# HOW PROFESSIONAL CODING ENGAGES WITH BETH ISRAEL LAHEY HEALTH (BILH) PROVIDERS

# PROFESSIONAL CODING & EDUCATION 2021

Beth Israel Lahey Health
Lahey Hospital & Medical Center

# Agenda

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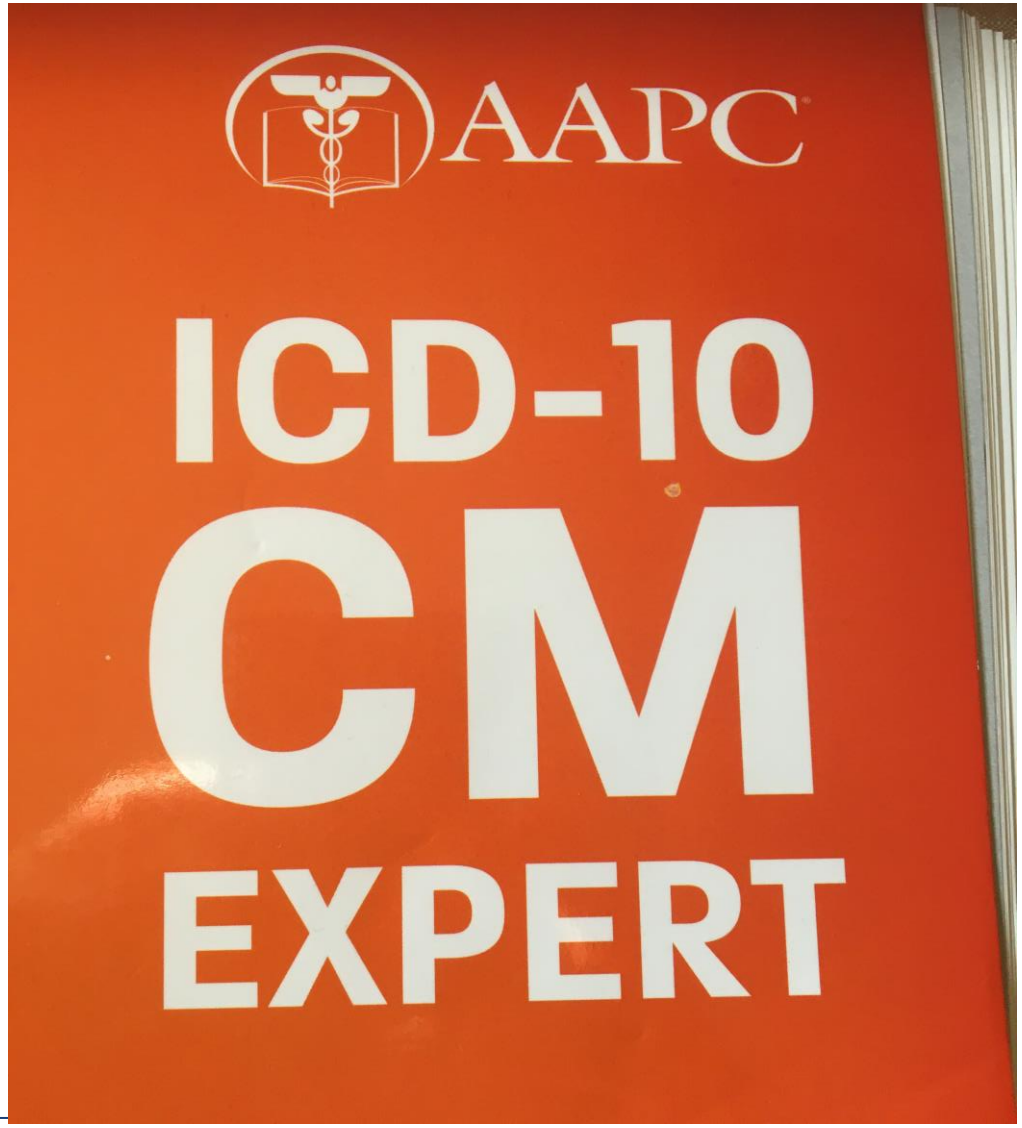
- Professional coding department mission
- Professional Coder
- Documentation of office/outpatient E/M
- Documentation of other E/M Codes
- Shared/Split Visit



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# Professional Coding Department Mission

# Professional Coding Department Mission

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- To provide quality professional coding services in the most compliant and timely manner for all areas of professional services at BILH Health
- To maintain a continuous coding program with dedicated coders committed to quality and compliance while assisting in the capture of the maximum revenue and optimizing technology

# Professional Coding Department Mission

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- To continually educate ourselves, physicians, care providers, and other colleagues as necessary on coding guidelines and regulations
- To continually improve clinical documentation to prevent denials and capture the resources utilized for patient care and severity of illness

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# Documentation Requirement for Coding/Billing

# Documentation Requirement for Coding/Billing

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- Documentation must be created for every patient encounter
- This documentation must clearly depict the level of disease severity, comorbidities, underlying disease and other factors that contribute to the level of complexity for the patient encounter
- Diagnostic coding determines the level of risk in selecting the procedure (CPT Code) for the patient encounter

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# New Versus Established Patient

# New Versus Established Patient

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- A new patient is defined as one who has not been seen by the provider or another provider of same group/specialty or an NP/PA within the past 3 years

➢ **Example:** All existing patients that has been seen within the specialty by any provider within the past 3 years will be coded as an **"established"** patient. If a patient presents to the office and has never been seen by anyone in the specialty within the past 3 years it will be coded as a new patient

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# Office/ Outpatient Evaluation & Management Services (E/M)

# Office/Outpatient E/M

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- Documentation of office/outpatient visit 99202 to 99215 is be based on either

  **1. Medical decision making**

  - **Or**

  **2. Time**

- ***NOTE: For Office/Outpatient encounter, the encounter does not have to be predominantly counseling or coordination of care to base it on time***

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# Medical Decision Making (MDM)

# Medical Decision making (MDM)

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- The level of Medical decision making MDM is based on **three elements**
- The level will be determined by the **two highest** of the **three elements**
- The provider's documentation of history and physical examination elements will not be factored in when selecting the level of E/M

# Medical Decision making (MDM)

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- The three elements are

***1. Number and complexity of problems addressed***

***2. Amount and/or complexity of data to be reviewed and analyzed***

***3. Risk of complications and/or morbidity or mortality of patient management***

# Medical Decision making (MDM)

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- The concept of MDM does not apply to 99211
- **The MDM level will based on**
  - **Straightforward, Low , Moderate or High**
- ***Note***
  - *Providers are required to perform a medically necessary **history and physical examination** but it will not be used for code selection*

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# First Element
# Number and complexity of problems addressed

# Number and complexity of problems addressed

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- Below is the documentation guide for number and complexity of problems addressed during an encounter
  - **Any symptom evaluated or treated without a definitive diagnosis**
  - **Any comorbidities or underlying diseases addressed that affects the patient encounter or increases the amount and/or complexity of data reviewed or risk of complications**
  - **Multiple conditions of a lower severity may in the aggregate create a higher risk due to their interactions**

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# Second Element
# Amount and/or complexity of data to be reviewed and analyzed

# Amount to be reviewed

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- The amount of data to be reviewed listed 3 categories for data
- The categories are:

➢ **Tests, Documents, or independent Historians**

❖ Each unique tests, order or document contributes to the combination of 2 or combination of 3 in the category

➢ **Example:**

❖ Ordered a chest X ray

❖ Review of results

# Amount to be reviewed

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- Categories continued:

## 2. Independent Interpretation of Tests:

- Interpretation and report of a test that has an assigned CPT code is customary so long as the provider is not separately billing for that service

- **Example:**

- Interpretation of a test performed by another physician or qualified health care provider

# Amount to be reviewed

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- Categories continued:

**3. Discussion of Management or Test Interpretation with External Providers (not in the same group) or appropriate sources**

- **Example:**
  - Discussed surgery

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# Third Element
# Risk of complications and/or morbidity or mortality of patient management

# Risk of Complications

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- The 4 levels of Risk are
- Minimal risk
- Low risk
- Moderate risk
- High risk
- **Note:**
- **Provider does not need to define or explain minimal, low, moderate or high risk because the CPT guide line states that these are common terms with a shared understanding**

# Risk of Complications

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- The 4 levels of Risk are:

➢ **Minimal risk**

- Examples of management options are:

❖ **Rest, Gargles, Elastic bandage, superficial dressings**

➢ **Low risk**

- Examples of management options are:

❖ **Over the counter drugs, Minor surgery with no identified risk factor**

# Risk of Complications Continued

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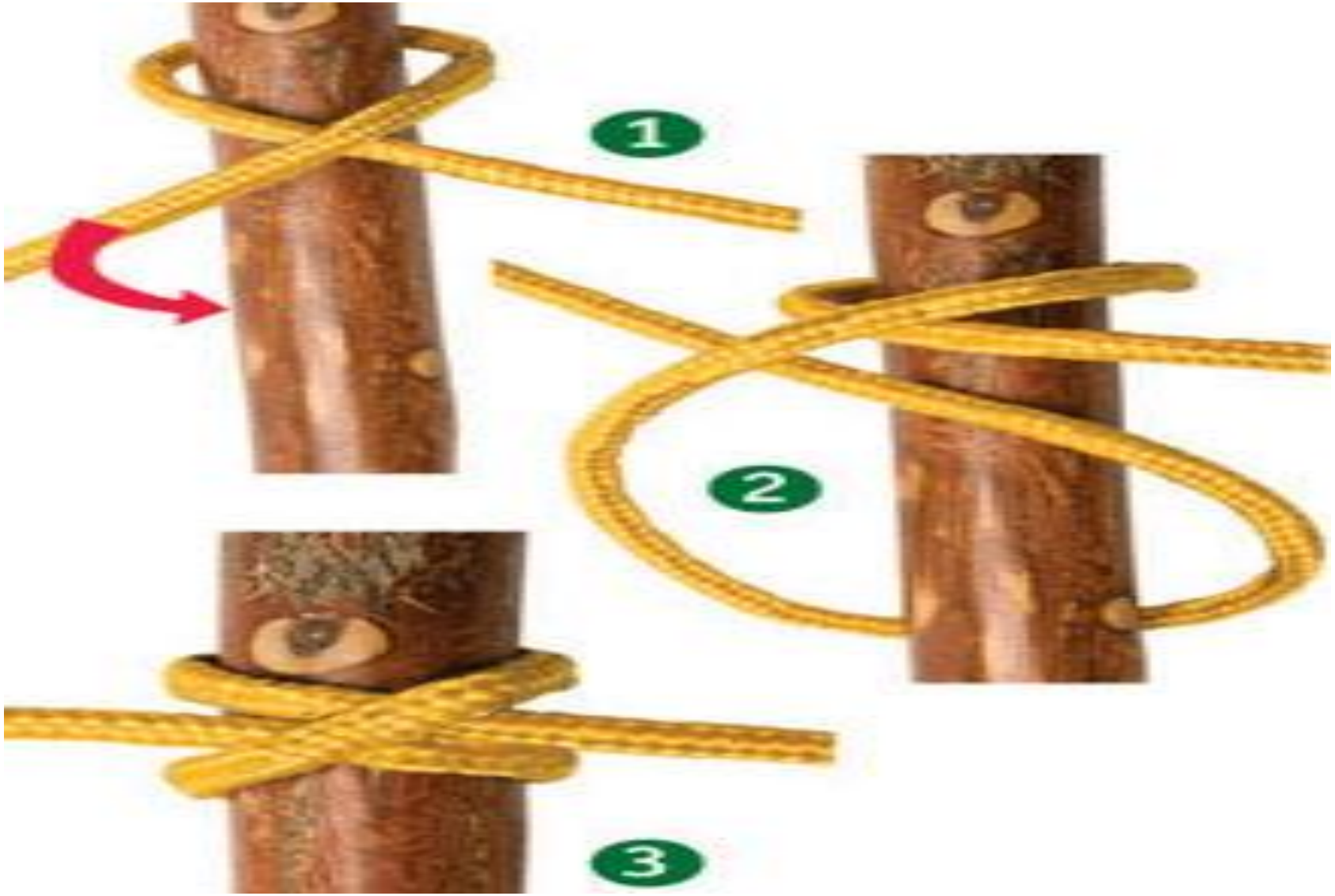
- Moderate risk
  - Examples of management options are:
    - **Prescription drug management, minor surgery with identified risk factor, major surgery without identified risk factors**
- High risk
  - Examples of management options are:
    - **Drug therapy requiring intensive monitoring for toxicity, major surgery with identified risk factor, decision regarding hospitalization**

# The goal is to tie the 3 elements together and arrive to an MDM



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# Medical Decision Making Table

# LEVEL OF MEDICAL DECISION MAKING (MDM)

| | | Elements of Medical Decision Making | | |
|---|---|---|---|---|
| **Code** | **Level of MDM (Based on 2 out of 3 Elements of MDM)** | **Number and Complexity of Problems Addressed** | **Amount and/or Complexity of Data to be Reviewed and Analyzed** *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below. | **Risk of Complications and/or Morbidity or Mortality of Patient Management** |
| 99211 | N/A | N/A | N/A | N/A |
| 99202<br>99212 | Straightforward | **Minimal**<br>• 1 self-limited or minor problem | **Minimal or none** | **Minimal risk of morbidity from additional diagnostic testing or treatment** |
| 99203<br>99213 | Low | **Low**<br>• 2 or more self-limited or minor problems;<br>**or**<br>• 1 stable chronic illness;<br>**or**<br>• 1 acute, uncomplicated illness or injury | **Limited**<br>(Must meet the requirements of at least 1 of the 2 categories)<br>**Category 1: Tests and documents**<br>• **Any combination of 2 from the following:**<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*<br>**or**<br>**Category 2: Assessment requiring an independent historian(s)**<br>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high) | **Low risk of morbidity from additional diagnostic testing or treatment** |

# LEVEL OF MEDICAL DECISION MAKING (MDM) CONT.

| Code | Level of MDM (Based on 2 out of 3 Elements of MDM) | Number and Complexity of Problems Addressed | Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below. | Risk of Complications and/or Morbidity or Mortality of Patient Management |
|---|---|---|---|---|
| 99204<br>99214 | Moderate | **Moderate**<br>• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;<br>**or**<br>• **2** or more stable chronic illnesses;<br>**or**<br>• **1** undiagnosed new problem with uncertain prognosis;<br>**or**<br>• **1** acute illness with systemic symptoms;<br>**or**<br>• **1** acute complicated injury | **Moderate**<br>(Must meet the requirements of at least 1 out of 3 categories)<br><br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following:**<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*;<br>  • Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported) | **Moderate risk of morbidity from additional diagnostic testing or treatment**<br><br>*Examples only:*<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health |

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# LEVEL OF MEDICAL DECISION MAKING (MDM) CONT.

| | | Elements of Medical Decision Making | | |
|---|---|---|---|---|
| **Code** | **Level of MDM (Based on 2 out of 3 Elements of MDM)** | **Number and Complexity of Problems Addressed** | **Amount and/or Complexity of Data to be Reviewed and Analyzed** *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below. | **Risk of Complications and/or Morbidity or Mortality of Patient Management** |
| **99205**<br>**99215** | **High** | **High**<br>• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;<br>**or**<br>• **1** acute or chronic illness or injury that poses a threat to life or bodily function | **Extensive**<br>(Must meet the requirements of at least 2 out of 3 categories)<br><br>**Category 1: Tests, documents, or independent historian(s)**<br>• Any combination of 3 from the following:<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*;<br>  • Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported) | **High risk of morbidity from additional diagnostic testing or treatment**<br><br>*Examples only:*<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization<br>• Decision not to resuscitate or to de escalate care because of poor prognosis |

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# Documentation Based on Time for Office/Outpatient Evaluation and Management Services

# Documentation Based on Time

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- The office/outpatient E/M documentation based on time does not have to be predominately counseling and /or coordination of care
- The documentation must support the medical necessity and the total time spent **including non face to face time**

# Documentation Based on Time

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- Documentation of the total time spent on the visit includes:

- **Time spent reviewing charts, previous test, films, etc.**
- **Counseling and educating the patient, family members, caregivers, etc.**
- **Interpreting results**
- **Communication with other providers**

# Documentation Based on Time

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- Ordering of tests or procedures
- All pre, intra and post service time
- **Note:**
- The clinical staff time is not included on this time

# E/M Time Table

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| E/M CODE | TIME IN MINUTES |
|---|---|
| 99202 | 15-29 |
| 99203 | 30-44 |
| 99204 | 45-59 |
| 99205 | 60-74 |
| 99211 | 5 |
| 99212 | 10-19 |
| 99213 | 20-29 |
| 99214 | 30-39 |
| 99215 | 40-54 |

# Documentation Based on Time

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- The office/out patient E/M documentation based on time includes non face to face time
- Hence prolonged E/M without direct patient **99358 and +99359** should not be billed on DOS
- **NOTE:**

➢ **+99417 prolonged service code for each additional 15 minutes should be used for over 74 minutes of 99205 and over 54 minutes of 99215**

## New Patient Office Visit

| E/M Code | History | Exam | MDM | NEW Time |
|---|---|---|---|---|
| 99202 | Appropriate Medical history and/or Physical exam | | SF | 15-29 |
| 99203 | | | LOW | 30-44 |
| 99204 | | | MODERATE | 45-59 |
| 99205 | | | HIGH | 60-74 |

## Established Patient Office Visit

| E/M Code | History | Exam | MDM | NEW Time |
|---|---|---|---|---|
| 99211 | N/A | N/A | N/A | 5 |
| 99212 | Appropriate Medical history and/or Physical exam | | SF | 10-19 |
| 99213 | | | LOW | 20-29 |
| 99214 | | | MODERATE | 30-39 |
| 99215 | | | HIGH | 40-54 |

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# Documentation Requirement for Other Evaluation and Management Services E/M codes

# Other Evaluation and Management Codes

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- All E/M codes with the exception of office /outpatient E/M codes 99202 to 99215 must be documented based on the three key components:

➢ **HISTORY**

➢ **EXAM**

➢ **MEDICAL DECISION MAKING**

- When counseling and /or coordination of care dominates the visit, time is the controlling factor to qualify for a particular level of E/M

# Other Evaluation and Management Codes

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- Outpatient Consultation Codes: 99241- 99245
- Inpatient Consultation Codes: 99251- 99255
- Initial H&P : 99221 to 99223
- Subsequent Hospital Code: 99231 to 99233
- Initial Observation Services: 99218 to 99220
- Subsequent Observation Services: 99224 to 99226
- Same day admit and discharge 99234 to 99236
- Emergency room  codes: 99281 to 99285
- Nursing Facility codes: 99304 to 99310

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# First Component
# HISTORY

# History: Three Elements

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- Chief Complaint: **Reason for the visit**
  - **Example COPD**
- History of the present illness (HPI)
- Review of systems (ROS)
- Past history, family history and social history (PFSH)

# History- Chief Complaint (CC)

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- A chief complaint is the reason for the encounter, usually stated in the patient's own words
- It should be clearly stated on every note
- It establishes medical necessity
- **No "rule out", "probable", or "f/u"**

➢ **Examples are:**

- "Patient presents today with severe shortness of breath"
- "Patient presents today with cough and fever"

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# First Element of History: History of Present illness (HPI)

# History of Present Illness (HPI)

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- History of present illness (HPI)- a description of present illness from the beginning of the symptoms to the time of the present encounter. There are eight elements of HPI
  - ***Location-Example: the right ear***
  - ***Severity-Example: 8 on a scale from 1 to 10***
  - ***Quality-Example: aching or burning***
  - ***Duration-Example: it started 4 days ago***

# History of Present Illness (HPI)

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- History of present illness (HPI) continues:
  - ***Context- Example: Went swimming last week***
  - ***Modifying Factors: Better when sitting up***
  - ***Associated Signs and Symptoms: Ringing in the ear***

# History of Present Illness (HPI)

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- HPI can either be:
- **Brief:** Documentation of 1-3 elements of HPI
- **Extended:** Documentation of 4 elements of HPI
- Documentation of HPI does not need to be complex
- A simple sentence will normally be enough to furnish an extended HPI
- **Example:** Patient has had knee **(location)** pain and sciatica **(associated symptom)** intermittently **(timing)** for two days **(duration)**

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# Second Element of History: Review of Systems (ROS)

# History- Review of Systems (ROS)

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- This is accounting for various organ systems obtained through a series of questions
- There are 14 systems that are recognized for ROS purposes:
  - **Constitutional (For Example: Fever, Weight Loss, BP)**
  - **Eyes**
  - **Ears, nose mouth and throat**
  - **Cardiovascular**
  - **Respiratory**

# History- Review of Systems (ROS)

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- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (Skin or Breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/ Immunologic

# History Review of Systems (ROS)

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- **Constitutional symptoms:** Usual weight, recent weight changes, fever, weakness, fatigue
- **Eyes (Ophthalmologic):** Glasses or contact lenses, last eye examination, visual glaucoma, cataracts, eyestrain, pain, diplopia, redness, lacrimation, inflammation, blurring
- **Ears, nose, mouth and throat (Otolaryngologic)**
- **Ears:** hearing, discharge, tinnitus, dizziness, pain
- **Nose:** Head colds, epistaxis, discharges, obstruction, postnasal drip, sinus pain

# History Review of Systems (ROS)

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- **Mouth and Throat:** Condition of teeth and gums, last dental examination, soreness, redness, hoarseness, difficulty in swallowing
- **Cardiovascular:** Chest pain, rheumatic fever, tachycardia, palpitation, high blood pressure, edema, vertigo, faintness, varicose veins, thrombophlebitis

# History- Review of Systems (ROS)

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- **Respiratory:** Chest pain, cough, dyspnea, sputum (color and quality),asthma, bronchitis, emphysema, pneumonia, tuberculosis, pleurisy,(note also shortness of breath)
- **Gastrointestinal:** Appetite, thirst, hematemesis, rectal bleeding, change in bowel habits, indigestion, food intolerance, flatus, jaundice
- **Genitourinary:** Urinary: painful urination, nocturia, pyuria, hematuria, incontinence, urinary infection

# History- Review of Systems (ROS)

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- **There are four types of review of systems**

- **None:** i.e. no organ system reviewed
- **Pertinent to problem:** review of 1 organ system pertinent to the chief complaint
- **Extended:** review of 2-9 organ systems
- **Complete:** review of 10 or more systems

# History- Review of Systems (ROS)

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- The notation of

**"all other systems reviewed and are negative"**

may be appropriate when multiple systems have been reviewed, for medically necessary reasons, but for which the patient reports no relevant events or symptoms

# History- Review of Systems (ROS)

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- A provider cannot document **“10-point review of symptoms negative unless noted in the HPI”** and get credit for 10-point reviews of systems
- Findings noted during ROS should be entered as such, then a statement “**all other systems reviewed and are negative** "will suffice for a complete review of systems

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# Third Element of History:
# Past, Family
# &
# Social History
# (PFSH)

# History- Past, Family and Social History (PFSH)

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- PFSH consists of a review of three areas:

➢ **Past History:** This contains information about the patient's past experience with illnesses, injuries, and treatments

➢ It may include information about the following:

- **Hospitalization**
- **Illness and or injuries**
- **Surgeries**
- **Current Medications**

# History- Past, Family and Social History (PFSH)

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- **Allergies to drugs or the environment**
- **Age appropriate immunizations status**
- **Age appropriate dietary or feeding status**

➢ **Family History:** This includes a review of medical events, diseases and hereditary conditions that may place the patient at risk. It may include information about the following:

# History- Past, Family and Social History (PFSH)

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- Disease of mother, father, siblings and/ or children
- Health status or cause of death of mother, father, siblings and/or children
- Disease of family members that may be hereditary or cause the patient to be at risk
- Note: The verbiage "family history noncontributory" is not accepted as family history reviewed

# History- Past, Family and Social (PFSH)

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- **Social History:** This includes age appropriate review of past and current activities. It may include information such as:

- **Marital Status**
- **Employment such as current employment**
- **Use of controlled substance such as alcohol**
- **Living arrangements**
- **Occupational History**
- **Level of education**

# History- Past, Family and Social History (PFSH)

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- **Past, Family and Social History (PFSH) can be**
  - **None:** for example none of the history is reviewed
  - **Pertinent to the problem:** review of 1 history area
  - **Complete:** review of 2 or 3 history areas
- **Note:**
  - ***For a new patient, all 3 areas of family history must be documented***

# Audit Sheet for History

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| HPI Elements | | | | Calculation | | | |
|---|---|---|---|---|---|---|---|
| ☐ Location<br>☐ Quality | ☐ Severity<br>☐ Duration | ☐ Timing<br>☐ Context | ☐ Modifying factors<br>☐ Associated signs and symptoms | ☐ **Brief** (1–3) | ☐ **Brief** (1–3) | ☐ **Extended (4 or more)** | ☐ **Extended (4 or more)** |
| **HPI: Status of Chronic Conditions** | | | | ☐ **N/A** | ☐ **N/A** | ☐ **Status of 3 chronic conditions** | ☐ **Status of 3 chronic conditions** |
| ☐ 3 conditions | | | | | | | |
| **ROS: (Review of Systems)** | | | | ☐ **None** | ☐ **Pertinent to Problem** (1 system) | ☐ **Extended** (2–9) | ☐ **Complete**<br>**Complete ROS**: Ten or more systems, or some systems with statement "all others negative." |
| ☐ Constitutional (weight loss, etc.)<br>☐ Eyes | ☐ Ears, nose, mouth, and throat<br>☐ Card/Vascular<br>☐ Respiratory | ☐ GI<br>☐ GU<br>☐ Musc\Skeletal<br>☐ Integumentary *(Skin, breast)* | ☐ Neuro<br>☐ Psych<br>☐ Endo<br>☐ Hem Lymph<br>☐ All/immuno<br>☐ All others negative | | | | |
| **PFSH (past medical, family, social history) areas** | | | | ☐ **None** | ☐ **None** | ☐ **Pertinent to problem** (1 history area) | ☐ **Complete (2 or 3 history area)**<br>Complete PFSH<br>**Two history areas**: a) Established patients – office (outpatient) care; b) Emergency dept.<br>**Three history areas**: a) New patients – office (outpatient) care, domiciliary care, home care; b) Initial hospital care; c) Hospital observation; d) Initial nursing facility care. |
| ☐ Past history *(patient's past experiences with illnesses, operations, injuries and treatments)*<br>☐ Family history *(a review of medical events in the patient's family, including diseases which may be hereditary or place the patient is at risk)*<br>☐ Social history *(an age-appropriate review of past and current activities)*<br>**Note**: For subsequent hospital and nursing facility E/M services, only an interval history is necessary. It is not necessary to record information about the PFSH. | | | | | | | |
| **Final Results** | | | | **Problem Focused** | **Expanded Problem Focused** | **Detailed** | **Comprehensive** |

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# Second Component: Examination

# Second Component-Examination

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- The extent of the exam performed is dependent on clinical judgment and on the nature of the presenting problem
- **There are 4 types:**

➢ **PF- Problem Focused (1 body area/ organ system)**

➢ A limited exam of the affected body area or organ system

# Second Component-Examination

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- **EPF- Expanded Problem Focused (2-7 body areas/organ systems)**
- Minimal detail for the affected body area or organ systems examined **(check list type of communication with out any expansion of documentation of findings)**

# Second Element-Examination

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- **D-Detailed (2-7 body areas/organ systems)**
  - An extended examination of the affected body areas **(Expanded documentation of the areas and /or systems examined; requires more than checklist; needs to have normal/abnormal findings expanded upon)**
- **C- Comprehensive (8 or more organ systems only)**
  - A general multisystem exam or a complete examination of a single organ system

# Second Component- Examination

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## The extent of the exam performed is dependent on clinical judgment and on the nature of the presenting problem

| Examination | Calculation – Choose either 1995 or 1997 rules to calculate result | | | |
|---|---|---|---|---|
| | 1995 | | | |
| Body areas:<br>☐ Head, including face<br>☐ Chest, including breast and axillae<br>☐ Abdomen<br>☐ Neck<br>☐ Back, including spine<br>☐ Genitalia, groin, buttocks<br>☐ Each extremity | ☐ One body area or system | ☐ 2–7 areas or systems (Minimal detail for areas and/or systems examined; check list type documentation without any expansion of documentation of findings) | ☐ 2–7 areas or systems (Expanded documentation of the areas and/or systems examined; requires more than checklists; needs to have normal/abnormal findings expanded upon) | ☐ 8 or more *systems only* |
| | 1997 | | | |
| Organ systems:<br>☐ Constitutional (e.g., vitals, gen app)<br>☐ Ears, nose, mouth, throat<br>☐ Respiratory<br>☐ GI<br>☐ GU<br>☐ Cardiovascular<br>☐ Musculoskeletal<br>☐ Skin<br>☐ Neuro<br>☐ Psych<br>☐ Hem/lymph/imm<br>☐ Eyes | ☐ 1–5 bullets (1 or more body areas or system) | ☐ 6 bullets (1 or more body areas or system) | ☐ 12 bullets in 2 or more body areas/systems or 2 bullets in 6 or more body areas/ systems (except eye and psych exams, which are 9 bullets) | ☐ 2 bullets in 9 or more body areas or systems; or complete single organ system |
| **Final Results** | **Problem Focused** | **Expanded Problem Focused** | **Detailed** | **Comprehensive** |

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# Third Component:
# Medical Decision Making (MDM)

# Medical Decision Making (MDM)

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- MDM is measured by 3 tables

➢ **Table 1: Number of diagnoses or treatment options** that require : active management or affect treatment (Treatment options)

➢ **Table 2: Amount and/ or complexity of data reviewed-** Medical records, diagnostic tests, and/or information that must be obtained, reviewed and analyzed

# Medical Decision Making (MDM)

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- **Table 3: Risk of complications and/ or morbidity or mortality,** as well as the co-morbidities, associated with the patient's presenting problems, the diagnostic procedure(s) and/or the possible management options

# Medical Decision Making Table (MDM)

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## Table 1: Number of Diagnosis or Treatment Options

| A—Problem(s) Status | B—Number | C—Points | D—Results |
|---|---|---|---|
| Self-limited or minor (stable, improved, or worsening) | Max = 2 | 1 | |
| Est. problem (to patient); stable, improved | | 1 | |
| Est. problem (to patient); worsening | | 2 | |
| New problem (to patient); no additional workup planned | Max = 1 | 3 | |
| New problem (to patient); add workup planned | | 4 | |
| | | **Total** | |

Multiply the number in columns B—Number and C—Points and put the product in column D—Results. Enter a total for column D, then **bring total to line A in the "Final Result for Complexity"** table below.

# Medical Decision Making Table (MDM)

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## Table 2: Amount and/or Complexity of Data Reviewed

| Reviewed Data | Points |
|---|---|
| Review and/or order of clinical lab tests | 1 |
| Review and/or order of tests in the radiology section of CPT | 1 |
| Review and/or order of tests in the medicine section of CPT | 1 |
| Discussion of test results with performing physician | 1 |
| Decision to obtain old records and/or obtain history from someone other than patient | 1 |
| Review and summarization of old records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider. | 2 |
| Independent visualization of image, tracing or specimen itself (not simply review of report) | 2 |
| **Total** | |

**Bring total to line C in final "Result for Complexity" table below.**

# Medical Decision Making Table (MDM)

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## Table 3: Risk of complications and/or Morbidity or Mortality

| Level of Risk | Presenting Problem(s) | Diagnostic Procedure(s) Ordered | Management Options Selected |
|---|---|---|---|
| Minimal | • One self-limited or minor problem, e.g., cold insect bite, tinea corporis | • Laboratory tests requiring venipuncture<br>• Chest X-rays<br>• EKG/ EEG<br>• Urinalysis<br>• Ultrasound, e.g., echo<br>• KOH prep | • Rest<br>• Gargles<br>• Elastic bandages<br>• Superficial dressings |
| Low | • Two or more self-limited or minor problems<br>• One stable chronic illness, e.g., well controlled hypertension or<br>• noninsulin dependent diabetes, cataract, BPH<br>• Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain | • Physiologic tests not under stress, e.g., pulmonary function tests<br>• Noncardiovascular imaging studies with contrast, e.g., barium enema<br>• Superficial needle biopsies<br>• Clinical laboratory tests requiring arterial puncture<br>• Skin biopsies | • Over-the-Counter drugs<br>• Minor surgery with no identified risk factors<br>• Physical therapy<br>• Occupational therapy<br>• IV fluids without additives |
| Moderate | • One or more chronic illness with mild exacerbation, progression, or side effects of treatment<br>• Two or more stable chronic illnesses<br>• Undiagnosed new problem with uncertain prognosis, e.g., lump in breast<br>• Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis<br>• Acute complicated injury, e.g., head injury with brief loss of consciousness | • Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test<br>• Diagnostic endoscopies with no identified risk factors<br>• Deep needle or incisional biopsy<br>• Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram cardiac catheter<br>• Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis | • Minor surgery with identified risk factors<br>• Elective major surgery (open, percutaneous or endoscopic with no identified risk factors)<br>• Prescription drug management (continuation & new prescription)<br>• Therapeutic nuclear medicine<br>• IV fluids with additives<br>• Closed treatment of fracture or dislocation without manipulation |
| High | • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment<br>• 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<br>• An abrupt change in neurologic status, e.g., seizure, TIA, weakness or sensory loss | • Cardiovascular imaging studies with contrast with identified risk factors<br>• Cardiac electrophysiological tests<br>• Diagnostic endoscopies with identified risk factors<br>• Discography | • Elective major surgery (open, percutaneous or endoscopic with identified risk factors)<br>• Emergency major surgery (open, percutaneous or endoscopic)<br>• Parental controlled substances<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis |

# Medical Decision Making

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- Medical decision making drives the overall level of care of the encounter with the focus on medical necessity
- The assessment, clinical impression for all diagnosis must be explicitly documented
- MDM will vary visit to visit depending on the patient's condition and what was performed on that day

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# Documentation Based on Time for Other Evaluation and Management Services

# Documenting based on time

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- Document other E/M services based on time only when counseling and/or coordination of care dominates **MORE than 50%** of the encounter
- **Document:**

➢ The total length of time of the encounter

# Documenting based on time

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- The total face-to-face time spent counseling/coordinating care
- Description of the counseling and/or activities to coordinate care
- **What time counts?**
  - **In the office setting: Face-to-face time**
  - **Inpatient setting: Face to face time including time at the bedside and on the patient's hospital floor or unit**

# Documenting based on time

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- **Example**
  - If 25 minutes were spent in follow-up with an established patient and more than half of that time was spent counseling or coordinating his or her care, CPT code 99214 should be selected.
- **Documentation:**

*"25 minute visit of which greater than 50% was* spent counseling the patient on need for surgery, recovery, rehabilitation"

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# Shared/ Split Visit

# Shared Visit

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- A service is split/shared between a physician and an NP/PA from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient eg history, exam and medical decision making.
- Shared service between an NP/PA and a physician is appropriate and may be billed out under **either** the NP/PA or the physician

# Shared Visit

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- Note:
- Split/shared service applies only to selected E/M visits and only for place of service of outpatient clinic
- It does not apply to
  - Consultation
  - Critical care
  - Procedures

# Shared/ Split Service

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- In a shared service, both the physician and the NP/PA must document their portion of the face-to-face visit
- However, if there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by only reviewing the patient's medical record) then the service may only be billed under the NP/PA

# Documentation Requirement

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- The documentation requirement for shared/split service is the same for inpatient, outpatient or emergency department
- The NP/PA and physician sharing the service must be from the same group practice
- The physician must provide face-to-face portion of the encounter

# Documentation Requirement

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- Note:
- There are two ways to document this encounter
  - **Two separate notes**
  - **Addendum by the MD to an PA/NP note**

# Selecting AP Shared Visit Code (AP, Outpatient)

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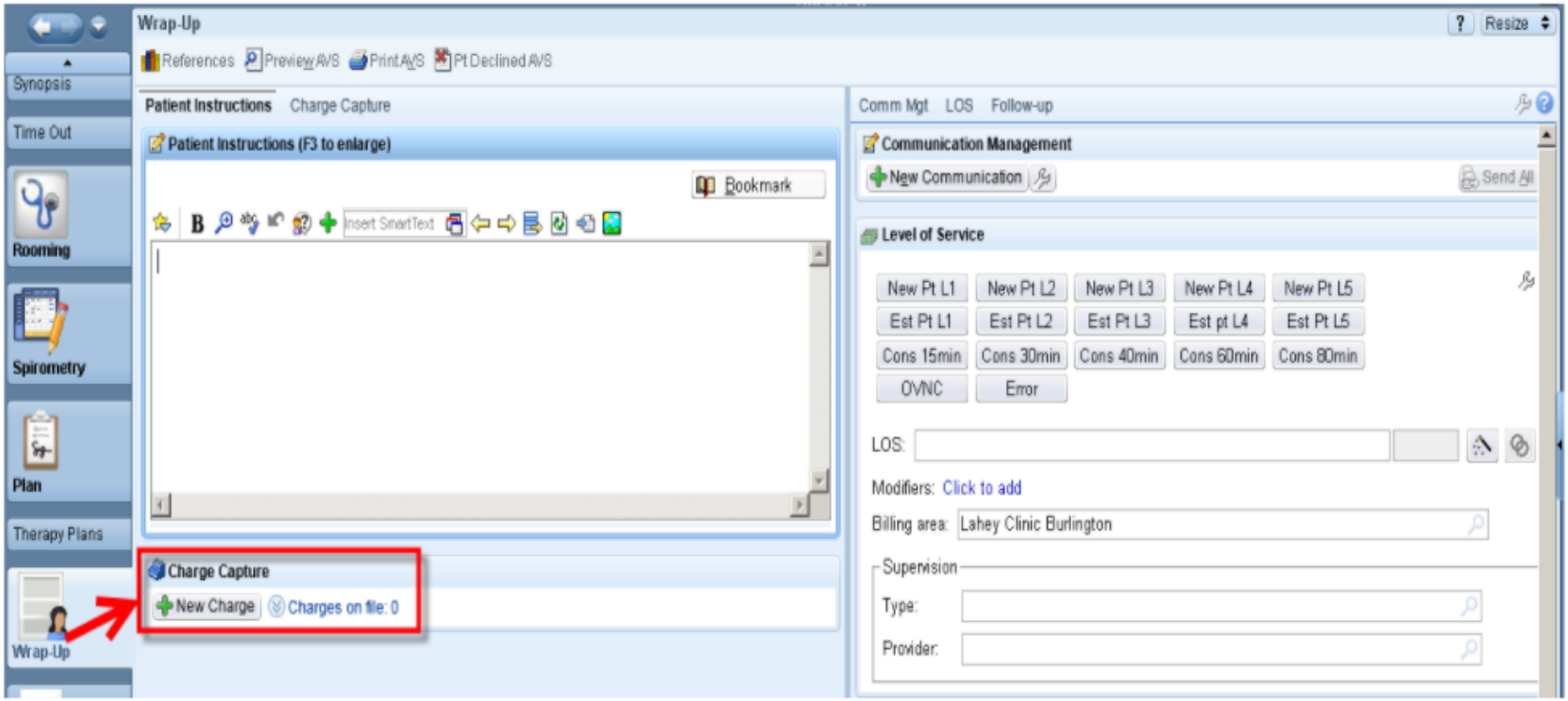

# More on AP selecting shared visit code

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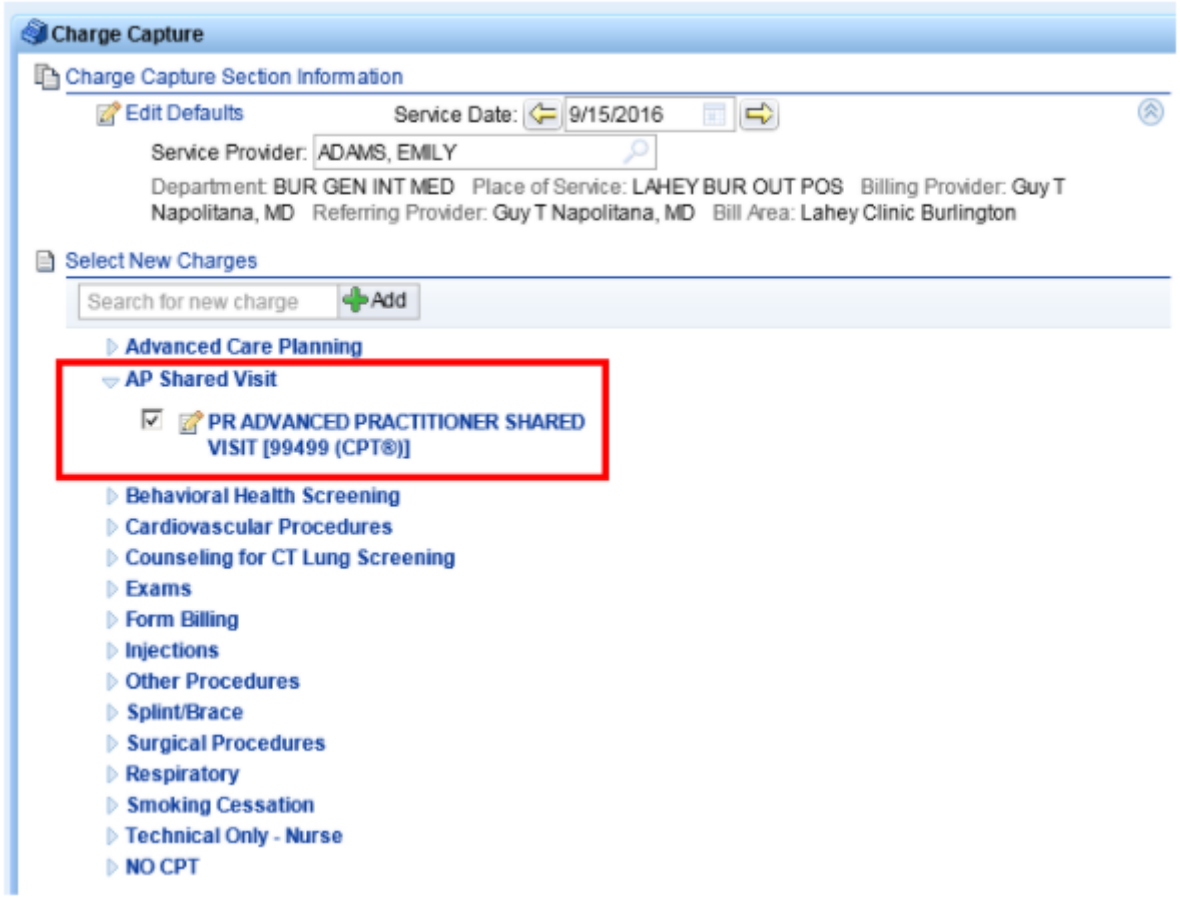

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# Independent Billing By An AP

# Ambulatory AP Charge Submission Workflow

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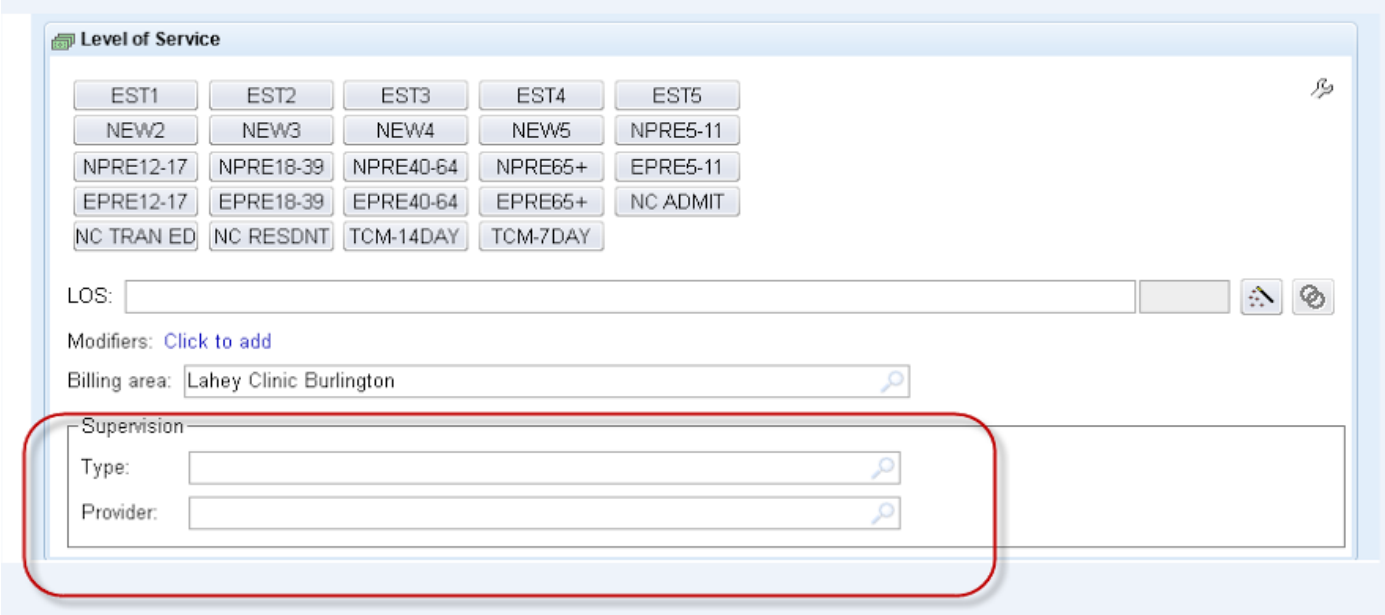
- For ALL outpatient visits where the Advanced Practitioner (AP) is seeing and billing for the patient visit independently (AP = encounter provider), the "Supervision" section must be COMPLETED
- It should be filled out as "INDIRECT SUPERVISION" with the supervising physician for that particular patient (i.e. physician identified by division-specific established process, such as Doctor of the Day) named directly



# Inpatient Independent AP Billing

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- AP creates/writes note and signs it
- AP is taken to charge screen automatically **EVEN IF CO-SIGN BUTTON IS CHECKED**
- AP submits charge and writes supervising physician name in **COMMENT** section
- AP clicks on “accept” and makes sure charges are “filed”

# Inpatient Independent AP Billing

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- **NOTE:**

- There are a few Epic note types that do not automatically take the provider to the charge screen upon signing; the AP must go to the charge “tab” on the left and complete the charge process

# Area to write the supervising physician name

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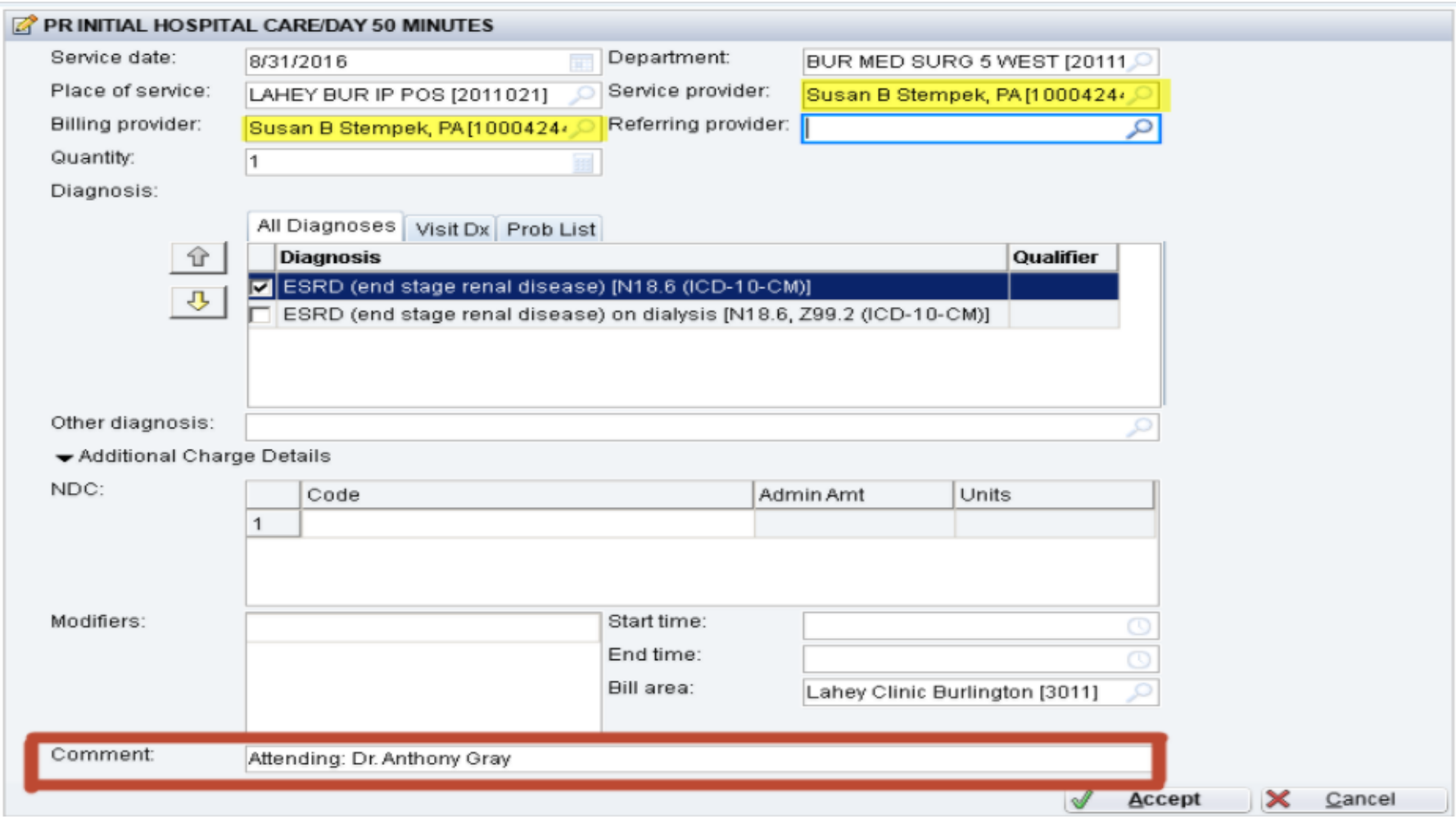

# Questions?

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- On Mass Net under Helpful Links Ask the Coder