

**Emory Standards For Documenting,
Coding, & Billing Professional Services**

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MEDICAL RECORD DOCUMENTATION

FOR BILLING, THE MEDICAL RECORD MUST INCLUDE:

1. Complete and legible information;
2. A reason for the encounter;
3. A relevant history, exam findings & diagnostic test results;
4. An assessment, impression or diagnosis;
5. The reason(s) (symptoms, diagnoses, etc.) for ordering diagnostic and other ancillary services;
6. Supporting documentation for the service(s) billed; and
7. Date of documentation, legible identity, and signature of the provider.

EVALUATION & MANAGEMENT (E/M) DOCUMENTATION GUIDELINES FOR BILLING

Evaluation and Management (E/M) services include inpatient and outpatient visits, consults, admits and discharges.

These E/M documentation guidelines were developed jointly by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services (CMS) to provide physicians and claims reviewers with information about preparing or reviewing documentation. Billing for E/M services is based upon compliance with these documentation guidelines.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.

DOCUMENTATION MUST INCLUDE INFORMATION ON THE FOLLOWING KEY COMPONENTS:

- HISTORY
- EXAMINATION
- DECISION MAKING

The extent of the history, physical examination, and decision-making documentation will be determined by the scope of the presenting problem.

DOCUMENTATION MAY ALSO INCLUDE INFORMATION ON THESE ADDITIONAL COMPONENTS:

- NATURE OF PRESENTING PROBLEM
- COUNSELING
- COORDINATION OF CARE
- TIME

E/M DOCUMENTATION GUIDELINES

Key Component: HISTORY

CHIEF COMPLAINT

The *Chief Complaint* is a concise statement describing the symptom, problem, condition, diagnosis or other reason for the encounter.

HISTORY OF PRESENT ILLNESS

The *History of Present Illness (HPI)* is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It may include the following elements:

Location	Timing
Quality	Context
Severity	Modifying Factors
Duration	Associated Signs & Symptoms

REVIEW OF SYSTEMS

A *Review of Systems (ROS)* is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced. The following systems are recognized in the Review of Systems:

Constitutional symptoms	Musculoskeletal
Integumentary (skin and/or breast)	Eyes
Neurological	Ears, nose, mouth, throat
Psychiatric	Cardiovascular
Endocrine	Respiratory
Hematologic/lymphatic	Gastrointestinal
Allergic/Immunologic	Genitourinary

Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating "all other systems are negative" is permissible.

E/M DOCUMENTATION GUIDELINES

Key Component: HISTORY (continued)

PAST MEDICAL HISTORY

The *Past Medical History* may include documentation of one or more of the following:

- Medications
- Allergies
- Chronic diseases
- Past injuries, hospitalizations, illnesses & surgeries
- Immunizations & feeding/dietary status, if appropriate

FAMILY HISTORY

The *Family History* may include documentation of one or more of the following:

- Health status, cause of death of parents, siblings & children
- Specific diseases related to problems identified in the history
- Diseases of family members which may be hereditary or place the patient at risk

SOCIAL HISTORY

The *Social History* may include documentation of one or more of the following:

- Marital status/family structure
- Current employment
- Occupational history
- Sexual history
- Use of drugs, alcohol & tobacco
- Level of education
- Hobbies

A *Review of Systems* and/or *Past, Family and Social History* obtained during an earlier encounter do not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. The review and update may be documented by describing any new information or noting there has been no change in the information and noting the date and location of the earlier documentation.

The *Review of Systems* and/or *Past, Family and Social History* may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.

If the physician is unable to obtain a history from the patient or other source, the record should describe the patient's condition or other circumstance which precludes obtaining a history.

E/M DOCUMENTATION GUIDELINES

Key Component: EXAMINATION

Documentation must include examination of one or more of the following body areas or organ systems in either a *General Multi-System Exam* or a *Single System Specialty Exam*. For best results, a template listing the body areas and organ systems should be used.

BODY AREAS

For purposes of examination, the following *body areas* are recognized:

- Head, including face
- Neck
- Chest, including breasts & axillae
- Abdomen
- Genitalia, groin & buttocks
- Back, including spine
- Each extremity

ORGAN SYSTEMS

For purposes of examination, the following *organ systems* are recognized:

- Constitutional
- Eyes
- Ears, nose, mouth & throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic / lymphatic / immunologic

E/M DOCUMENTATION GUIDELINES

Key Component: EXAMINATION (continued)

Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. Notation of “abnormal” without elaboration is insufficient.

A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).

E/M DOCUMENTATION GUIDELINES

Key Component: MEDICAL DECISION MAKING

Each of the elements of medical decision making is described below:

1. **Number of diagnoses or management options** – The number of possible diagnoses and/or the number of management options that must be considered is based on the number and type of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

2. **Amount and/or complexity of data to be reviewed** – The amount and complexity of data to be reviewed are based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data type to be reviewed.

A discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

3. **Risk of significant complications, morbidity and/or mortality** – The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is minimal, low, moderate or high. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.

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AMA / HCFA TABLE OF RISK

LEVEL OF RISK	PRESENTING PROBLEM(S)	DIAGNOSTIC PROCEDURE(S) ORDERED	MANAGEMENT OPTIONS SELECTED
<i>Minimal</i>	<ul style="list-style-type: none"> • One self-limited or minor problem, e.g., cold, insect bite, tinea corporis 	<ul style="list-style-type: none"> • Laboratory tests requiring venipuncture • Chest X-rays • EKG / EEG • Urinalysis • Ultrasound, e.g., echocardiography • KOH prep 	<ul style="list-style-type: none"> • Rest • Gargles • Elastic bandages • Superficial dressings
<i>Low</i>	<ul style="list-style-type: none"> • Two or more self-limited or minor problems • One stable chronic illness, e.g., well controlled hypertension or non-insulin-dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain 	<ul style="list-style-type: none"> • Physiologic tests not under stress, e.g., pulmonary function tests • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies 	<ul style="list-style-type: none"> • Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
<i>Moderate</i>	<ul style="list-style-type: none"> • 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, e.g., lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g., head injury with brief loss of consciousness 	<ul style="list-style-type: none"> • Physiologic tests under stress, e.g., 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, e.g., arteriogram, cardiac catheterization • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis 	<ul style="list-style-type: none"> • 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
<i>High</i>	<ul style="list-style-type: none"> • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that may pose a threat to life or bodily function, e.g., 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 • An abrupt change in neurologic status, e.g., seizure, TIA, weakness, or sensory loss 	<ul style="list-style-type: none"> • Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic endoscopies with identified risk factors • Discography 	<ul style="list-style-type: none"> • 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

E/M DOCUMENTATION GUIDELINES

Additional Component: NATURE OF PRESENTING PROBLEM

The E/M codes recognize five types of presenting problems defined as follows:

1. A *MINIMAL PROBLEM*: May not require the presence of the physician, but the service is provided under the physician's supervision.
2. A *SELF-LIMITED OR MINOR PROBLEM*:
 - Runs a definite and prescribed course;
 - Is transient in nature, and is not likely to permanently alter health status; and
 - Has a good prognosis with management/compliance.
3. A *LOW SEVERITY PROBLEM HAS*:
 - A low risk of morbidity without treatment;
 - Little to no risk of mortality without treatment; and
 - An expected full recovery without functional impairment.
4. A *MODERATE SEVERITY PROBLEM HAS*:
 - A moderate risk of morbidity without treatment;
 - A moderate risk of mortality without treatment;
 - An uncertain prognosis; and
 - An increased probability of prolonged functional impairment.
5. A *HIGH SEVERITY PROBLEM HAS*:
 - A high to extreme risk of morbidity without treatment;
 - A moderate to high risk of mortality without treatment; and
 - A high probability of severe, prolonged functional impairment.

E/M DOCUMENTATION GUIDELINES

Additional Component: COUNSELING

Documentation of counseling must reflect a discussion with patient and/or family concerning one or more of the following areas:

1. Diagnostic results, impressions, and/or recommended diagnostic studies;
2. Prognosis;
3. Risks & benefits of management/treatment options;
4. Instructions for management/treatment and/or follow-up;
5. Importance of compliance with chosen management/treatment options;
6. Risk factor reduction; and/or
7. Patient & family education.

Additional Component: COORDINATION OF CARE

Coordination of care may include arranging for further services and communicating with providers such as nursing homes or home health agencies through written reports and/or telephone contact.

E/M DOCUMENTATION GUIDELINES

Additional Component: TIME

For E/M services, *time* is a determining factor for E/M level of service **only** when COUNSELING and COORDINATION OF CARE dominates the patient/family encounter (more than 50% of total patient encounter time). Both total patient/family encounter time and time spent counseling or coordinating care must be documented in the medical record. Time spent by non-physician providers **may not** be counted in time used for determining E/M code selection.

Time is not a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

Time is defined differently for outpatient and inpatient services.

FACE-TO-FACE TIME (*office and other outpatient visits and office consultations*)

Face-to-face time is time that the **physician spends face-to-face with the patient and/or family**. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination and counseling the patient. This definition of time is used for office and outpatient visits and office consults.

UNIT/FLOOR TIME (*observation and inpatient hospital services*)

Unit/floor time is time that the **physician is present on the patient's hospital unit and at the bedside rendering services for that patient**. This includes the time in which the physician establishes and/or reviews the patient's chart, examines the patient, writes notes and communicates with other professionals and the patient's family. This definition of time is used for hospital observation services, inpatient hospital care, inpatient consultations, and nursing facility visits.

***Time* must also be documented in the medical record when codes are billed which include a time descriptor such as critical care, prolonged service and hospital discharge.**

CODING E/M SERVICES

DETERMINING THE LEVEL FOR EACH KEY COMPONENT

In order to select the appropriate E/M code, one must first determine the level of each documented key component (history, examination, and medical decision making).

Determining the Level of HISTORY:

There are four levels of HISTORY, ranging from Problem-Focused through Comprehensive. The documentation requirements for the various levels are as follows:

PROBLEM-FOCUSED

Chief complaint
Brief history of present illness (1-3 elements)

EXPANDED PROBLEM-FOCUSED

Chief complaint
Brief history of present illness (1-3 elements)
Problem pertinent system review (1 system)

DETAILED

Chief complaint
Extended history of present illness (4 or more elements)
Extended system review (2 to 9 systems)
Pertinent past, family &/or social history (1 item from any of the 3 areas)

COMPREHENSIVE

Chief complaint
Extended history of present illness (4 or more elements)
Complete system review (10 or more systems)
Complete past, family & social history
 One item from two areas for established patients
 One item from all three areas for new patients, admits & consults

NOTE: Beginning for services performed on or after September 10, 2013, an *Extended* HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

CODING E/M SERVICES

DETERMINING THE LEVEL FOR EACH KEY COMPONENT (continued)

Determining the Level of EXAMINATION:

There are four levels of EXAMINATION, ranging from Problem-Focused through Comprehensive. The documentation requirements (according to CPT and the 1995 CMS guidelines) for the various levels are as follows:

PROBLEM-FOCUSED

A limited examination 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 examination of the affected body area(s) and other symptomatic or related organ system(s)

COMPREHENSIVE

A general multi-system examination or a complete examination of a single organ system
Documentation of a general multi-system exam should include findings about 8 or more of the 12 organ systems.

NOTE: The provider may elect to follow either the 1995 CMS guidelines listed above or the 1997 CMS guidelines when documenting an examination. The 1997 guidelines specify a General Multi-System Exam as well as the following single organ system exams: Cardiovascular, Ear/Nose/Throat, Eye, Neurological, Genitourinary, Respiratory, Hematologic/-Lymphatic/Immunologic, Musculoskeletal, Psychiatric, and Skin. Requirements for the 1997 exams are available upon request from the Office of Compliance Programs at 404-778-2757.

CODING E/M SERVICES

DETERMINING THE LEVEL FOR EACH KEY COMPONENT
(continued)

Determining the Level of MEDICAL DECISION MAKING:

There are four levels of MEDICAL DECISION MAKING ranging from Straightforward through High Complexity. The documentation requirements for the various levels are as follows:

STRAIGHTFORWARD

Number of Diagnoses or Management Options	Minimal
Amount and/or Complexity of Data to be Reviewed	Minimal or none
Risk of Complications and/or Morbidity or Mortality	Minimal

LOW COMPLEXITY

Number of Diagnoses or Management Options	Limited
Amount and/or Complexity of Data to be Reviewed	Limited
Risk of Complications and/or Morbidity or Mortality	Low

MODERATE COMPLEXITY

Number of Diagnoses or Management Options	Multiple
Amount and/or Complexity of Data to be Reviewed	Moderate
Risk of Complications and/or Morbidity or Mortality	Moderate

HIGH COMPLEXITY

Number of Diagnoses or Management Options	Extensive
Amount and/or Complexity of Data to be Reviewed	Extensive
Risk of Complications and/or Morbidity or Mortality	High

CODING E/M SERVICES

SELECTING THE LEVEL OF E/M SERVICE

The level of E/M service is based upon the documented levels of all three of the key components – history, examination and medical decision making – combined.

The level of each key component required for each E/M code can be found in the latest version of AMA's CPT manual.

For the following E/M services, ALL THREE key components must be documented and the level of each key component must meet or exceed the CPT requirements for a given level of service. The LOWEST level of the three key components determines the E/M code selected.

- New Patient Office Visit
- Hospital Observation Services
- Initial Hospital Care
- Office, Inpatient and Confirmatory Consultations
- Emergency Department Services
- Comprehensive Nursing Facility Assessments
- New Patient Domiciliary Care
- New Patient Home Service

For the following E/M services, TWO OF THE THREE key components must be documented and meet or exceed the CPT requirements for a given level of service. If only two components are documented, the lowest level component determines the E/M code selected. If all three key components are documented, the two highest level key components determine the E/M code.

- Established Patient Office Visit
- Subsequent Hospital Care
- Follow-up Inpatient Consultation
- Subsequent Nursing Facility Care
- Established Patient Domiciliary Care
- Established Patient Home Service

E/M SERVICES

CONSULTATIONS

Medicare and GA Medicaid no longer recognize CPT codes used to report Consultation services. Physicians shall code patient evaluation and management visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed.

For Commercial and Managed Care Payers:

A consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.

REQUIREMENTS FOR A CONSULTATION

1. A consultation must be requested by a physician or other appropriate source (except for Confirmatory Consults).
2. A written or verbal request for a consult must be documented in the medical record.
3. A consultant must render an opinion or advice regarding the evaluation &/or management of a specific problem.
4. The consultant's opinion must be documented in the medical record and communicated by written report to the requesting physician or other appropriate source.
5. The consultant may initiate diagnostic &/or therapeutic services.

Subcategories of consultations:

- OFFICE OR OTHER OUTPATIENT CONSULTATIONS (CPT 99241-99245)
- INITIAL INPATIENT CONSULTATIONS (CPT 99251-99255)

Ongoing inpatient management by the consultant should be billed with subsequent hospital care codes (99231 - 99233), NOT follow up consult codes.

E/M SERVICES

OFFICE OR OTHER OUTPATIENT SERVICES

A **new patient** is one who has not received any professional services from the physician or another physician of the same specialty in the same group practice within the past three years.

An **established patient** is one who has received professional services from the physician or another physician of the same specialty in the same group practice within the past three years.

A patient is considered an outpatient until inpatient admission to a health care facility occurs.

The following codes are used to report E/M services provided in the physician's office or in an outpatient or other ambulatory facility.

NEW PATIENT OFFICE OR OUTPATIENT VISITS (99201-99205)

ESTABLISHED PATIENT OFFICE OR OUTPATIENT VISITS (99211-99215)

OFFICE OR OTHER OUTPATIENT CONSULTATIONS (Not for Government payers) (99241-99245)

PROLONGED PHYSICIAN SERVICE (99354-99355)

EMERGENCY DEPARTMENT SERVICES (99281-99285)

HOSPITAL OBSERVATION SERVICES (99217-99220)

PREVENTIVE MEDICINE SERVICES (99381-99429)

BASIC LIFE AND/OR DISABILITY EVALUATION SERVICES (99450)

WORK RELATED OR MEDICAL DISABILITY EVALUATION SERVICES (99455-99456)

E/M SERVICES

PREVENTIVE MEDICINE SERVICES

Preventive Medicine codes are used to report the preventive medicine evaluation and management of infants, children, adolescents and adults.

The **comprehensive history** obtained as part of the preventive medicine E/M service is not problem-oriented and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history as well as a comprehensive assessment/history of pertinent risk factors.

The **comprehensive examination** performed as part of the preventive medicine E/M service is multi-system, but its extent is based on age and risk factors identified.

If a **significant** clinical problem is assessed during a routine physical, **both** the preventive medicine service and an appropriate problem-oriented E/M service may be charged and a "-25" modifier should be attached to the E/M code. For Medicare, the fee for the preventive service should be reduced by the amount of payment for the E/M service (e.g. Medicare allowable).

NEW PATIENT PREVENTIVE MEDICINE SERVICE (99381-99387)

These codes are used to report an evaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures. Within this range, code selection is based upon the age of the patient.

ESTABLISHED PATIENT PREVENTIVE MEDICINE SERVICE (99391-99397)

These codes are used to report a periodic reevaluation and management of an individual including a comprehensive history, a comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures. Within this range, code selection is based upon the age of the patient.

COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION (99401-99429)

These codes are used to report services provided to individuals at a separate encounter for the purpose of promoting health and preventing illness or injury.

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The services provided will vary with age and should address such issues as family problems, diet and exercise, substance abuse, sexual practices, injury prevention, dental health, and diagnostic and laboratory test results available at the time of the encounter.

E/M SERVICES

PREVENTIVE MEDICINE SERVICES (continued)

Medicare Initial Preventive Physical Examination

Medicare will pay for one initial preventive physical examination (IPPE) or “Welcome to Medicare Visit” per beneficiary per lifetime. A beneficiary is eligible when he/she first enrolls in Medicare Part B on or after January 1, 2005, and receives the IPPE benefit within the first six months of the effective date of the initial Part B coverage period.

The IPPE is a preventive evaluation and management service (E/M) that includes:

1. Review of the individual’s medical and social history with attention to modifiable Risk factors for disease detection
2. Review of the individual’s potential (risk factors) for depression or other mood disorders
3. Review of the individual’s functional ability and level of safety
4. A physical examination to include measurement of the individual’s height, weight, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the examining physician or qualified non-physician practitioner (NPP)
5. Performance and interpretation of an electrocardiogram (EKG)
6. Education, counseling, and referral, as deemed appropriate, based on the results of the review and evaluation services described in the previous five elements
7. Education, counseling, and referral including a brief written plan (e.g., a checklist or alternative) provided to the individual for obtaining the appropriate screening and other preventive services, which are separately covered under Medicare Part B benefits.

HCPCS codes used for IPPE are:

- G0402 - IPPE
- G0403 - EKG
- G0404 - EKG Tracing
- G0405 - EKG Interpretation and report

Medicare Annual Well Visits

The AWV is an annual Medicare preventive physical examination, available for eligible beneficiaries, and identified by HCPCS codes G0438 (Annual wellness visit, including PPS, first visit) and G0439 (Annual wellness visit, including PPS, subsequent visit).

PREVENTIVE MEDICINE SERVICES (continued)

AWV services providing PPS (HCPCS G0438) are a 'one-time' allowed Medicare benefit and include the following key elements furnished to an eligible beneficiary by a health professional:

- Establishment of the individual's medical/family history,
- Measurement of the individual's height, weight, body mass index (or waist circumference, if appropriate), blood pressure (BP), and other routine measurements as deemed appropriate, based on the individual's medical and family history,
- Establishment of a list of current providers and suppliers that are regularly involved in providing medical care to the individual,
- Detection of any cognitive impairment that the individual may have,
- Review of an individual's potential risk factors for depression , including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the health professional may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations,
- Review of the individual's functional ability and level of safety, based on direct observation of the individual, or the use of appropriate screening questions or a screening questionnaire, which the health professional may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations,
- Establishment of a written screening schedule for the individual, such as a checklist for the next 5 to 10 years, as appropriate, based on recommendations of the USPSTF and Advisory Committee of Immunizations Practices (ACIP), the individual's health status, screening history, and age-appropriate preventive services covered by Medicare,
- Establishment of a list of risk factors and conditions of which primary, secondary, or tertiary interventions are recommended or underway for the individual, including any mental health conditions or any such risk factors or conditions that have been identified through an IPPE, and a list of treatment options and their associated risks and benefits,
- Provision of personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management or community-based lifestyle

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interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, fall prevention, and nutrition, and,

- Any other element(s) determined appropriate by the Secretary through the NCD process.

E/M SERVICES

- Update to the individual's medical /family history,
- Measurements of an individual's weight (or waist circumference), BP, and other routine measurements as deemed appropriate, based on the individual's medical and family history,
- Update to the list of the individual's current medical providers and suppliers that are regularly involved in providing medical care to the individual as that list was developed for the first AWV providing PPS,
- Detection of any cognitive impairment that the individual may have,
- Update to the individual's written screening schedule as developed at the first AWV providing PPS,
- Update to the individual's list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or are underway for the individual, as that list was developed at the first AWV providing PPS,
- Furnish appropriate personalized health advice to the individual and a referral, as appropriate, to health education or preventive counseling services or programs, and,
- Any other element determined appropriate by the Secretary through the NCD process.

E/M SERVICES

HOSPITAL SERVICES

HOSPITAL OBSERVATION SERVICES

Observation services are E/M services provided to patients designated or admitted as observation status in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital.

INITIAL OBSERVATION CARE (99218-99220)

These codes report the initial encounter(s) by the supervising physician with the patient when designated as “observation status.” One service is reported per calendar date.

SERVICES INCLUDE:

- Initiation of observation status;
- Supervision of the care plan for observation; and
- Performance of periodic reassessments

OBSERVATION CARE DISCHARGE SERVICES (99217)

This code is used to report the discharge of a patient from “observation status.”

SERVICES INCLUDE:

- Final examination of patient;
- Discussion of hospital stay;
- Instructions for continuing care; and
- Preparation of discharge records.

OBSERVATION OR INPATIENT ADMISSION & DISCHARGE SERVICES (99234-99236)

These codes are used to report observation or inpatient hospital care services provided to patients admitted **and** discharged on the same date of service (calendar date, not 24 hour period).

E/M SERVICES

HOSPITAL SERVICES (continued)

HOSPITAL INPATIENT SERVICES

Hospital inpatient services are E/M services provided to hospital inpatients including those provided to patients in “partial hospital” setting.

INITIAL HOSPITAL CARE (Also referred to as a hospital admit code) (99221-99223)

Initial hospital care is the first hospital inpatient encounter with the patient by the admitting physician.

All E/M services provided by that physician, on the same date as and in conjunction with that admission are considered part of the initial hospital care.

The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in other sites of service as well as in the inpatient setting.

SUBSEQUENT HOSPITAL CARE (99231-99233)

These codes are used to report all inpatient hospital visits other than consults, admits and discharges. This includes services provided to a patient who is not critically ill, but happens to be in the intensive care unit. All levels of subsequent hospital care include reviewing:

- The medical record;
- The result of diagnostic studies; and
- Changes in patient’s status since the last assessment.

HOSPITAL DISCHARGE SERVICES (99238-99239)

These codes are used to report the total duration of time spent by a physician for final hospital discharge of a patient, even if the time spent by the physician on that date is not continuous. (More than 30 minutes must be documented in order to qualify for 99239). Services include:

- Final examination of the patient
- Discussion of the hospital stay
- Instructions for continuing care to all relevant caregivers
- Preparation of discharge records, prescriptions and referral forms

E/M SERVICES

HOSPITAL SERVICES (*continued*)

CONCURRENT CARE

"Concurrent Care" is the term used to describe ongoing care rendered to an inpatient by more than one physician at the same time on the same day. It is recognized that patients with multi-system disease or multiple primary disorders may require the services of physicians of different specialties. Concurrent care is considered medically necessary and reasonable when the patient's condition requires active management by more than one physician and if:

1. Each physician billing for concurrent care manages one or more distinct medical problems;
2. No physician is managing a problem(s) which is generally within the scope of practice of other physicians already seeing the patient;
3. The services provided by each physician are medically necessary and reasonable.

When multiple physicians/specialties are concurrently treating a patient, it is important that each physician only report the ICD-10 diagnosis code(s) that are specific to the medical condition(s) that they are treating. It is usually not considered medically necessary for more than one physician to manage a single diagnosis.

EMERGENCY DEPARTMENT SERVICES (99281-99285)

These codes are used to report services provided in the Emergency Department (ED), which is defined as an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day.

- There is no distinction between new & established visits.
- Time is not a factor for emergency department services.
- If the ED physician and the patient's primary care physician both see the patient in the ED, each may charge an ED visit if the patient is not admitted.
- If a physician (other than the ED physician) admits the patient, only the admission should be billed by the admitting physician. The ED physician may bill an appropriate ED service for his or her services.

E/M SERVICES

CRITICAL CARE

CRITICAL CARE SERVICES (99291-99292)

Critical care is the direct delivery by a physician of medical care to the critically ill or critically injured patient. CPT defines a critical illness or injury as one that acutely impairs one or more vital organ systems such that the patient's survival is jeopardized. Services are usually, but not always, given in a critical care area, such as the coronary, intensive, respiratory care units or emergency care facility.

Critical care codes are used to report the total duration of time spent by a physician providing critical care services to a patient on a given date, even if the time spent is not continuous. The time that can be reported as critical care is the time spent engaged in work directly related to the individual patient's care whether that time was spent at the immediate bedside or elsewhere on the floor or unit. For any period of time reported as critical care time, the physician must devote his or her full attention to the patient and cannot provide services to any other patient during that time. **Time spent providing critical care must be documented in the medical record.**

CPT code **99291** is used to report the **first 30-74 minutes** of critical care and should be reported only once per calendar day; CPT code **99292** is used to report **additional blocks of time of up to 30 minutes each** beyond the first 74 minutes and may be reported in multiple units as necessary. Critical care of **less than 30 minutes** should be charged as an appropriate level of E/M service.

Services for a patient who is not critically ill, but happens to be in a critical care unit, should be reported using other appropriate E/M codes, **NOT** critical care codes.

PROCEDURES BUNDLED INTO THE CRITICAL CARE CODES:

<u>CPT CODE</u>	<u>DESCRIPTION</u>
93561, 93562	Cardiac Output Measurements
71010, 71015, 71020	Chest X-rays
94760, 94761, 94762	Pulse Oximetry
82800-82810	Blood Gases
99090	Analysis of Information Data Stored in Computers (ECGs, blood pressures, hematologic data)
43752, 91105	Gastric Intubation
92953	Temporary Transcutaneous Pacing
94656-94662	Ventilator Management
36000, 36410, 36415	Vascular Access Procedures
36540, 36600	Vascular Access Procedures

Any services performed that are not listed above should be reported separately.

E/M SERVICES

PEDIATRIC AND NEONATAL CRITICAL CARE

Inpatient Neonatal and Pediatric Critical Care (99468 – 99476)

The same definitions for critical care services apply for the adult, child, and neonate.

Codes 99468, 99469 are used to report the services of directing the inpatient care of a critically ill neonate or infant 28 days of age or younger. They represent care starting with the date of admission (99468) to a critical care unit and subsequent day(s) (99469) that the neonate remains critical. These codes may be reported only by a single individual and only once per day, per patient, per hospital stay in a given facility. If readmitted to the neonatal critical care unit during the same day **or stay**, report the subsequent day(s) code 99469 for the first day of readmission to critical care, and 99469 for each day of critical care following readmission.

Codes 99471-99476 are used to report direction of the inpatient care of a critically ill infant or young child from 29 days of postnatal age through less than 6 years of age. They represent care starting with the date of admission (99471, 99475) to all subsequent day(s) (99472, 99476) the infant or child remains critical. These codes may be reported only by a single individual and only once per day, per patient in a given setting.

Report 99471, 99475 only once per hospital stay in a given facility. If readmitted to the pediatric critical care unit during the same **day or stay**, report 99472 or 99476 for the first day of readmission to critical care and 99472 for each day of critical care following readmission.

Services for the critically ill or critically injured child 6 years of age or older would be reported with the time-based critical care codes (99291, 99292).

These codes include/bundle those procedures listed for critical care services 99291-99292. In addition, they include:

<u>CPT CODE</u>	<u>DESCRIPTION</u>
36000	Peripheral Vessel Catheter
36140, 36620	Arterial Catheters
36510	Umbilical Venous Catheter
36555	Central Vessel Catheter
36400, 36405, 36406	Vascular Access Procedures
36420, 36600	Vascular Punctures
36660	Umbilical Arterial Catheter
31500	Endotracheal Intubation

94002-94004

Vent Management

E/M SERVICES

PEDIATRIC AND NEONATAL CRITICAL CARE (continued)

<u>CPT CODE</u>	<u>DESCRIPTION</u>
94375	Bedside Pulmonary Function Testing
94610	Surfactant Administration
94660	CPAP
94760-94762	Monitoring or Interpretation of Blood Gasses or O2 Saturation
94780-94781	Car Seat Evaluation
36430, 36440	Blood Transfusion Components
43752	Oral or Nasogastric Tube Placement
51100	Suprapubic Bladder Aspirations
51701, 51702	Bladder Catheterization
62270	Lumbar Puncture

Any service performed that is not listed above should be reported separately.

E/M SERVICES

PROLONGED SERVICES

PROLONGED SERVICES (99354-99359)

- These codes are used when a physician provides a service that is beyond the usual service in either the inpatient or outpatient setting.
- They are reported in addition to other physician services, including E/M services at any level.
- Separate codes are used to report direct face-to-face versus non face-to-face patient contact.
- They are used to report the total time spent by the physician, even if the time spent on that date is not continuous.
- Prolonged service of less than 30 minutes is not separately reported.
- Physician must personally document the amount of additional time spent with the patient and the reason this time was required.

SUPERVISING PHYSICIANS IN TEACHING SETTINGS

A SERVICE PROVIDED BY A TEACHING PHYSICIAN MAY BE BILLED IF IT WAS:

1. Personally furnished by the teaching physician; or
2. Furnished jointly by a teaching physician & resident (NOT A STUDENT); or
3. Furnished by the resident with the teaching physician present during the **key portion** of the service or procedure. (The key portion may be the entire service or procedure.)

EVALUATION & MANAGEMENT SERVICES

The Teaching Physician must:

1. Document they performed the service or were physically present during the key or critical portions of the services when performed by the resident, and
2. Document the participation of the teaching physician in the management of the patient.

Documentation by the resident of the presence and participation is not sufficient to establish presence and participation of the teaching physician.

NOTE: The teaching physician (TP) does not have to be physically present when the resident performs the E/M service. The TP, however, must personally see the patient on the same date of service as the resident and confirm the resident's findings by personally performing the critical or key portion(s) of the service. TP documentation should reflect personal confirmation of the resident's work. Review of the resident's documentation is not a billable service.

EXCEPTION: CMS has verbally approved the teaching physician billing an admit when the resident admits the patient late one night, and the teaching physician sees the patient the next morning and documents the key components of the admit and links the note to the resident's note. The admission must be billed on the date the teaching physician saw the patient.

Teaching Physician Minimum Documentation Requirements:

1. The teaching physician must document that he/she personally saw the patient, and
2. The teaching physician must document that he/she participated in the management of the patient, and
3. The teaching physician must document that he/she reviewed the resident's note and/or discussed the case with the resident.

SUPERVISING PHYSICIANS IN TEACHING SETTINGS

Examples of Minimally Acceptable Documentation

Teaching Physician personally performs all the required elements of an E/M service without a resident. The resident may or may not have performed the E/M independently.

Admitting note: “I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident’s note and agree with the documented findings and plan of care.”

Follow-up visit: “Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident’s note.”

Follow-up visit: “Hospital Day #5. I saw and evaluated the patient. I agree with the resident’s note except the heart murmur is louder, so I will obtain echo to evaluate.”

Resident Performs elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service.

Initial or follow-up visit: “I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident’s note.”

Follow-up visit: “I saw the patient with the resident and agree with the resident’s findings and plan.”

Resident performs some or all of the required elements in the absence of the teaching physician and documents his/her service. The teaching physician independently performs the critical or key portions of the service with or without the resident present, and, as appropriate, discusses the case with the resident.

Initial visit: “I saw and evaluated the patient. I reviewed the resident’s note and agree, except that the picture is more consistent with pericarditis than myocardial ischemia; will begin NSAIDs.”

Initial or follow-up visit: “I saw and evaluated the patient. Discussed with resident and agree with findings and plan as documented in the resident’s note.”

Follow-up visit: “See resident’s note for details. I saw and evaluated the patient and agree with the resident’s findings and plans as written.”

SUPERVISING PHYSICIANS IN TEACHING SETTINGS

Examples of Unacceptable Documentation

- “Agree with above,” followed by legible countersignature or identity
- “Rounded, Reviewed, Agree,” followed by legible countersignature or identity
- “Discussed with resident. Agree,” followed by legible countersignature or identity
- “Seen and Agree,” followed by legible countersignature or identity
- “Patient seen and evaluated,” followed by legible countersignature or identity
- A legible countersignature or identity alone

SUPERVISING PHYSICIANS IN TEACHING SETTINGS

TIME-BASED SERVICES

The teaching physician must be present for the entire period of time required by the CPT code description. (Resident or other staff time may not be counted.) Teaching physician must personally document his or her time in the medical record in order to bill these services.

THESE SERVICES INCLUDE:

1. Critical care
2. Prolonged care
3. Discharge day management

MINOR SURGICAL PROCEDURES & HIGH RISK DIAGNOSTIC PROCEDURES

THE TEACHING PHYSICIAN MUST BE PRESENT DURING THE ENTIRE PROCEDURE FOR THE FOLLOWING:

1. Endoscopic procedures
2. Cardiac Catheterization
3. Treadmill
4. Trans esophageal echocardiography
5. Minor procedures (less than 5 minutes in length)

SUPERVISING PHYSICIANS IN TEACHING SETTINGS

MAJOR SURGICAL PROCEDURES

(Note: See detailed documentation instructions for teaching physicians in “Billing for Surgical Procedures” section.)

THE TEACHING PHYSICIAN MUST:

1. Be present during all critical & key portions of the procedure (as defined by the teaching physician);
2. Be responsible for pre-op, operative and post-op care of the patient (he/she may determine which post-op visits are key and require presence);
3. Not bill for the entire global package if he/she is not involved in the post-op care;
4. Be present during the key or critical portions(as defined by the teaching physician) of both surgeries when two overlapping surgeries are being performed; and
5. Not bill for supervision of more than two concurrent or overlapping surgeries.

The following information is based on CMS requirements for the billing of surgical services. The purpose of these guidelines/policies is to ensure that all surgical services billed by faculty of the Emory University School of Medicine and Emory Clinic physicians are in compliance with all pertinent government payer regulations. These guidelines also establish a standard against which all surgical charges will be compared as a part of the institution’s internal review process.

Documentation Requirements for Billing Surgical Procedures

All surgical procedures billed by Emory University School of Medicine Faculty physicians and Emory Clinic physicians must be supported by a dictated and signed operative report in the patient’s medical record. All coding should be verified against the completed operative report before submission for billing purposes. Surgical procedures involving resident surgeons have specific documentation requirements as defined below.

SUPERVISING PHYSICIANS IN TEACHING SETTINGS

Documenting Teaching Surgeon's Presence:

The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be critical or key portions of the procedure. During the non-critical or non-key portions of the surgery, if the teaching surgeon is not physically present, he or she must be immediately available to return to the procedure, i.e., he or she cannot be performing another procedure. If circumstances prevent a teaching physician from being immediately available, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.

When the teaching surgeon is present for the entire period, his or her presence may be demonstrated by notes in the medical record made by the physician or resident. A simple statement of presence is all that is required.

For two overlapping or concurrent procedures, the teaching physician must **personally** identify and document the key portions of each procedure. Resident documentation alone is insufficient. When the teaching surgeon is present for the critical portions of the procedure, it must be documented that the teaching surgeon was present for the critical portions and immediately available during the remainder of the case.

SUPERVISING PHYSICIANS IN TEACHING SETTINGS

Documentation of Teaching Physician Presence

Resident Dictated Operative Reports

If the resident dictates the operative report, he/she must be identified as the person dictating the report and he/she must dictate a statement in the operative report regarding the physical presence of the teaching physician at the time of the procedure.

1. *If the TP was present in the operating room for the entire procedure*, the resident should state: “The attending physician, Dr. (full name of TP), was present for the entire procedure.”
2. *If the TP was only present for the critical portions of the procedure*, the resident should dictate the following statement: “The attending physician, Dr. (full name of TP), was present for all critical portions of this case and was immediately available during the remainder of the case.”

Additionally, *if the TP is billing for two overlapping surgeries*, “the teaching physician must **personally** document in the medical record that he/she was physically present during the critical or key portion(s) of both procedures. When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he or she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise.”

Teaching Physician Dictated Operative Reports

If the TP dictates the operative report, he or she is required to dictate a statement regarding his or her own physical presence at the time of the procedure. This statement will be in one of two formats.

1. *If the TP was present in the operating room for the entire procedure*, the TP should state, “I, Dr. (full name of TP), the attending physician, was present for the entire procedure.”
2. *If the TP was only present for the critical portions of the procedure*, the TP should dictate the following statement, “I, Dr. (full name of TP), the attending physician, was present for all critical portions of this case and was immediately available during the remainder of the case.”

Additionally, *when billing for two overlapping surgeries*, “the teaching physician must **personally** document in the medical record that he/she was physically present during the critical or key portion(s) of both procedures. When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he or she

must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise.”

SUPERVISING PHYSICIAN IN TEACHING SETTING

Documentation Requirements for Minor Endoscopy Procedures

For minor endoscopic procedures, the TP must be present for the entire viewing (including insertion and removal of the scope) in order to bill. Presence for the entire procedure may be substantiated by either resident or TP notes.

NOTE: Surgical endoscopies follow the standard rules for major surgical procedures.

Documentation Requirements for Surgeon When No Resident is Present

When a faculty physician performs a surgical procedure without the assistance of a resident surgeon, **teaching physician documentation rules do not apply**. This is the case even when a non-resident surgeon is assisting. The dictated operative report is sufficient documentation of the faculty physician’s services. **No statements of presence are required or recommended.**

Reporting the GC Modifier

The GC modifier should be applied to all CPT codes billed for surgical services performed on Medicare beneficiaries that involve a resident surgeon. The modifier should be applied uniformly to all codes regardless of whether the resident acted as the primary surgeon or acted only in an assistant role. This modifier is for Medicare only.

Interpretation of Diagnostic Radiology & Other Tests

The teaching physician must document that he/she personally reviewed the image and the resident’s interpretation & indicate agreement with or edit the resident’s findings.

SUPERVISING PHYSICIANS IN TEACHING SETTINGS

RESIDENT MOONLIGHTING

Definition: Services of Moonlighting Residents (including fellows) are services provided outside the scope of an approved GME program.

SERVICES WHICH MAY NOT BE BILLED

Faculty may not bill for supervising moonlighting services by residents because the services are not part of the training program and teaching physician rules do not apply.

Hospital Inpatient Setting

CMS presumes that everything a resident does in a teaching hospital, including on-call time and training of junior residents, is related to the residency program.

- Services of residents to inpatients of all hospitals in which the residents have their approved GME program cannot be billed as physician services because these services are reimbursed to the hospital.
- Teaching physician presence requirements must be met for Faculty to bill for inpatient cases involving residents.

Hospital Outpatient Setting

- Services of residents in outpatient settings, which are included in their training program, may not be billed as physician services.
- Teaching physician presence and involvement requirements must be met for Faculty to bill for outpatient services involving residents.

SUPERVISING PHYSICIANS IN TEACHING SETTINGS

RESIDENT MOONLIGHTING (*continued*)

SERVICES WHICH MAY BE BILLED

Services of moonlighting residents may be billed as physician services under the following circumstances:

Setting

1. Services are performed by residents outside the scope of the training program in an outpatient setting or emergency department at the home or affiliated teaching hospital.
2. Services are performed at a hospital or institution not affiliated with the training program.

Requirements for Billing

Moonlighting services in the settings described above may only be billed IF:

- The services are identifiable physician services and meet payer requirements for payment.
- The resident is fully licensed to practice medicine in the State where the moonlighting services are performed.
- The services performed can be separately identified from those services that are required as part of the approved GME program. (This requires confirmation by the Program Director that the resident has completed the start and stop times required by the individual training program.)
- The time spent by the resident or fellow is not included in any teaching hospital resident count for purposes of GME payment.
- There must be a contract between the resident or fellow and the entity where the moonlighting occurs.

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SUPERVISING PHYSICIAN IN TEACHING SETTINGS

BILLING FOR FELLOWS

According to CMS, the law requires CMS to pay *as hospital services* all services of individuals meeting the definition of residents in an approved training program.

Resident is defined as: an intern, resident, OR FELLOW who participates in an approved residency program as required in order to become certified by the appropriate specialty board.

FELLOWS PARTICIPATING IN APPROVED MEDICAL RESIDENCY PROGRAMS

There can be no Part B (physician services) payment for Fellows in programs approved by either the ACGME or American Board of Medical Specialties (ABMS).

All teaching physician billing rules which apply to services of residents apply equally to services of fellows in ACGME or ABMS programs.

To bill for services of a Fellow, the answer to ALL the following questions must be NO:

1. Is the Fellow registered in the Emory GME office?
2. Is the Fellow in a program approved by The Accreditation Council for Graduate Medical Education of the AMA?
3. Is the Fellow in a program that counts toward certification in a specialty or subspecialty listed in either the Directory of Graduate Medical Education Programs (published by the AMA) OR The Annual Report and Reference Handbook published by the ABMS OR a fellowship program in geriatric medicine approved by the ACGME?
4. Is the Fellow being counted in any teaching hospital's full-time equivalency count of residents for direct GME payments? (Here, it is irrelevant whether the hospital pays the Fellow's salary.)

HOSPITAL SETTING

If the answer to any of the questions is "YES," then there can be NO Part B billing for the Fellow's services to INPATIENTS in the hospital, and there can ONLY be Part B billing for the Fellow's services to OUTPATIENTS if the service is outside the scope and time of the teaching program and all criteria for resident moonlighting are met. (See the policy on resident moonlighting.)

SUPERVISING PHYSICIANS IN TEACHING SETTINGS

BILLING FOR FELLOWS (*continued*)

NON-HOSPITAL SETTING

If the Fellow is a resident in an approved program and is providing services in a non-hospital setting, the following questions must be answered.

Is the non-hospital setting a teaching setting, i.e., is there an agreement between the non-hospital entity and a teaching hospital indicating that the hospital bears the costs of the fellow's time in the non-hospital setting, OR is the Fellow's time in the non-hospital setting included in a teaching hospital's GME count?

If YES to either question, there can be NO billing for the Fellow's patient care services in the non-hospital setting.

If NO to BOTH questions, the Fellow's services may be billed only if they meet the criteria for services as a moonlighting resident.

FELLOWS NOT IN FORMALLY ORGANIZED PROGRAMS

Services of Fellows licensed to practice medicine who have completed all residency programs, but who are staying on at Emory for a chance to develop or refine skills outside the context of the residency program, may be billed as physician services if they have a faculty appointment and a Clinic or Foundation billing number. The teaching physician presence policy does not apply to their services because the Fellows are furnishing services in the capacity of treating physicians.

FELLOWS IN UNLISTED PROGRAMS

Services of licensed Fellows who have completed a general residency program and who are in a subspecialty program which is not listed in either the AMA or ABMS publications may be billed as physician services if they have a faculty appointment and a Clinic or Foundation billing number. The teaching physician presence policy does not apply to their services because the Fellows are furnishing services in the capacity of treating physicians.

To avoid confusion, it is recommended that individuals not in formally recognized training programs or in unlisted programs not be referred to as "Fellows."

SUPERVISING PHYSICIANS IN TEACHING SETTINGS

MEDICAL STUDENT SERVICES AND DOCUMENTATION

Any contribution of a medical student to the performance of a service or billable procedure must be performed in the physical presence of a teaching physician or jointly with a resident in a service meeting the requirements for teaching physician billing.

Students may document services in the medical record. However, the documentation of an E/M service by a student that may be referred to by the teaching physician is limited to documentation related to the review of systems and/or past family/social history. The teaching physician may not refer to a student's documentation of physical exam findings or medical decision making in his or her personal note. If the medical student documents E/M services, the teaching physician must verify and re-document the history of present illness as well as perform and re-document the physical exam and medical decision making activities of the service. (MCM15016, C, 2)

The **ONLY** documentation by medical students that may be used for coding and billing purposes is the Review of Systems (ROS) and Family & Social History portions of the History component of an E/M service.

Medical student documentation of the History of Present Illness (HPI), the examination, or the medical decision-making co-signed by the resident or teaching physician **MAY NOT BE USED** for billing.

SUPERVISING PHYSICIANS IN TEACHING SETTINGS

PRIMARY CARE CENTER EXCEPTION

The Primary Care Exception is recognized by both Medicare and Medicaid.

RESIDENCY PROGRAMS THAT MAY QUALIFY FOR THE MEDICARE EXCEPTION

- Family Practice
- General Internal Medicine
- Geriatric Medicine
- Pediatrics
- Obstetrics/Gynecology
- Psychiatry (only those GME programs that furnish comprehensive care as well as psychiatric care to chronically mentally ill patients) (Medicare only)

EXCEPTION CRITERIA

Payment may be made to teaching physicians for Evaluation and Management services furnished by residents in approved residency programs without the presence of the teaching physician when an attestation is filed with the carrier (Medicare only) that the following criteria are met:

SERVICES MUST BE FURNISHED IN A:

1. Hospital outpatient department where time spent by residents in patient care activities is included in determining direct GME payments to the teaching hospital; or a
2. Non-hospital entity with an agreement with the hospital concerning GME payment

THE PATIENTS MUST BE an identifiable group who consider the center to be the continuing source of their health care.

THE RESIDENTS MUST:

1. Have completed more than six (6) months of an approved residency program;
2. Generally follow the same group of patients throughout the course of the residency program; (It is not required that the teaching physician be the same over any period of time.)
3. Provide a range of services including:
 - a. Acute care of undifferentiated problems;
 - b. Chronic care for ongoing conditions;
 - c. Coordination of care furnished by other physicians and providers; and
 - d. Comprehensive care not limited by organ system or diagnosis.

PRIMARY CARE CENTER EXCEPTION (*continued*)

MEDICARE EXCEPTION CRITERIA

THE SERVICES MUST BE:

1. Furnished under the medical direction of teaching physicians;
2. Included in determining direct GME payment to a hospital; and
3. Billed under the following lower and mid-level E/M codes:
 - a. New patient: 99201, 99202, 99203
 - b. Established patient: 99211, 99212, 99213
4. Billed with the GE modifier (Medicare only).

THE TEACHING PHYSICIAN MUST:

1. Supervise no more than four residents at any given time;
2. Be immediately available to direct the patient's care;
3. Have no other responsibilities (including the supervision of other personnel) during the time of the service for which payment is sought;
4. Assume management responsibility for those patients seen by the residents;
5. Ensure that the services furnished are reasonable and necessary;
6. Review with each resident during or immediately after each visit the
 - a. physical examination,
 - b. diagnosis,
 - c. medical history, and
 - d. record of tests and therapies.
7. Document the extent of his/her own participation in the review and direction of the services furnished to each patient.

BILLING FOR SURGICAL SERVICES

Assistants at Surgery

Federal law prohibits Medicare physician fee schedule payments for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. There are, however, certain circumstances where it is permissible to bill for the service of a non-resident physician in the role of assistant at surgery.

It is appropriate to bill for an assistant at surgery if a “qualified” resident is unavailable. The teaching physician rules state that the availability of "qualified residents" may be due to their involvement in other activities, complexity of the surgery, numbers of residents in the program, or other valid reasons.

There are also special circumstances in which Medicare will allow payment for assistant at surgery *even though* a qualified resident is available. The three exceptions that may apply are:

1. Exceptional medical circumstances, such as life-threatening emergencies, which require immediate treatment,
2. Physicians who have an across-the-board policy of never involving residents in the pre-operative, operative, and post-operative care of his or her patients, and
3. Complex medical procedures requiring multiple surgical specialties, such as transplants, where each physician is performing a unique, discrete function, rather than simply assisting another physician.

Developing a Departmental Policy

Since each surgical specialty is unique in the procedures it performs and each residency program differs in its size and scope, the Office of Compliance Programs recommends that each department develop its own written policy regarding billing for assistants at surgery. A copy of the approved policy should be maintained on file with the Office of Compliance Programs. **Each department’s policy should include:**

- The department’s definition of a “qualified” resident and the circumstances in which one would be considered unavailable, e.g. physical availability, level of training, etc.,
- In the case of certain surgical procedures (defined by CPT code) in which some residents may be judged unqualified to assist, the training level required by the resident in order to be qualified,
- A definition of what the department considers “exceptional circumstances,”

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- A list of procedures by CPT code which require multiple surgical specialties and/or sub-specialties, and
- A list of any surgeons who never involve residents in the care of their patients.

BILLING FOR SURGICAL SERVICES

Billing Procedure for Assistants at Surgery

If, according to departmental policy, it is appropriate to bill for an assistant at surgery, the following procedure should be followed:

1. CPT codes billed by the surgical assistant must be modified with the 82 modifier, unless a payer does not recognize the modifier (currently Medicaid), then the “80” modifier must be used.
2. A surgical assistant can only be used when there is no qualified resident available.
3. The dictated operative report should contain a statement defining the reason that a qualified resident was unavailable.
4. Medicare will only pay an assistant-at-surgery fee for certain procedures. One must only bill Medicare for assistant-at-surgery for those approved procedures.
5. If a PA or NP is the assistant-at-surgery, he/she must bill under their own number for Medicare and the “AS” modifier must be used. Medicare and Medicaid pay 16% of the global fee schedule rate for an assistant-at-surgery. Medicare will pay 85% of the 16% for a PA or NP assistant-at-surgery. Medicaid does not pay for a PA or NP assistant-at-surgery.
6. If a non-qualified resident was present for the operation, the resident may not be listed as an “assistant” on the operative report. The resident’s name must be listed with the qualifying statement “observation only.”

Please see The Emory Clinic Policy CA-21 Coding and Billing of Co-Surgery.

BILLING FOR SURGICAL SERVICES

GLOBAL SURGICAL BILLING

When a surgeon bills for a surgical procedure, he or she is billing for the Global Surgery Package. The global package includes all necessary services normally furnished by a surgeon before, during, and after the procedure (usually for 90 days).

If the surgeon or another physician in the same specialty in the same group practice **will not be involved** with the surgical follow-up care, the surgeon must bill the surgical code with the -54 modifier to indicate “surgical care only.” The surgeon will then be paid for the operative services only. **Teaching physicians must provide identifiable follow-up care in order to qualify for the full global surgical payment.**

The Global Surgical Fee Includes:

- Dressing changes
- Local incisional care
- Removal of operative packs
- Post-surgical pain management – by the surgeon
- Removal of cutaneous sutures, staples, lines, wire, tubes, drains, and splints
- Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric or rectal tubes; and change and removal of tracheostomy tubes
- Services for complications which do not require an additional trip to the operating room
- Visits related to surgery (except decision to perform surgery), preoperative and postoperative

*The Global Surgical Fee **Does Not** Include:*

- The initial consultation or evaluation of the problem by the surgeon
- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to a complication of surgery
- Treatment for underlying conditions or an added course of treatment which is not a part of the normal recovery from surgery
- Diagnostic tests and procedures, including diagnostic radiological procedures
- Clearly distinct surgical procedures during the postoperative period
- Treatments for postoperative complications that require a return trip to the operating room
- If a less extensive procedure fails and a more extensive procedure is required, the second procedure is payable separately
- Immunosuppressive therapy for organ transplant patients

- Critical care services unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician

BILLING FOR SURGICAL SERVICES

GLOBAL SURGICAL BILLING

Reporting Follow-up Care

Routine follow-up care visits should be reported with CPT code 99024 with a \$0 charge. Teaching physicians must document physical presence and involvement in order to receive credit for providing follow-up care.

Global Surgery – Departmental Policy

While non-surgical care for routine complications of surgical procedures is not separately billable service, it may be appropriate to bill for treating “unusual” complications. Each surgical department should develop its own written policies that define which complications are routine and which are not. This will serve as a guide to billing.

GLOBAL SURGERY AND THE TEACHING PHYSICIAN RULE

- Because surgical fees include all postoperative follow-up services, the teaching physician must not only document presence at the surgical procedure, but must also document involvement in postoperative visits.
- The teaching surgeon may determine which post-operative visits are considered key and require his or her presence.
- CPT code 99024 with a “\$0” charge is appropriate for reporting this service.
- If the teaching surgeon is aware that either he/she or another teaching physician in the same specialty will not be available for the patient’s post-operative care, the surgeon must bill the surgical code with the -54 modifier to indicate “surgical care only.” Payment will be reduced accordingly.

Emory Standards For Documenting,
Coding, & Billing Professional Services

EMORY GUIDELINES FOR BILLING ADVANCED PRACTICE PROVIDER (APP) SERVICES (Updated November 2013)							
	MEDICARE Direct Billing by APP	MEDICARE Billing "Incident To" Only Applies to Office Encounters	MEDICARE Shared Services Applies to Inpatient Encounters Billed by MD	MEDICAID Direct Billing by APP	MEDICAID Billing "Incident to" (Only Applies to RN & LPN)	CONTRACTED MANAGED CARE Billing Under MD	NON-CONTRACT COMMERCIAL Billing Under MD
EMPLOYMENT	Employed, leased or contracted by physician practice	Employed, leased or contracted by physician practice	Employed, leased or contracted by physician practice	NP-No specified employment relationship indicated; PA-Must be employee of physician practice	Employed only by physician practice	Per Contract	Check with payer
SUPERVISION	General for PA, collaboration for NP and CNS	MD in suite during entire service	N/A	General for PA; collaboration for NP and CNS	MD in suite during entire service	Per Contract	Check with payer
SITE OF SERVICE	Not Limited	Physician's office with MD in suite	MD and APP must document independent service encounters. MD/APP encounters can be combined into one billable service.	Not Limited	Not Limited	Per Contract	Check with payer
TYPE OF SERVICES	Any service, if in scope of practice	Only established patient office visits	Hospital inpatient service: Shared Service billed by MD	Any Service	E&M limited to (99211) and other services adjunct to a physician's personal service.	Not Specified	Check with payer
DOCUMENTATION	Must support service billed.	Must support service billed; notation in documentation must state MD presence or MD must sign.	MD and APP must document independent service encounters. MD/APP encounters can be combined into one billable service.	Must support service billed; APP & MD documentation MAY NOT be combined to support billing.	Must support services billed; notation in documentation must state MD presence or MD must sign.	Must support service billed; notation in documentation must state MD presence or MD must sign; APP & MD documentation MAY be combined to support billing.	Must support service billed; notation in documentation must state MD presence or MD must sign; check with payer for combination of documentation required.
REIMBURSEMENT	85% of the MD Fee Schedule	100% of the MD Fee Schedule	100% of the MD Fee Schedule	90% of the MD Fee Schedule	100% of the MD Fee Schedule	100% of the MD Fee Schedule	Check with payer

BILLING FOR SURGICAL SERVICES

BILLING FOR MID-LEVEL PROVIDER SERVICES

In order for a physician or group to bill for any services provided by Physician Assistants (PA), Nurse Practitioners (NP), or Clinical Nurse Specialists (CNS) the physician group must employ them. If the PA, NP or CNS has a billing number, the employment agreement must require, as a condition of employment, that the PA, NP, or CNS reassign all fees for professional services to the employer.

If a valid employment or contractual arrangement does not exist, a physician may not seek payment for services provided by a PA, NP, or CNS even if he or she personally supervises the services.

When billing for services provided in conjunction with mid-level providers who are not Emory employees (e.g. Grady Hospital employees), the physician may not take credit for the work performed by the mid-level in determining the appropriate procedures or level of service to bill. The physician's billings must be based solely upon the services that he or she personally performed and documented in the chart. The physician may, however, reference any review of systems, past medical, family, or social history documented by another health care provider, including the mid-level provider in question.

Pertinent Definitions:

Collaboration: This term means a process whereby an NP works with a physician to deliver health care services within the scope of the NP's professional expertise with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms defined by federal regulations and the law of the state in which the services are performed.

Direct Supervision: Direct supervision requires that the physician providing supervision be present in the office suite and immediately available to provide assistance and direction throughout the time services are performed.

General Supervision: General supervision simply requires the supervising physician to be available by telephone and does not require physical presence. Note that supervision requirements for billing purposes do not supersede the supervision requirements of state licensure laws.

"Incident To": This is a term used by both Medicare and Medicaid to describe services or supplies that are furnished as an integral, although incidental, part of the physician's professional services in the course of diagnosis or treatment of an injury or illness. These are services that are commonly furnished in a particular medical setting (physician office only for Medicare) and must be performed under the physician's direct supervision. "Incident to" services are furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her participation in and management of the course of treatment.

Specific billing rules are provided on the following page.

MEDICAL NECESSITY FOR DIAGNOSTIC PROCEDURES

- Title XVIII of the Social Security Act allows Medicare coverage and payment for only those services that are considered to be **reasonable and medically necessary**.
- Medicare specifically does not pay for routine screening tests.
- Medicare Carriers have established **Local Medical Review Policies** (LCD's) and National Coverage Determinations (NCD's) to define limitations of coverage and indications of medical necessity for specific diagnostic tests.
- Medical Review Policies have been established for a large number of diagnostic tests including most clinical laboratory tests, chest x-rays, EKGs, and echocardiograms.
- Each policy includes a list of **diagnosis codes (ICD-10)** which support medical necessity for the ordering of the test(s) in question.
- Medicare requires that the diagnosis supporting the order must be documented in the patient's medical record in order for a procedure to be paid.
- Medicare will deny payment to the testing facility or interpreting physician if charges for certain diagnostic procedures are not submitted with appropriate ICD-10 codes.

When ordering diagnostic tests for Medicare patients, physicians are required to:

1. Provide to the testing facility a diagnosis that supports the medical necessity of the ordered procedure. If a patient's condition is not yet determined then signs, symptoms, or complaints are appropriately reported. **"Rule out" statements are not appropriate.**
2. Document the reason for ordering the test (signs, symptoms, or known conditions) in the patient's medical record.
3. Independently consider the medical necessity of each test ordered. A separate diagnosis may be required for each test ordered.
4. Inform the patient that Medicare may not cover the service and that payment will be the patient's responsibility if the diagnosis does not support medical necessity of the services under Medicare policy.
5. Then have the patient sign a Waiver of Liability or Advanced Beneficiary Notice (ABN) to document informing the patient prior to the test being performed.
6. If the patient signs an ABN, the physician must notify the testing facility so that billing will be done appropriately. Please see The Emory Clinic policy "CA-15 Advanced Beneficiary Notice" for additional details

DIAGNOSTIC (ICD-10-CM) CODING

In 1948, the World Health Organization published a statistical listing that could be used to track both morbidity and mortality. This listing led the way for the current text in use today. The National Center for Health Statistics modified the statistical study with clinical information and provided a way to classify morbidity data for indexing medical records, medical case reviews and ambulatory and other medical care programs, as well as for basic health statistics.

BASIC DIAGNOSTIC CODING GUIDELINES ARE:

1. Always code to the highest level of specificity.
2. List first the primary diagnosis (the most significant reason for the encounter).
3. List also any secondary codes, co-existing conditions, or developing conditions that pertain to the treatment of the patient at that encounter.
4. Code signs & symptoms when no definitive diagnosis has been confirmed.
5. Do not code “Rule-out,” possible, probable, suspected, and questionable conditions.
6. Do not code (for billing purposes) past medical conditions, which are not assessed or treated.
7. Include a diagnosis (reason for ordering) on **all** requisitions for medical services.

MODIFIERS

Modifiers are two-digit numbers or letters that are added to a CPT or HCPCS¹ code to further explain the circumstances under which the billing code is used.

COMMONLY USED CPT MODIFIERS INCLUDE:

- 22 Unusual services
- 24 Unrelated E/M by same physician during a post-op period
- 25 Separately identifiable E/M service by same physician same day of a minor procedure
- 26 Professional component
- 50 Bilateral procedure
- 51 Multiple surgeries on the same day
- 52 Reduced services
- 53 Discontinued Procedure
- 54 Surgical care only
- 57 Decision for surgery on the day of or day before surgery
- 58 Staged or related procedure or service by same physician during postoperative period
- 59 Distinct procedural service
- 62 Co-surgery
- 76 Repeat procedure by the same physician
- 77 Repeat procedure by another physician
- 78 Return to the operating room for a complication
- 79 Unrelated procedure by same physician during the post operative period
- 82 Assistant surgeon (when qualified resident surgeon not available)

COMMONLY USED HCPCS MODIFIERS INCLUDE:

- AA Anesthesia services performed by anesthesiologist
- GC Service performed in part by a resident
- GE Service performed under the primary care exception
- TC Technical component
- GA Waiver of liability statement (ABN) on file

¹ **HCPCS** is the acronym for **H**ealth **C**are **F**inance **A**dministration (**HCFA**) **C**ommon **P**rocedure **C**oding **S**ystem, which is a uniform method for health care providers and medical suppliers to report professional services, procedures, and supplies. CPT is a part of the HCPCS coding system.