Coding Primer

ASAPA Spring Conference
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What's all the fuss about?

- Clinical, legal and economic implications
- Max reimbursement versus fraud
  - Large fines for fraud even if unintentional
  - Providers 'overcode' because of ambiguity/interpretation of guidelines/rules
  - Providers 'undercode' out of fear, poor training, poor understanding of guidelines/rules
    - Financial loss to practice/provider

What payors look at – "Red Flags"

- Nearly every encounter coded at equal complexity (especially high complexity)
- Inadequate documentation to back up coding
- Coding for service never performed or duplicate coding
- Incorrect date or place of service on claim
- hospital records not supporting necessity of hospitalization
- Lack of physician order for diagnostic test
- Lack of justification of clinical necessity of test/lab
- Meeting incident-to rules

Carolyn Buppert, NP, JD, Medscape article 754651

Purpose of Documentation

- Running record of pt's care
- Assist clinicians who follow in performing subsequent care
- Show that the service was medically necessary
- Justify billing the service at the level billed
- Demonstrate that the standard of care was met, if needed, to defend against an action for malpractice

Codes, Codes, Codes

- CPT (Current Procedural Terminology) Codes (established by AMA)
  - Identifies services rendered – "what I did"
- ICD-10 (International Classification of Diseases) Codes (Established by WHO)
  - Identifies diagnosis on claims – 'why I did it"
- E/M (Evaluation/Management) Codes (established by Medicare/Congress)
  - Standard documentation guidelines for billing – "I can prove it"

ICD-10 Codes

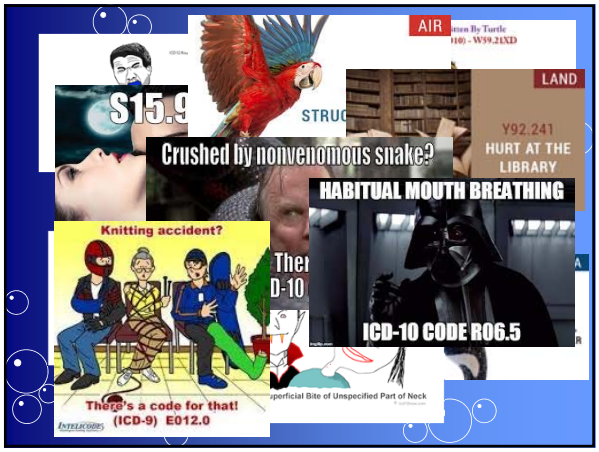
- Introduced in 1994 and used all other the world (USA last country to adopt in Oct 2015)
- Used for reporting diagnoses, morbidity and other health data
  - ICD-10: 160,000 codes – alphanumeric (IDC-9 had only 17,000 – numeric only)
- Proper coding = less denials

ICD-10

- Code to highest level of specificity
  - Acuity
  - Severity
  - Stage or type
  - Site
  - Morphology (eg. Neoplasm)
  - Etiology/underlying disease
  - Laterality
  - Associated diagnoses/conditions/sequela
- Avoid use of symptom as diagnosis
  - Link cause and effect

ICD-10 Examples of Specificity

- Cardiac:
  - Acute systolic HF, acute on chronic diastolic HF
- Pulmonary:
  - Acute hypoxic respiratory failure
  - PNA due to possible aspiration
- Neurologic:
  - Acute right middle cerebral artery CVA
  - Right-sided hemiplegia with right dominance
- Renal:
  - AKI on CKD Stage 3
- Orthopedics:
  - Non-displaced fx of right radial styloid process



E/M Codes

- Subset of CPT codes
- Should reflect work that was done
- Be supported by documentation
  - Content, not volume
- Reflect care that is reasonable and necessary
  - compliant with standards of good medical practice
- Medical necessity is the over-arching determinant of what code is used

E/M Codes

- Determined by
  - Type of service
    - Initial visit, consultation, existing patient, etc
  - Site of service
    - Inpatient, outpatient, nursing home, etc
  - Level of service
    - Either: History, exam and medical decision making
      - Documenting 'by elements'
    - Or: Time spent in counseling and coordination of care
      - Documenting 'by time'

Three Key Components

- Level of service based on *complexity* of:
  - Extent of patient history
    - Problem-focused, expanded problem-focused, detailed, comprehensive
  - Extent of physical exam
    - Problem-focused, expanded problem-focused, detailed, comprehensive
  - Complexity of decision making
    - straightforward, low complexity, moderate complexity, high complexity

Three Key Components

- Type of service determines how many components need to be included
  - For new patients, need all three components
  - For established patients, need only two components
- My recommendation:
  - *Medical decision-making* should always be one of the needed components

Evaluation/Management Coding

- E/M Codes: 99201–99499
  - (99201–99215) Office/other outpatient services (most commonly used)
  - (99217–99220) Hospital observation services
  - (99221–99239) Hospital inpatient services
  - (99241–99255) Emergency department services
  - (99291–99292) Critical care services
  - (99304–99318) Nursing facility services
  - (99341–99350) Home health services
  - (99374–99380) Care plan oversight services
  - (99381–99429) Preventive medicine services
  - (99441–99444) Non-face-to-face physician services
  - … (There are more) …

99201–99215 Office/other outpatient services

- 99201 – 99205
  - New pt office or other outpatient services
  - New: not seen by any provider within same practice for 3 years
- 99211 – 99215
  - Established pt office or other outpatient services
- 99214 most commonly billed code with 99213 being close second

2 Sets of Guidelines

- 1995 versus 1997
  - both still in used and you have a choice
- But – cannot 'mix and match' within same note
- They differ mainly in the exam
  - 1997 guidelines less ambiguous/more rigid
    - Modern EMR systems may help as templates can be adapted for which guideline a provider prefers
- They don't dictate the format of your documentation, just the content

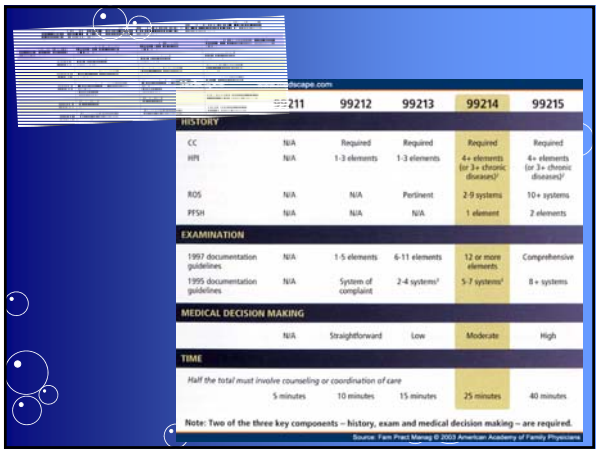
Documentation Format

- No prescribed format
  - Just need to have all elements required for coding level
  - Content over volume
- Still need to document to shows standard of care, no matter what E/M code rules require
  - In case of litigation or board investigation, your documentation will be best confirmation of 'what happened'
- "Audit yourself before someone else does"

99211 - 99215 Established Office Visits

E/M Code	History	Physical Exam	Medical Decision Making	Time
99211	None required	None required	None required	5 min
99212	Problem focused	Problem focused	Straight forward	10 min
99213	Expanded problem focused	Expanded problem focused	Low	15 min
99214	Detailed	Detailed	Moderate	25 min
99215	Comprehensive	Comprehensive	High	40 min

only 2 of 3 elements are needed for established patients



	99211	99212	99213	99214	99215
HISTORY					
CC	N/A	Required	Required	Required	Required
HPI	N/A	1-3 elements	1-3 elements	4+ elements (or 3+ chronic diseases)[2]	4+ elements (or 3+ chronic diseases)[2]
ROS	N/A	N/A	Pertinent	2-9 systems	10+ systems
PFSH	N/A	N/A	N/A	1 element	2 elements
EXAMINATION					
1997 documentation guidelines	N/A	1-5 elements	6-11 elements	12 or more elements	Comprehensive
1995 documentation guidelines	N/A	System of complaint	2-4 systems[3]	5-7 systems[4]	8+ systems
MEDICAL DECISION MAKING					
	N/A	Straightforward	Low	Moderate	High
TIME					
Half the total must involve counseling or coordination of care					
	5 minutes	10 minutes	15 minutes	25 minutes	40 minutes

Note: Two of the three key components – history, exam and medical decision making – are required.

Source: Fam Pract Manag © 2003 American Academy of Family Physicians

A word about 99211

- Should NOT used by physicians/PAs/NPs
  - 'nursing visit'
  - does not require presence of physician or any medical decision-making
  - presenting problems minimal
  - Require 'supporting' documentation but no specific requirements for Hx, PE, decision making
  - Used for things like
    - BP check, suture removal, dressing changes, allergy injections with observation by a nurse, peak flow meter instruction

Coding "Backwards'

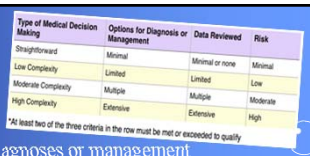
- Instead of thinking
  - History -> Exam -> Medical Decision-making
- Think
  - Medical Decision-making -> history and/or exam
- Presenting problem -> logical beginning
  - Use as tentative code selection and mold your history/exam documentation based on presenting problem
  - Medical decision making permeates what you do and shapes visit and exam

Medical Decision-Making

Type of Medical Decision Making	Options for Diagnosis or Management	Data Reviewed	Risk
Straightforward	Minimal	Minimal or none	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Multiple	Moderate
High Complexity	Extensive	Extensive	High

*At least two of the three criteria in the row must be met or exceeded to qualify

Think of this as 'presenting problem"



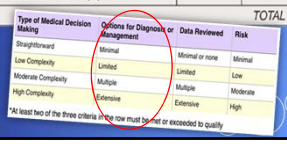
- 'Presenting Problem'
  - Number of possible diagnoses or management options to be considered
- Data
  - Amount and/or complexity of diagnostic tests, medical records and other info that must be obtained or analyzed to make a diagnosis
- Risk
  - Risk of complications and/or comorbidities associated w/patient's presenting problem and possible management options.

Dx or Mgt Options – Presenting Problem(s)

- Diagnosis
  - Minor or self-limited, established or new
  - e,.g. already-diagnosed problem improved/ well-controlled/resolved versus new diagnosis with uncertain outcome/requiring further workup
- Document:
  - Number of problems you are dealing with
  - Uncertainty about diagnosis
  - Number of management options you have and why/what you ordered

How to determine level of management options

Table A. Number of Diagnoses or Management Options			
A	B x C = D		
Problem(s) Status	*Number*	*Points*	*Result*
Self-limited or minor (stable, improved or worsening)	Max = 2	1	
Established problem (to examiner); stable, improved		1	
Established problem (to examiner); worsening		2	
New problem (to examiner); no additional work-up planned	Max = 1	3	
New problem (to examiner); additional work-up planned		4	
		TOTAL	



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Data

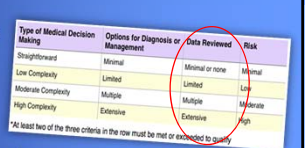
- Information gathered from sources other than history and physical
  - Lab, imaging, other diagnostic studies, old records …
- Document:
  - Test/lab reviewed, summarize results
  - Decision to request outside/old records
  - Review of records and summarize findings
  - History obtained from persons other than patient
  - Personal/direct visualization or independent interpretation of tests

How to determine level of data

Data Reviewed	Points
Clinical laboratory tests	1
Radiology (except cardiac cath and echo)	1
Medical tests (PFTs, ECG, cath and echo)	1
Discuss tests with performing physician	1
Independent review of image, tracing, specimen	2
Decision to obtain old records	1
Review and summation of old records	2

Total Data Points	Amount/Complexity of Data Reviewed
1	Minimal or None
2	Limited
3	Moderate
≥4	Extensive

- Can only get points listed, no matter how many different labs or other tests you review
- But can get 2 points for independent visualization/ interpretation
  - MUST document that you did so **and** summarize



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Risk

- Quantification of risks of complications, morbidity and mortality
  - Considers presenting problems, diagnostic procedures and management options selected
- Document
  - Comorbidities, underlying diseases, other factors that increase risk
  - Needed surgical/invasive interventions
  - Urgency of intervention

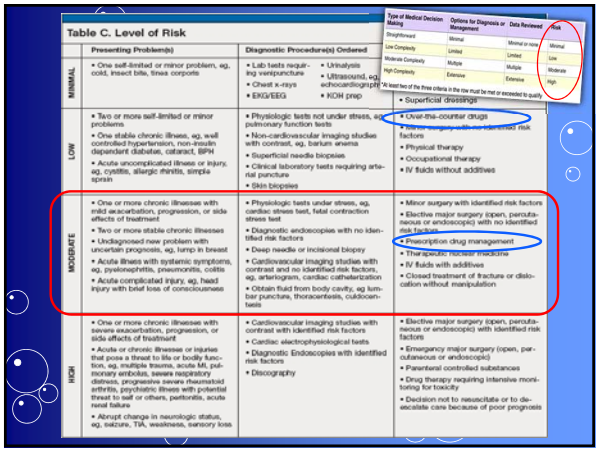


Table C. Level of Risk

	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
MINIMAL	• One self-limited or minor problem, eg, cold, insect bite, tinea corporis	• Lab tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, eg, echocardiography • KOH prep	• Superficial dressings
LOW	• Two or more self-limited or minor problems • One stable chronic illness, eg, well controlled hypertension, non-insulin dependant diabetes, cataract, BPH • Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, eg, pulmonary function tests • Non-cardiovascular imaging studies with contrast, eg, barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
MODERATE	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, eg, lump in breast • Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis • Acute complicated injury, eg, head injury with brief loss of consciousness	• Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization • Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
HIGH	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • Abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic Endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Medical Necessity

- Medical decision-making helps convey medical necessity
  - While only 2 of 3 elements (history, exam, decision-making) are needed for any established visit E/M code, don't document high-level history and high-level exam for minor problem
  - Always use medical decision-making as one of your 3 elements and you lessen chances of denials or audits

How to determine level of Medical Decision-Making

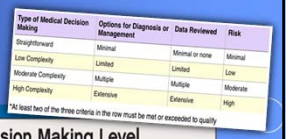
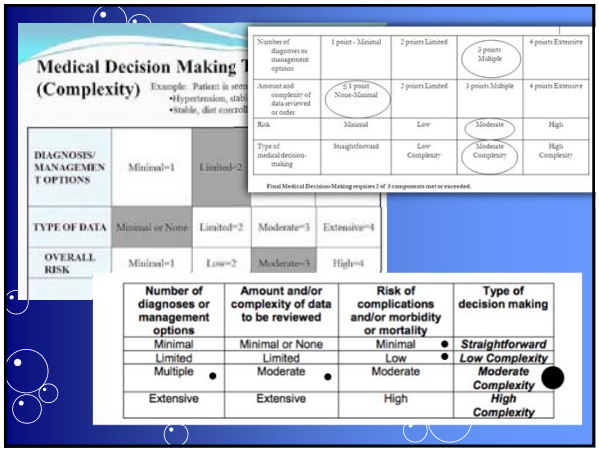


Figure 2. Determining Medical Decision Making Level

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the 2nd circle from the left

Table A	Number of Diagnoses or Management Options	<1 Minimal	2 Limited	3 Multiple	> 4 Extensive
Table B	Amount & Complexity of Data	<1 Minimal or Low	2 Limited	3 Multiple	> 4 Extensive
Table C	Highest Risk	Minimal	Low	Moderate	High
Type of Decision Making		Straight-forward	Low Complexity	Moderate Complexity	High Complexity

Remember: Managing prescription meds → mod risk!



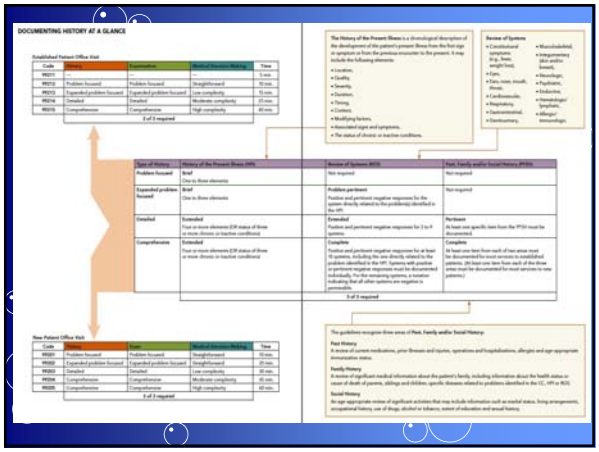
Elements of History

- History of Present Illness (HPI)
  - 9 elements: location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms
  - or can also comment on status of three or more chronic or inactive conditions (cannot with 1995 guidelines)
- Review of Systems (ROS)
  - 14 systems: Constitutional, Eyes, Ears/nose/mouth/throat, CV, Respiratory, GI, GU, MS, Integumentary, Neuro, Psych, Endocrine, Hem/Lymphatic, Allergic/Immunologic
- Past, family and social history (PFSH)

Elements of History

History: Level of Service	HPI	ROS	PFSH
Problem-focused	1-3 elements	Not required	Not required
Expanded problem-focused	1-3 elements	1 system	Not required
Detailed	4 or more elements	2-9 systems	1 area
Comprehensive	4 or more elements	10 or more systems	2 or more areas

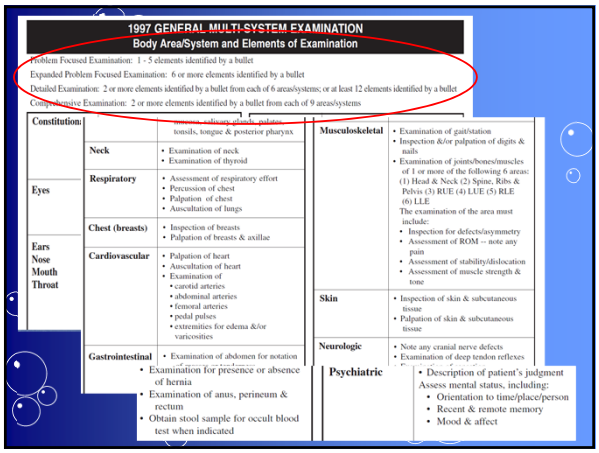
- Reviewing meds/allergies considered an element of Past Medical Hx
- Ok to list pertinent positives/negatives for ROS and then have following statement
  - "All other systems reviewed and are negative"

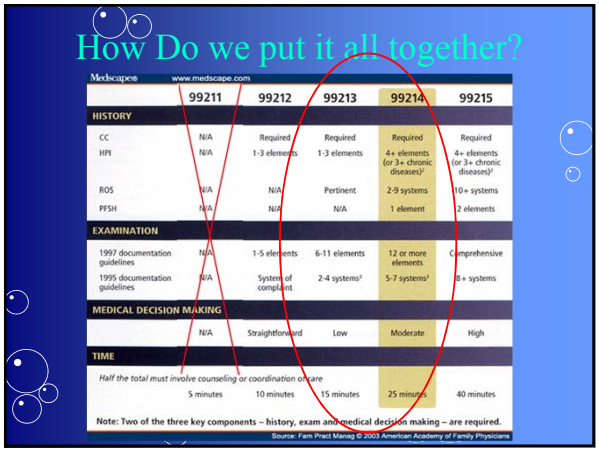


Elements of Exam

Exam: Level of Service	Number of Body Areas/Organ Systems
Problem-focused	1-5 elements in one or more organ systems or body areas
Expanded problem-focused	At least 6 elements in one or more organ systems or body areas
Detailed	Includes at least 6 organ systems or body areas. For each area or system selected, documentation of at least two elements is expected. Alternately, may include documentation of at least 12 elements within two organ systems or body areas.
Comprehensive	Includes at least 9 organ systems or body areas. For each area or system selected, documentation of at least two elements is expected.

- General multi-system exam versus Single organ system exam
- Recognized Organ Systems under 1997 Guidelines
  - Constitutional (three vital signs = 1 bullet), Eyes, Ears/Nose/Mouth/Throat, Neck, Respiratory, CV, Chest, GI, GU, Lymphatic, MS, Skin, Neurologic, Psych


1997 GENERAL MULTI-SYSTEM EXAMINATION
Body Area/System and Elements of Examination
Problem Focused Examination: 1 - 5 elements identified by a bullet
Expanded Problem Focused Examination: 6 or more elements identified by a bullet
Detailed Examination: 2 or more elements identified by a bullet from each of 6 areas/systems; or at least 12 elements identified by a bullet
Comprehensive Examination: 2 or more elements identified by a bullet from each of 9 areas/systems
Constitutional
Eyes
Ears Nose Mouth Throat
tonsils, tongue & posterior pharynx
Neck
• Examination of neck
• Examination of thyroid
Respiratory
• Assessment of respiratory effort
• Percussion of chest
• Palpation of chest
• Auscultation of lungs
Chest (breasts)
• Inspection of breasts
• Palpation of breasts & axillae
Cardiovascular
• Palpation of heart
• Auscultation of heart
• Examination of
• carotid arteries
• abdominal arteries
• femoral arteries
• pedal pulses
• extremities for edema &/or varicosities
Gastrointestinal
• Examination of abdomen for notation
• Examination for presence or absence of hernia
• Examination of anus, perineum & rectum
• Obtain stool sample for occult blood test when indicated
Musculoskeletal
• Examination of gait/station
• Inspection &/or palpation of digits & nails
• Examination of joints/bones/muscles of 1 or more of the following 6 areas: (1) Head & Neck (2) Spine, Ribs & Pelvis (3) RUE (4) LUE (5) RLE (6) LLE
The examination of the area must include:
• Inspection for defects/asymmetry
• Assessment of ROM -- note any pain
• Assessment of stability/dislocation
• Assessment of muscle strength & tone
Skin
• Inspection of skin & subcutaneous tissue
• Palpation of skin & subcutaneous tissue
Neurologic
• Note any cranial nerve defects
• Examination of deep tendon reflexes
Psychiatric
• Description of patient's judgment
Assess mental status, including:
• Orientation to time/place/person
• Recent & remote memory
• Mood & affect


How Do we put it all together?
Medscape www.medscape.com
99211
99212
99213
99214
99215
HISTORY
CC
N/A
Required
Required
Required
Required
HPI
N/A
1-3 elements
1-3 elements
4+ elements (or 3+ chronic diseases)²
4+ elements (or 3+ chronic diseases)²
ROS
N/A
N/A
Pertinent
2-9 systems
10+ systems
PFSH
N/A
N/A
N/A
1 element
2 elements
EXAMINATION
1997 documentation guidelines
N/A
1-5 elements
6-11 elements
12 or more elements
Comprehensive
1995 documentation guidelines
N/A
System of complaint
2-4 systems²
5-7 systems²
8+ systems
MEDICAL DECISION MAKING
N/A
Straightforward
Low
Moderate
High
TIME
Half the total must involve counseling or coordination of care
5 minutes
10 minutes
15 minutes
25 minutes
40 minutes
Note: Two of the three key components – history, exam and medical decision making – are required.
Source: Fam Pract Manag © 2003 American Academy of Family Physicians


Putting it all together
History
N/A
Problem focused
Expanded
Detailed
Comprehensive
Examination
N/A
Problem focused
Expanded
Detailed
Comprehensive
Decision-making
N/A
Straightforward
Low complexity
Moderate complexity
High complexity
Code
99211
99212
99213
99214
99215

Optimal Coder

- *Step 1*: Choose the levels of RISK and DIAGNOSES
- *Step 2*: Choose the level of complexity of Medical Decision Making (CMDM)
- *Step 3*: Choose the E/M CPT code
- *Step 4*: Document the History based on the requirements of the chosen E/M CPT code
- *Step 5*: Document the Physical Exam based of the requirements of the chosen E/M CPT code

www. optimalcoder.com

Relative Value Units (RVUs)

- Created by Medicare but used by many other healthcare organizations for reimbursement
  - determines $ amount of reimbursement
- Adjusted by geographic cost indices multiplied by a fixed 'conversion factor' to determine dollar amount of payment
- Composed of three factors
  - Physician work (54%)
  - Practice expense (41%)
  - Malpractice expense (5%)

99213 versus 99214

99213
Decision Making (presenting problem)
- ≥ 2 Self-limited problems
- 1 Stable chronic illness
- Acute uncomplicated illness (cystitis, sprain)

Plus ...

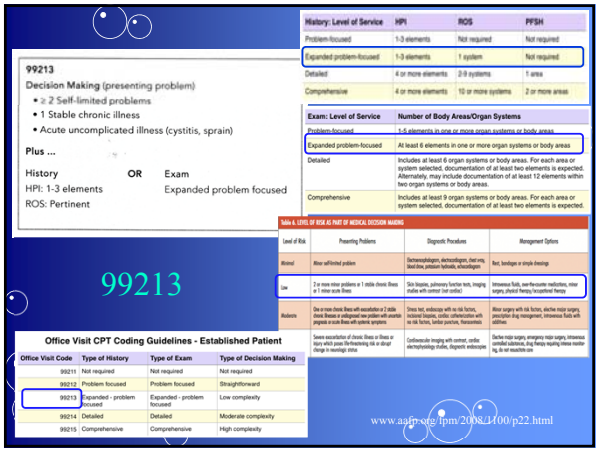
History — HPI: 1-3 elements; ROS: Pertinent
OR
Exam — Expanded problem focused

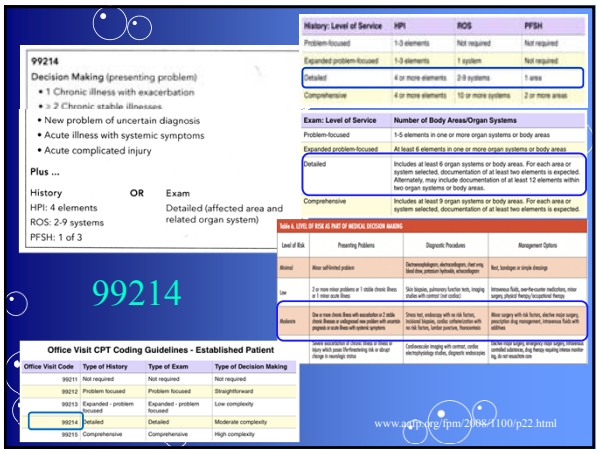
99214
Decision Making (presenting problem)
- 1 Chronic illness with exacerbation
- ≥ 2 Chronic stable illnesses
- New problem of uncertain diagnosis
- Acute illness with systemic symptoms
- Acute complicated injury

Plus ...

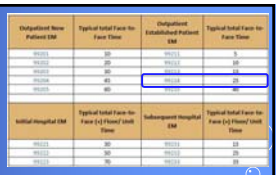
History — HPI: 4 elements; ROS: 2-9 systems
OR
Exam — Detailed (affected area and related organ system)

	New Patients 99201 - 99205	Established Patients 99211 - 99215
Level I	0.48	0.18
Level II	0.93	0.48
Level III	1.42	0.97
Level IV	2.43	1.5
Level V	3.17	2.11





Coding based on Time



- If >50% of visit time is spent on "counseling and coordination"
- Must meet/exceed established time limits
- In office: face-to-face time
- Hospital/nursing home: floor or unit time
- Document *total* time spent and include description of the counseling/coordination of care activities

- Example of Detailed Exam
- Template can be easily adapted

Vitals & Measurements

T: 96.6 °F (Tympanic) **TMIN:** 96.6 °F (Tympanic) **TMAX:** 97.0 °F (Temporal Artery) **T:** 97.3 °F **T:** Temporal (Method) **HR:** 70 (Monitored) **HR:** 126 **RR:** 20 **BP:** 135/76 **BP:** 128/99 (Cuff) **MAP:** 105 (Cuff) **SpO2:** 99% **WT:** 109.4 kg

General: well appearing 77-year-old male in no acute distress at this time, breathing comfortably and talking complete sentences
HEENT: atraumatic, eyes EOMI
Neck: no carotid bruit, no JVD
Respiratory: CTA bilaterally, no crackles, rhonchi, wheezes, good respiratory effort
Cardiovascular: RRR, normal S1 and S2, no murmurs, trace bilateral lower remedy edema
Abdomen: Soft, non-tender, non-distended, normal bowel sounds
Genitourinary: Deferred
Rectal: deferred
Musculoskeletal: moving all extremities without difficulty
Integumentary: warm, and dry, no rash
Heme/Lymph: no bruises
Neurological: AA&O x 3, grossly non-focal
Psychiatric: cooperative with normal mood, affect, and cognition

- Example of 'undercoding'
- Significant risk but documentation does not support higher level of coding

Cardiology Progress Note

Resting quietly, remains on high flow O2 but is able to lie flat and breathing comfortably. s/p initial HD session last night with removal of about 1L. Cr much improved. Hemodynamically stable. Ok to proceed with CCLV this afternoon as planned with HD to follow. Pt's questions answered, plan reviewed w/RN.

Vital Signs (last 24 hrs) — **Last Charted**

Temp Axillary	97.8 DegF (FEB 16 04:00)
Heart Rate Peripheral	80 bpm (FEB 16 06:00)
Resp Rate	21 br/min (FEB 16 06:00)
SBP	**H** 121mmHg (FEB 15 17:48)
DBP	60 mmHg (FEB 15 17:48)

Labs (Last four charted values)

WBC	H **12.8** (FEB 16)	10.6 (FEB 15)	H **11.7** (FEB 14)	H **14.9** (FEB 13)
Hgb	12.3 (FEB 16)	12.1 (FEB 15)	L **11.6** (FEB 14)	12.6 (FEB 13)
Hct	L **33.7** (FEB 16)	L **33.8** (FEB 15)	L **32.4** (FEB 14)	L **36.1** (FEB 13)
Plt	238 (FEB 16)	241 (FEB 15)	220 (FEB 14)	212 (FEB 13)
Na	136 (FEB 16)	138 (FEB 15)	138 (FEB 14)	140 (FEB 13)
K	L **3.1** (FEB 16)	3.5 (FEB 15)	3.9 (FEB 14)	4.4 (FEB 13)
CO2	26 (FEB 16)	23 (FEB 15)	20 (FEB 14)	20 (FEB 13)
Cl	L **97** (FEB 16)	98 (FEB 15)	101 (FEB 14)	104 (FEB 13)
Cr	H **2.96** (FEB 16)	H **4.20** (FEB 15)	H **4.18** (FEB 14)	H **4.40** (FEB 13)
BUN	H **81** (FEB 16)	H **100** (FEB 15)	H **95** (FEB 14)	H **79** (FEB 13)
Glucose Random	H **134** (FEB 16)	H **124** (FEB 15)	H **121** (FEB 14)	H **128** (FEB 13)
Phos	4.0 (FEB 16)	H **5.2** (FEB 15)		
Ca	L **8.3** (FEB 16)	L **8.3** (FEB 15)	L **8.3** (FEB 14)	L **8.4** (FEB 13)
PTT	H **43.9** (FEB 16)	H **51.2** (FEB 16)	H **51.3** (FEB 15)	H **77.0** (FEB 15)

Telemetry
NSR, No AFib or other arrhythmia

Incident-to Rules

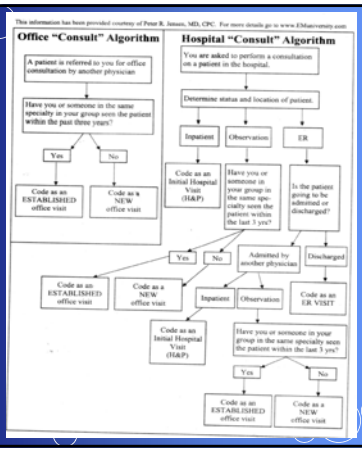
- Frequently audited service
  - Documentation must clearly show NPPA service linked to physician service
    - Physician established plan, NPPA follows it
  - NPPA must be employed/contracted by same entity as physician
  - Service must be provided under general supervision
    - Physician must be on-site during incident-to service
      - Does not need to be physician who performed initial service
  - Can only be used in office/clinic setting

Shared Billing

- Applies to E/M services only
  - Cannot use in the office/clinic, SNF, for procedures, critical care services, consultations, home visits
  - Can use for hospital-based initial and subsequent visits, ER visits, observation and discharge services
  - Physician MUST personally provide some face-to-face time with patient and MUST document what portions of E/M services he provided
    - Simply co-signing NPPA note not sufficient

Consultation codes

- Never allowed for shared or incident-to billing
- Eliminated by Medicare in 2010, but may still be used by private payors
- Although use of consultation codes eliminated, rule re: shared billing was not
  - Previous guidelines still apply
    - i.e. 'consultations' under Medicare still cannot be shared



Critical Care Services

- Critical illness or injury
  - Acute impairment of one or more vital organ systems such as there is high probability of imminent or life threatening deterioration
  - Probability of death if interventions not done immediately
  - Can be used on multiple days
  - BUT just being in ICU does not institute critical care
- Represents intensity of care > standard E/M codes

Critical Care Services

- No specific documentation requirements
  - Must convey critical nature of patient's condition and what you did about it, must show involvement of highly complex decision making
- Use wording such as
  - "Time spent includes multiple re-examinations, speaking with family, discussions with other providers, overseeing administration of multiple medications, titrating drips"
- Time-base code
  - Must be one-on-one but necessarily face-to-face not, i.e. cannot take care of another pt during same period of time
  - 1st hour = minutes 31 – 74 of care

EMR Cloning

- "Clinical plagiarism"
  - copy and paste text from other physicians' notes documenting work that you did not perform
- Medicare defines cloning as multiple entries in a patient chart that are identical or similar to other entries in the same chart
  - Has become specific target for auditors
  - Has lead to 'upcoding'
  - Claims have been denied

Same exam for *every* visit:

PHYSICAL EXAM

Exam	Findings	Details
Const	Neg	Level of Distress - Awake / Alert. No Acute Distress. Nourishment - Well Nourished. Appearance - Well Developed.
Neck	Neg	JVP - Less Than 8.
Resp	Neg	Respirations - Nonlabored. Breath Sounds - Clear Throughout. Rales - Absent. Wheezes - Absent. Rhonchi - Absent. Percussion - Clear.
Cardiac	Neg	Rhythm - Regular. Palpation - PMI Normal. Heart Sounds - S1 Normal, S2 Normal, No S3, No S4. Extra Sounds - None. Murmurs - None.
Vasc	Neg	Carotid - Bilateral Normal Pulse, No Bruits Noted. Aorta - Normal Size. No Bruit Noted. Radial - Bilateral Normal Pulse. Femoral - Bilateral Normal Pulse, No Bruits Noted. Popliteal - Bilateral Normal Pulse. Posterior Tibial - Bilateral Normal Pulse. Dorsalis Pedis - Bilateral Normal Pulse.
Abd	Neg	Tenderness - None. Palpation - Soft, No Guarding, No Rigidity, No Rebound, No Ascites. Hepatomegaly - Absent. Splenomegaly - Absent. Masses - Absent. Bowel sounds - Present.
EXT	Neg	Skin Temperature - Warm. Clubbing - Absent. Elevation Pallor - Absent. Dependent Rubor - Absent. Cyanosis - Absent. Mottled - Absent. Stasis Dermatitis - None. Varicosities - Absent. Discoloration - None. Homan's Sign - Absent. Calf Tenderness - Absent. Ischemic Ulcers - Absent. Venous Stasis Ulcers - Absent. Upper Extremity Edema - Absent. Lower Extremity Edema - Absent. Monofilament Exam - Normal.
Neuro	Neg	Level of Consciousness - Alert. Aphasia - Absent.
Psych	Neg	Orientation - Oriented to Time, Person, Place. Mood - Appropriate.

Visit Information

AKDHC Nephrology Consult Note

Chief Complaint

2/20/2018 06:14 MST chest pain unknown onset, FS 150

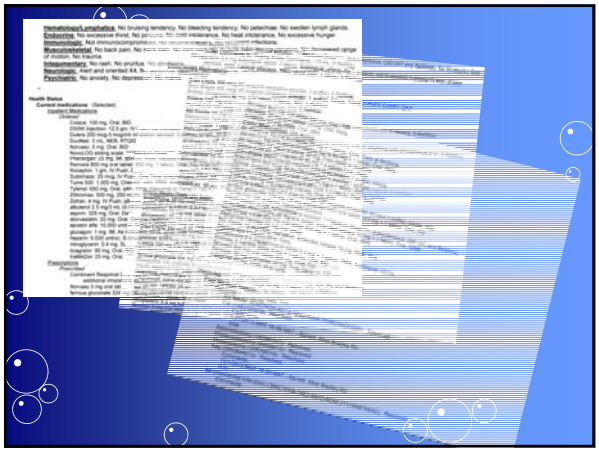
Interval History

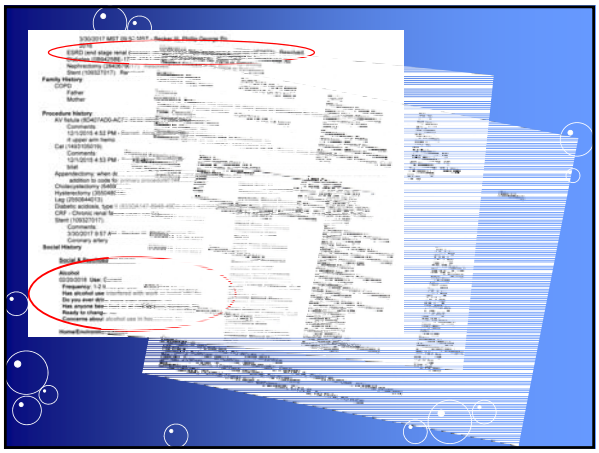
HPI: Patient is a 78 year old female with PMH of ESRD on HD TTS at FMC NW, CAD, HTN, anemia and DM type 2 who was admitted here for chest pain. she was recently discharged from UMC to Life Care for generalized weakness and debility one week ago.Her hisband noticed [illegible] more confusion with memroy loss as brought to ER. In ER she has no hypotension or fever, t[illegible] ead no acute findings. Her K 5.2 and last HD last Saturday.

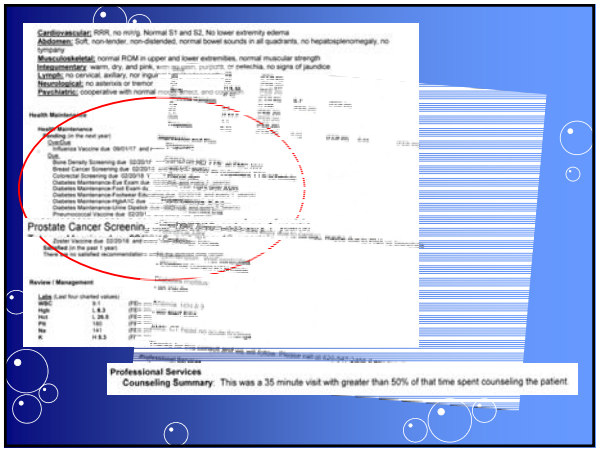
No change to past medical history, family history, social history and allergy history.

Review of Systems

Constitutional: No fever, No chills, No sweats, + weakness, + fatigue, No decreased activity.
Eye: No recent visual problem, No icterus, No discharge, No double vision.
Ear/Nose/Mouth/Throat: No decreased hearing, No ear pain, No nasal congestion, No sore throat.
Respiratory: No shortness of breath, No cough, No sputum production, No hemoptysis, No wheezing, No cyanosis.
Cardiovascular: + chest pain, No palpitations, No bradycardia, No tachycardia, No peripheral edema, No syncope.
Gastrointestinal: No nausea, No vomiting, no diarrhea, No constpation, No heartburn, No abdominal pain.
Genitourinary: No dysuria, No hematuria, No change in urine stream, No urethral discharge, No lesions.







EMR Cloning

- Always document HPI based on pt's description that day
- Don't copy/carry forward whole notes, carefully review and edit whatever you do copy
- Review auto-fill and edit
- Use templates with care, review and edit them thoroughly
- Remember that *volume* of info in note does not determine *complexity* for level of billing

"Chart-must-have" Recommendations

- Document reason of visit or procedure
- Document reason that pt need hospitalization that day
- Document aspects of medical work (for coding)
- State that previously documented problem has resolved, or if not, what is being done
- Note pt's lack of progress, document change of plan or referral

Carolyn Buppert, NP, JD Medscape article 756963

Resources

- E/M University (www.emuniversity.com)
- AAPA (www.aapa.org)
- Family Practice management (www. aafp.org)
- www.codinginstitute.com
- www.cms.gov/Outreach-and.../eval-mgmt-serv-guide-ICN006764.pdf
- medicaleconomics.modernmedicine.com
- www.optimalcoder.com