<td>578</td>
<td>578</td>
<td>549</td>
<td>491</td>
<td>574</td>
<td>608</td>
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<tr>
<td>2012 RVUs</td>
<td>661</td>
<td>618</td>
<td>510</td>
<td>631</td>
<td>559</td>
<td>541</td>
<td>626</td>
<td>641</td>
<td>572</td>
<td>604</td>
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<td>424</td>
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<tr>
<td>Specialty Average</td>
<td>438</td>
<td>400</td>
<td>389</td>
<td>410</td>
<td>328</td>
<td>348</td>
<td>394</td>
<td>387</td>
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<tr>
<td>Specialty Average</td>
<td>403</td>
<td>380</td>
<td>386</td>
<td>428</td>
<td>384</td>
<td>379</td>
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<td>390</td>
<td>407</td>
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<tr>
<td>12 Month Rolling Average</td>
<td>586</td>
<td>589</td>
<td>595</td>
<td>590</td>
<td>583</td>
<td>585</td>
<td>581</td>
<td>578</td>
<td>595</td>
<td>596</td>
<td>593</td>
<td>583</td>
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YTD WRVUs Analysis

<table>
<thead>
<tr>
<th>Month</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
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<tr>
<td>FY2013 WRVUs</td>
<td>1.12</td>
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<tr>
<td>MGMA Percentile</td>
<td>90%</td>
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<tr>
<td>VE WRVUs at next percentile</td>
<td>7,392</td>
<td>87%</td>
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<td>Current YTD WRVUs</td>
<td>4,723</td>
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<tr>
<td>VE WRVUs for next percentile</td>
<td>2,668</td>
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<tr>
<td>Additional Visits per FTE per Bus. Day</td>
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</table>
Agenda

• Understanding Documentation Guidelines and key components of E/M Services

• Understanding coding guidelines and identify risk areas for E/M services with:
  – Admission
  – Subsequent Visits
  – Consultations
  – Observation
  – Discharge
  – Admission and Discharge Same Day
  – Critical Care
  – Shared/Split Billing
  – Physicians at Teaching Hospitals

• Understanding code range based on patient status and POS
• Understanding Time Based Services
Levels of Service
“The Seven Components”

• Patient History
• Extent of Examination
• Medical Decision Making
• Extent of Counseling
• Coordination of Care with Others
• Nature of Patient Problem(s)
• Time Requirement
E & M Level of Service Breakdown

S  Level of History
O  Level of Exam
AP  Level of Decision Making

Level of Service
History

• History of Present Illness
  – Location, severity, timing, modifying factors, quality, duration, context, associated signs and symptoms
  – 2 Levels
    • Brief 1-3
    • Extended 4 elements or status of >3 chronic or inactive conditions
History

• Review of Systems
• Both positive and negative patient answers must be documented in the HPI to be relevant

<table>
<thead>
<tr>
<th>Constitutional</th>
<th>Eyes</th>
<th>Ears</th>
</tr>
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<tbody>
<tr>
<td>Cardiovascular</td>
<td>Respiratory</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Integumentary</td>
<td>Neurological</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>Endocrine</td>
<td>Hematological/Lymphatic</td>
</tr>
<tr>
<td>Allergic/Immunology</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

• Problem Focused: none
• Exp Problem focused: Pertinent to Problem, 1 system
• Detailed: 2-9 Systems, Extended
• Comprehensive: Complete, 10 systems, or some systems with statement “all others negative”
  – Medicare carriers do include “all others negative” on their audit templates but have pulled back in allowing broad use of this phrase
History

- **PFSH (Past, Family and Social)**
  - **Past** *(Allergies, Current Medications, Immunizations, previous traumas, surgeries, previous illness/hospitalizations)*
  - **Family** *(Health of Parents, Siblings, children. Family Members w/ diseases related to the chief complaint.)*
  - **Social** *(Drug, Alcohol, tobacco use, Employment, Sexual History, Marital Status, Education, Occupational History)*

- **Required only for Initial Hospital Care and Observation Admission**
- **Not required for INTERVAL history (subsequent hospital visit)**
<table>
<thead>
<tr>
<th>HPI</th>
<th>Brief 1-3</th>
<th>Brief 1-3</th>
<th>Extended &gt;4 or 3 chronic conditions</th>
<th>Extended &gt;4 or 3 chronic conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ROS</strong></td>
<td>None</td>
<td>Pertinent to problem, 1 system</td>
<td>Extended 2-9 Systems</td>
<td>Complete &gt;10 systems, or “all others negative***”</td>
</tr>
<tr>
<td><strong>PFSH</strong></td>
<td>None</td>
<td>None</td>
<td>One</td>
<td>Two or Three</td>
</tr>
<tr>
<td>Est. pt</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PFSH</strong></td>
<td>None</td>
<td>None</td>
<td>One or Two</td>
<td>Three</td>
</tr>
<tr>
<td>New/consult/Admit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Problem Focused</strong></td>
<td>Exp Problem Focused</td>
<td>Detailed</td>
<td>Comprehensive</td>
<td></td>
</tr>
</tbody>
</table>
Physical Exam

- **Problem Focused**: A limited exam of the affected body area or organ system.

- **Expanded Problem Focused**: A **limited examination** of the affected body area or organ system and other symptomatic or related organ system(s).

- **Detailed**: An **extended exam of** the affected body area(s) and other symptomatic or related organ systems.

- **Comprehensive**: A general multisystem exam or a complete exam of a single organ system.
1995 Physical Exam

- Constitutional (record at least 3 vital signs)
- Eyes
- Ears, nose, throat, mouth
- Cardiovascular
- Respiratory
- GI
- GU
- Musculoskeletal
- Skin
- Neurological
- Physiological
- Hem/Lymph/Imm
- Affected body area

Slash all normal exams, remarks on positive findings

Note: All elements must be supported by HPI
Medical Decision Making

Considered by CMS to be the “driver” in code selection

1. Straightforward
2. Low Complexity
3. Moderate Complexity
4. High Complexity
Documentation

• A
  – Assessment
  – Number of Diagnoses (must be specific)
  – Complexity and Amount of Reviewed Data

• P
  – Treatment Plan Options
  – Risk of Complications
Number of Diagnoses or Treatment Options

(1) Self-limited or minor
(1) Est. Problem stable, improved
(2) Est. Problem worsening
(3) New problem; no additional workup planned (systemic involvement)
(4) New problem (to examiner); additional workup planned

**Note: new vs. self limited problem values: If the problem warrants the initiation of a new treatment plan (ie: prescription drug management, additional diagnostic workup, referral to a specialist, over the counter medications with provider follow up if needed, etc), it's new. If the problem does not warrant the creation of a treatment plan, it's self limited**
Amount and/or Complexity of Data to be Reviewed

(1) Review and/or order of clinical lab tests
(1) Review and/or order of tests in the radiology section of CPT
(1) Review and/or order of tests in the medicine section of CPT
(1) Decision to obtain old records and/or obtain history from someone other than patient
(2) Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider
(2) Independent visualization of image, tracing or specimen itself (not simply review of report)
Risk of Complications and/or Morbidity or Mortality

- Presenting Problem(s)
- Diagnostic Procedure(s) Ordered
- Management Options Selected

The highest level of risk in any one category determines the overall risk
Final Result of Complexity

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>A</th>
<th></th>
<th></th>
<th>B</th>
<th></th>
<th></th>
<th>C</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td># dx</td>
<td>&lt;1</td>
<td>2</td>
<td>&gt;4</td>
<td></td>
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<td>Risk</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td></td>
<td>minimal</td>
<td>limited</td>
<td></td>
<td>extensive</td>
<td></td>
<td></td>
<td>Minimal</td>
<td>Straight-forward</td>
</tr>
<tr>
<td>B</td>
<td>data</td>
<td>low</td>
<td>limited</td>
<td></td>
<td>extensive</td>
<td></td>
<td></td>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>MDM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>High</td>
</tr>
</tbody>
</table>

- To determine Medical Decision Making, refer to the table and draw a line down the column with **2 or 3 circles** or draw a line down the columns with the center circle. **MDM is the most important factor is supporting medical necessity for level of service.**
Time definition was revised in 2010 to require face-to-face time for Hospital inpatient visits or consult services is defined as only that time that the physician spends face-to-face with the patient (bedside) and/or family.

When greater than 50% of the face-to-face time is spent in counseling or coordination of care, time may be considered in selecting the code level for the encounter.

Tip: If the visit does not include any interval history (“S” of SOAP note), no Physical Exam (“A”), such as a return visit to discuss test results, treatment options, compliance with treatment plan, etc. this lengthy visit would qualify for the “Time” component for code selection.
Choosing the correct range

- Patient Status
  - New, established
- Type of Service
  - referred for consult, self referred, preventative
- Location
  - Observation “other” outpatient, inpatient
- Admission on the same date
  - Other outpatient services “roll up” into the admission code
  - Observation – be sure location is OH
- Note: Observation/Inpatient must match the hospital’s status (check with managed care coordinators)
The Status and Setting of Patient Care

- **Inpatient** – Patient is admitted to an inpatient facility
  - Use inpatient codes

- **Outpatient** – Patient may be in a facility in outpatient status (e.g., emergency department), or in an office
  - Use outpatient or ED codes

- **Observation** – Patient may be in a designated observation unit or in another setting in observation status
  - Use observation codes
Major Factors Influencing E/M Code Assignment in the Hospital Setting

- Is the encounter an admission or a subsequent visit?
- Is the service a consultation?
  - If so, is this a Medicare Beneficiary or a Medicare Advantage Plan following the CMS Consultation Rules?
- Only one E/M code should be assigned per provider, per patient, per day (with a few exceptions—critical care)
- Documentation level of history, examination and medical decision making
- Setting of service and status of patient (e.g. inpatient, outpatient, observation status)
E/M Codes for Hospital Visits

- Initial hospital care visit (99221 – 99223)
- Subsequent hospital care visit (99231- 99233)
- Hospital discharge management (99238 – 99239)
- Observation initial Day(99218 – 99220, 99234 – 99236)
- Observation discharge management (99217)
- Observation Subsequent Day (99224-99226)
- Emergency department service (99281 -99285)
- Critical Care (99291-99292)
- Prolonged Services (99356-99358)
- Physician outpatient visit-established patient with established plan of treatment (99211 – 99215)
Hospital Inpatient Services Coding Guidelines

- For initial inpatient encounters by physicians other than the admitting physicians other than the admitting physician, see initial inpatient consultation codes (9925X) or subsequent hospital care codes (9923X) as appropriate.

- Codes may be assigned based on unit/floor time when counseling is more than 50% of the total encounter.
Documentation

• Each physician/NP should personally document in the medical record his/her portion of the E/M visit
• Shared/split visits are allowed, documentation must support the combined service level reported on the claim
• Ancillary staff may document the review of systems and past/family/social history. The physician or NPP must personally review this documentation and confirm and/or supplement in the medical record
Hospital Inpatient Services Coding Guidelines

• One E/M Code Assignment Per Day:
  – When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (e.g., hospital emergency department, observation status in a hospital, physician’s office, nursing facility) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission.
Hospital Inpatient Services

- 99221 – 99223: Initial Hospital Care
- 99231 – 99233: Subsequent Hospital Care
- 99238 – 99239: Hospital Discharge Services
Hospital Admission 99221 - 99223

- Initial hospital admission date
- New or established patient
- Codes are used to report the first hospital inpatient encounter with the patient by the admitting physician/provider. – Append “AI” modifier for Medicare
  - Effective 1/1/2010 this will be used by all other physicians for their initial inpatient encounter
- Only three levels of code assignment available
- Level I requires a detailed History and Exam
- Levels II and III require a comprehensive History and Exam
# Initial Hospital (Admission) Care Codes

<table>
<thead>
<tr>
<th>Hospital Admission 3/3</th>
<th>HISTORY</th>
<th>EXAM</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221 Initial Admission, Low</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Straightforward</td>
<td>30</td>
</tr>
<tr>
<td>99222 Initial Admission, Moderate</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate</td>
<td>50</td>
</tr>
<tr>
<td>99223 Initial Admission, High</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
<td>70</td>
</tr>
</tbody>
</table>
Hospital Visit 99231 – 99233

• Subsequent hospital care
  – Includes:
    • Reviewing the medical record
    • Reviewing lab and other diagnostic studies
    • Assessing patient’s status since last encounter
## Subsequent Hospital Care Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231</td>
<td>Inpt Follow Straightforward</td>
<td>Prob. Focused</td>
<td>Problem Focused</td>
<td>Low/ Stable, Recovering, Improving</td>
<td>15 min bedside, floor or unit</td>
</tr>
<tr>
<td>99232</td>
<td>Inpt Follow Moderate</td>
<td>Exp Prob Foc.</td>
<td>Exp. Problem Focused</td>
<td>Moderate Inadequate response/Minor Complication</td>
<td>25 min bedside, floor or unit</td>
</tr>
<tr>
<td>99233</td>
<td>Inpt Follow High</td>
<td>Detailed Interval</td>
<td>Detailed</td>
<td>High. Unstable, significant complication significant new problem</td>
<td>35 min bedside and floor or unit</td>
</tr>
<tr>
<td>99238</td>
<td>Discharge under 30 minutes</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>99239</td>
<td>Discharge over 30 minutes</td>
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</tbody>
</table>

Be sure to dictate time spent in your discharge summary.
Hospital Observation Services

- 99217 ~ Discharge
- 99218 – 99220 ~ Hospital Observation Services
- 99224-99226 ~ Hospital Observation Subsequent Day
- 99234 – 99236 ~ Hospital Observation or Inpatient Care Services on the same date (Including Admission and Discharge Services)

- New or established patient
- Documentation tip ~ include time
Subsequent Observation Codes

• **99224** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:
  – Problem focused interval history;
  – Problem focused examination;
  – Medical decision making that is straightforward or of low complexity.
  – Time: 15 minutes

• **99225** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:
  – An expanded problem focused interval history;
  – An expanded problem focused examination;
  – Medical decision making of moderate complexity
  – Time: 25 minutes

• **99226** Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:
  – A detailed interval history;
  – A detailed examination;
  – Medical decision making of high complexity.
  – Time: 35 minutes
Sequence of Observation Codes

- 99217 Observation Discharge
- 99218-99220 Observation Admission
- 99224-99226 Observation Subsequent
- 99234-99236 – Observation (or inpt) admission and discharge on the same day

- The addition of 99224-99226 eliminates the need to use outpatient 99211-99215
# Observation Codes

<table>
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<tr>
<th>Observation Codes 3/3</th>
<th>HISTORY</th>
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<th>MDM</th>
<th>Time</th>
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<tr>
<td>Observation care discharge</td>
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</tr>
<tr>
<td>99218</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low</td>
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</tr>
<tr>
<td>Initial Observation Low</td>
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<tr>
<td>99219</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate</td>
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<tr>
<td>Initial Observation Moderate</td>
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<tr>
<td>99220</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
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<tr>
<td>Initial Observation High</td>
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<tr>
<td>99234</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low</td>
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</tr>
<tr>
<td>Admit/Discharge same day Low</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>99235</td>
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<td>Comprehensive</td>
<td>Moderate</td>
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<tr>
<td>Admit/Discharge same day Mod</td>
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<td></td>
</tr>
<tr>
<td>99236</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
<td></td>
</tr>
<tr>
<td>Admit/Discharge same day High</td>
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</table>
Two Midnight Rule

• In the 2014 Medicare inpatient prospective payment system final rule, CMS included a new regulation for hospitals and health systems: the two-midnight rule.

• CMS has issued guidance on the rule in a couple separate instances. For hospitals and health systems trying to grasp the foundational elements of the two-midnight rule, here are 10 points to know.
Two Midnight Rule

1. Reasonable and necessary for “more than a one day stay” or for “inpatient only”
2. Stays lasting less than 2 midnights must be billed as outpatient
3. RACS and MACS will not review claims that span more than 2 midnights
4. Medicare audits will review claims that span less than 2 midnights and have admission dates 10/1/13 – 3/31/14
5. MACS will review 10 to 25 claims per hospital depending on the size of the hospital
Two Midnight Rule

6. Critical access hospitals are exempt from MAC and RAC Reviews

7. Audit will be based on a physicians’ expectation of medically necessary care surpassing 2 midnights on the information known at the time of admission

8. Hospitals can rebill for medically reasonable and necessary Part B inpt services if Part A claims are denied

9. Physician documentation will be crucial for hospitals. (pt history, comorbidities, severity, risk

10. CMS will conduct education outreach later in 2014 based on the results of the initial reviews
Hospital Observation Services Coding Guidelines

• Observation is defined as an outpatient service and therefore should be billed with place of service 22
  – Not all payers and carriers follow this logic
• Observation services are included in the postoperative package, unless they are for an unrelated problem
  – E/M services provided in the postoperative period that are unrelated to recovery from the surgical procedure should be billed with modifier -24
• Do not report separate E/M services on the same date of service for “initiation” of observation
Effective Date: 10/31/2013

- CMS has a Frequently Asked Questions information sheet on their website
- [Click here](#)
Hospital Observation Services Coding Guidelines

- Observation codes are assigned by the supervising physician for a patient on observation status.

- No typical times established for these services.

- Non-supervising physicians should report outpatient consultation (9924X) or outpatient or office codes (9920X, 9921X).
Hospital Observation Services Coding Guidelines

- Assign observation codes relative to calendar date (date or service), not in 24-hour time periods
- One E/M Per Day: If the patient is admitted on the same date as observation services, report only initial inpatient care (9922X)
  - Cont the work in the observation encounters toward E/M codes assignment
- For a patient admitted and discharged from observation or inpatient status on the same date, reports same day admit and discharge (99234 – 99236)
  - Do not report observation discharge (99217) in conjunction with the hospital admission
Hospital Observation Services Coding Guidelines

• One E/M Code Assignment Per Day:

  – When “observation status” is initiated in the course of an encounter in another site of service (e.g., hospital emergency department, physician’s office, nursing facility) all evaluation and management physician in conjunction with initiating “observation status” are considered part of the initial observation care when performed on the same date.
Admission/Discharge Same Day

- Federal Register Clarification Hospital Observation Services
- CMS Program Memorandum B-00-65, November 21, 2000 – Page 2
- Federal Register, November 1, 2000
  - Page 65409
  - For a physician to appropriately report CPT codes 99234 – 99236 for Medicare payment, the patient must be an inpatient or an observation care patient for a minimum of 8 hours on the same calendar date.
Federal Register Clarification
Hospital Observation Services

• CMS Program Memorandum (Cont.)
• Federal Register (Cont.)
  – When the patient is admitted to observation status for less than 8 hours on the same date, then CPT codes 99218 – 99220 should be used by the physician and no discharge code should be reported.
  – When patients are admitted for observation care and then discharged on a different calendar date, the physician should use CPT codes 99218 – 99220 and CPT observation discharge 99217.
  – When a patient has a follow-up on a day in between the admission for observation and the discharge use Established Other Outpatient codes 99211 to 99215 range
Hospital Observation Services Areas of Risk

- Misinterpretation of notations in medical record regarding observation status
  - Patient must be admitted to formal observation status to assign the observation codes
- Errors related to definition of “same day”
- Assignment of observation codes in addition to other E/M codes on same date of service
- Lack of documentation for initial observation care codes
  - 99219, 99220 require documentation of a comprehensive history and examination
Hospital Inpatient Services Areas of Risk and Opportunity

- Assignment of initial hospital care codes by more than one physician
- Lacking documentation for initial hospital care codes
  - 99222 and 99223 require documentation of comprehensive history and examination
- Failure to document time for discharge services
  - Lost opportunity to assign CPT code 99239
Consultations

• 99241 – 99245: Outpatient Consultations
  – Use if patient is considered observation status or consult is requested in ED and patient is discharged

• 99251 – 99255: Initial Inpatient Consultations
  – Use if patient status is inpatient admission
## Consultation Codes

<table>
<thead>
<tr>
<th>Inpatient Consultation 3/3</th>
<th>Rule of R's</th>
<th>Use &quot;alternate&quot; code for Medicare</th>
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<tbody>
<tr>
<td>99251 Initial inpt consult</td>
<td>Prob. Focused</td>
<td>Problem Focused Straightforward</td>
</tr>
<tr>
<td>99252 Initial inpt consult</td>
<td>Exp. Problem Focused</td>
<td>Exp Problem Focused Straightforward</td>
</tr>
<tr>
<td>99253 Initial inpt consult</td>
<td>Detailed</td>
<td>Detailed Low</td>
</tr>
<tr>
<td>99254 Initial inpt consult</td>
<td>Comprehensive</td>
<td>Comprehensive Moderate</td>
</tr>
<tr>
<td>99255 Initial inpt consult</td>
<td>Comprehensive</td>
<td>Comprehensive High</td>
</tr>
</tbody>
</table>

Outpatient codes are reported with 99241-99245, same 5 levels of service
Is the Service a Consultation?

- Was the advice or opinion of the provider requested?
- Was the opinion issued as per guidelines?
- Are these facts clearly documented in the medical record?
- “Six R’s”
  - Request (From whom?)
  - Reason for consultation
  - Review of previous records
  - Render patient evaluation (H&P)
  - Recommendation for plan of treatment
  - Report (separate if not shared record)
Consultations Areas of Risk and Opportunity

- Assignment of consultation codes without appropriate documentation of request and/or report, where appropriate
- Failure to clearly ascertain intent of requestor when the record is shared
- Failure to assign consultation coding for specialty preoperative clearance
- Preoperative consultations are payable for new or established patients performed by any physician at the request of a surgeon, as long as all of the requirements for billing the consultation codes are met and preoperative clearance is not a routine request (must be medically necessary)
Pre-Op Consults

• Pre-operative Visits
  • Are coded as appropriate level consult
    • Pre-Operative Diagnosis Code listed first
    • V72.81 Pre-operative cardiovascular examination
    • V72.82 Pre-operative respiratory examination
    • V72.83 Other specified pre-operative examination
    • V72.84 Unspecified pre-operative examination
  • Reason for Surgery listed second
  • Any other diagnosis patient being treated for in the third and fourth diagnosis
Consultations Areas of Risk and Opportunity

- Consultation for Preoperative Clearance
  - Per Medicare Transmittal 788
  - G. Consultation for Preoperative Clearance
  - Preoperative consultations are payable for new or established patients performed by any physician or qualified NPP at the request of a surgeon, as long as all of the requirements for performing and reporting the consultation codes are met and the service is medically necessary and not routine screening.
# Level of Consultation

<table>
<thead>
<tr>
<th>Office Consults 3/3</th>
<th>HISTORY</th>
<th>EXAM</th>
<th>MDM</th>
<th>Time</th>
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<tr>
<td>99241</td>
<td>Office Consult minimal</td>
<td>Problem Focused</td>
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<td>Straightforward</td>
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<tr>
<td>99242</td>
<td>Office Consult Prob. Focused</td>
<td>Exp. Problem Focused</td>
<td>2-4</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99243</td>
<td>Office Consult (Low)</td>
<td>Detailed</td>
<td>5-7</td>
<td>Low</td>
</tr>
<tr>
<td>99244</td>
<td>Office Consult (Mod.)</td>
<td>Comprehensive</td>
<td>8+</td>
<td>Moderate</td>
</tr>
<tr>
<td>99245</td>
<td>Office Consult (High)</td>
<td>Comprehensive</td>
<td>8+</td>
<td>High</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inpatient Consultation 3/3</th>
<th>Rule of R's</th>
<th>Only one per hospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>99251</td>
<td>Initial inpt consult straightforward</td>
<td>Prob. Focused</td>
</tr>
<tr>
<td>99252</td>
<td>Initial inpt consult Expanded</td>
<td>Exp. Problem Focused</td>
</tr>
<tr>
<td>99253</td>
<td>Initial inpt consult Detailed</td>
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<td>99255</td>
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</table>
Critical Care Defined

• Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition.

• Critical care involves high complexity decision making to assess, manipulate and support vital system funcion(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient’s condition.
Critical Care Documentation

- Patient is in critical condition
- Critical Care episode exceeds 30 minutes
  - Start and end time
- Personal Attendance
Examples of Organ System Failure

• Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic and/or respiratory failure.
Critical Care Services

- 99291 – 99292: Adult (over 24 months of age)
- 99293 – 99294: Pediatric Critical Care (age = 29 days through 24 months)
- 99295 – 99296: Neonatal Critical Care (age = 28 days or less)
- 99298 – Subsequent Intensive Care – Low Birth Weight (less than 1500 grams)
- 99299 – Subsequent Intensive Care – Low Birth Weight (1500 – 2500 grams)
- 99300 – Subsequent Intensive Care – Low Birth Weight (2501 – 5000 grams)
- 99289 – 99290: Pediatric Patient Transport
Critical Care Services

- The following examples illustrate the correct reporting of critical care services:
- Total Duration of Critical Care Services
- less than 30 minutes ~ appropriate E/M codes
- 30-74 minutes ~ 99291
- 75-104 minutes ~ 99291 AND 99292
- 105-134 minutes ~ 99291 AND 99292 X 2
- 135-164 minutes ~ 99291 AND 99292 X 3
- 165-194 minutes ~ 99291 AND 99292 X 4
- 194 minutes or longer ~ 99291 AND 99292 as appropriate
Services Included in Critical Care

The following services are included in reporting critical care when performed during the critical period by the physician(s) providing critical care:

- The interpretation of cardiac output measurements (93561, 93562);
- Chest x-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762);
- Blood gases, and information data stored in computers (e.g., ECGs, blood pressures, hematologic data (99090));
Services Included in Critical Care (Cont.)

- Temporary transcutaneous pacing (92953);
- Ventilator management (94002 – 94004, 94660, 94662); and
- Gastric intubation (43752, 91105);
- Vascular access procedures (36000, 36410, 36415, 36540, 36600).

Any services performed which are not listed above should be reported separately.
Example of Critical Care Documentation

“total critical care time, excluding procedures, 1 hour 45 minutes”

• Documentation of Total Time

• Documentation to Exclude Any Separately Reportable Procedures

• Documentation of discussions with family members and caregivers and related time
Critical Care Services Areas of Risk and Opportunity

- Reporting critical care when patient no longer considered critically ill
- Time component not met or not documented
- Not subtracting time for separately reportable services (Ex. CPR 92950)
- Failure to add all time spent on a calendar date performing critical care services
Hospital ED visits

• If the provider took over the patient’s care from the ED physician, report 99281-99285 for treatment rendered
• Medicare will now pay more than one provider for 99281-99285 effective 01/01/2010
• Do not use initial hospital care unless the patient is admitted
• If the ED physician requested a consultation and you did not take over the patient’s care, report outpatient consultation 99241-99245
Hospital Discharge 99238 - 99239

- Discharge management includes:
  - Final exam of patient
  - Discussion of hospital stay
  - Discharge instruction (including time to instruct family or other caregivers)
  - Preparation of discharge records, prescriptions and referral forms
  - Time – 30 minutes or less ~ 99238
    - Time – More than 30 minutes ~ 99239
  - Include all time even if not continuous on the same date
PATH Guidelines

- PATH stands for Physicians at Teaching Hospitals
- The coding for Teaching Hospitals requires some special knowledge of the rules to ensure billing compliance
- The Primary Care exception exists in order to train Residents to build relationships with patients in the primary care and obstetrical fields
PATH Audits

• Coded and billed under the teaching physician’s name

• Documentation criteria
  – History
    • Notations such as “noncontributory” are inadequate
  – Exam
  – Medical decision making
PATH Audits

• Authorship
  – Illegible teaching physician and resident signature
  – Unauthenticated medical record entries
    • Auditor unable to differentiate between physician and nurse entries, or from teaching physician to resident
  – Legible signatures are required to certify services
PATH Audits

• Proof of Teaching Physician’s Presence & Participation
  – The teaching physician’s presence and participation in the resident’s services with the shared patient are only substantiated (i.e., proven) by his/her contribution to the MR documentation for the service (e.g., an inpatient hospital visit or a surgical procedure).
  – Brief, simplistic statements by the teaching physician such as “Discussed with resident and agree ... J.Smith, MD” are inadequate to substantiate active participation in the care of the shared patient.
  – Documentation by the resident of the teaching physician’s presence/participation is unacceptable “proof” of the service.
PATH Audits

• Coding Restrictions Under the Primary Care Exception
  – Meeting basic E/M documentation guidelines and proving the teaching physician’s presence and participation aside, a very basic coding misunderstanding under the primary care exception (PCE) is the cause of the majority of errors in this category.
  – Whether due to provider misconception of the rule or coder/biller lack of understanding in terms of which codes are valid under the PCE, high level E/M services such as 99204/99205 and 99214/99215 have been reported in error.
  – Only low to mid-level E/M codes
    • 99201-99203, 99211-99213
    • G0402 for the IPPE (“Welcome to Medicare”) physical exam
    • G0438 and G0439 for Annual Wellness Visits, Initial and Subsequent, are authorized under the PCE.
PATH Audits

• Misapplication of PATH Modifiers -GC and –GE
  – There are two basic modifiers associated with PATH services
    • GC ‘This service has been performed in part by a resident under the direction of a teaching physician’
    • GE ‘This service has been performed by a resident without the presence of a teaching physician under the primary care exception.’
  – Problems arise when the modifiers are mis-reported, erratically reported or not reported at all
PATH Audits

• Critical Care Often = Critical Errors in MR Documentation
  – Residents in teaching settings can participate in critical care services.
  – The reporting of critical care services under CPT code 99291 Critical care, first 30-74 minutes and CPT code 99292 Critical care, each additional 30 minutes, is predicated upon “duration of time” being documented in the MR notes.
  – Exact minutes do not have to be documented but the total duration of time spent face-to-face in critical care with the patient must be documented.
• Federal auditors often find lapses in the MR documentation in terms of time spent in critical care, as well as confusion in terms of “who did what?” because the MR notes are unclear.
• Authentication (signature) issues also surface with critical care.
PATH Audits

• Time-Based Coding and Reporting Errors
  – The teaching physician must be present for the total amount of ‘claimed time’ in order for the service to be paid at that level, e.g., a time-based service of 30 minutes is only paid if the teaching physician is present for 30 minutes.
  – The time involved always depends on the time spent by the teaching physician, not the resident. Federal auditors find – due to documentation disparities in the MR notes – that the teaching physician’s presence for the ‘claimed time’ is in doubt or appears unclear.
PATH Audits

• Poorly or Ambiguously Documented Surgical Sessions
  – In the typical surgical suite in the PATH arena, teaching surgeons work with residents and might oversee a single surgical session or two overlapping sessions (three or more are not paid under PATH guidelines), as well as different kinds of surgical sessions (e.g., an endoscopic surgery session, a diagnostic endoscopy procedure, a traditional open surgery and/or a minor surgical procedure)
  – PATH guidelines and documentation standards are similar for all of these surgeries with one exception
  – Federal auditors typically find discrepancies in the documentation of the procedures, such as the teaching surgeon’s presence for the key/critical portions of the service, the teaching surgeon’s contribution to the surgical note, and/or authentication issues (e.g., a resident dictating and signing the operative report without the teaching surgeon’s contribution and signature).
PATH Audits

• Residents and Diagnostic Reports
  – federal auditors find that the residents have dictated and signed the diagnostic test, study or radiology report without any diagnostic study documentation or countersignature by the teaching physician
Incident To

• The use of nonphysician providers in medical practices has expanded, and it is very important to understand the incident to rules.
Incident-To Rules

• The nonphysician providers must be W-2 or leased employees of the physician, and the physician must be able to terminate the employee and direct how the Medicare services are provided by that employee.

• The physician must perform the initial patient visit and ongoing services of a frequency that demonstrate active involvement of the physician in the patient’s care, thereby creating a physician service to which the nonphysician providers’ services relate.

• A physician must be on the premises, but not necessarily in the room, when incident-to services are performed.

• Diagnostic tests must be done under the testing supervision requirements: general, direct and personal, which are designated by CPT code.

• Incident-to services cannot be performed in the hospital.
Shared/Split Rule

• Reports inpatient services provided by both a physician and a non-physician
• Each personally performs a substantive portion of an E/M visit face-to-face with the same patient on the same date of service
• Common documentation errors:
  – Insufficient documentation to support that both the physician and NPP performed a substantive portion of the split/shared E/M service
Documentation for Shared/Split Visit

• Each physician/NP should personally document in the medical record his/her portion of the E/M visit
• Shared/split visits are allowed, documentation must support the combined service level reported on the claim
• Ancillary staff may document the review of systems and past/family/social history. The physician or NPP must personally review this documentation and confirm and/or supplement in the medical record
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Nancy is a Fellow of the American College of Medical Practice Executives. She serves as co-chair of the IT Advisory Panel of the Information Management Society for MGMA and serves as a College Forum Representative for the American College of Medical Practice Executives. She is a Past President of the Rhode Island/Massachusetts MGMA and serves on the Eastern Section Executive Committee for MGMA.
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# CHMB Webinar Lineup

## Upcoming Webinars

12:00 p.m. EST AND 12:00 p.m. PST

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<tr>
<th>Date</th>
<th>Topic</th>
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<tbody>
<tr>
<td>Thursday December 12th, 2013</td>
<td>2014 ICD-9 Code Changes and ICD-10 for Orthopedics</td>
</tr>
<tr>
<td>Wednesday January 15th, 2014</td>
<td>2014 ICD-9 Code Changes and ICD-10 for OB/GYN</td>
</tr>
<tr>
<td>Wednesday February 12th, 2014</td>
<td>2014 ICD-9 Code Changes and ICD-10 for Urgent &amp; Primary Care</td>
</tr>
<tr>
<td>Wednesday March 12, 2014</td>
<td>Capturing missing revenue opportunities for Orthopedics</td>
</tr>
<tr>
<td>Wednesday April 9, 2014</td>
<td>Capturing missing revenue opportunities for Cardiology and Cardiovascular Surgery</td>
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