CME Accreditation

This activity has been planned and implemented in accordance with the Accreditation and policies of the Medical Society of the State of New York (MSSNY) through the joint providership of the Academy of Medicine of Queens County and HANYS. The Academy of Medicine of Queens County is accredited by MSSNY to provide Continuing Medical Education for physicians.

The Academy of Medicine of Queens County designates this educational activity for a maximum of 1.5 AMA PRA Category 1 Credit™. Physicians should claim credit commensurate with the extent of their participation in the activity.

The planners and faculty participants do not have any financial arrangements or affiliations with any commercial entities whose products, research, or services may be discussed in these materials.

This activity has been funded by an educational grant from the New York State Department of Health. No commercial funding has been accepted for the activity.
GOALS FOR SESSION

1. Know what the rules are
2. Know where the rules come from
3. Know how to use the rules
4. So that you can:

GET PAID FOR WHAT YOU DO
2013 MEDICARE B BILLING TRENDS

With Contributions from Chuck Credelius, M.D.
Trends in NH Initial Visit Code Billing Frequency 2006-2013
Trends in NH Subsequent Code Billing Frequency 2006-2013
Trends in Discharge and Annual Visit NH Code Billing Frequency
## Comparison NH Reimbursement

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Comparison NH Reimbursement

2007-2013 Average 43% increase
2007-2013 Inflation rate 11.1%
REGULATIONS
vs.
BILLING
vs.
CODING
CONNECTED BUT DIFFERENT
How?
REGULATIONS:
Survey Enforcement

BILLING:
Medicare

CODING:
AMA
TWO MAIN TOPICS FOR TODAY:

BILLING: Medicare

CLAIMS PROCESSING MANUAL

CODING: AMA

CPT
MEDICARE CLAIMS PROCESSING MANUAL
MEDICARE ADMINISTRATIVE CONTRACTORS

• Local insurance companies that contract with CMS to do Part B billing (some also do Part A, DME)

• Physician billing - Part B
MEDICARE ADMINISTRATIVE CONTRACTORS

- National Policy
  - National Coverage Decisions (NCDs);
  - Broad guidelines, may be modified by
    - LMRP (Local Medical Review Policy)
    - LCD (Local Coverage Determinations)
CMS Manuals

– cms.hhs.gov

– Look for Regulations and Guidance, Internet Only Manuals
CMS Manuals

100 Introduction
100-01 Medicare General Information, Eligibility and Entitlement Manual
100-02 Medicare Benefit Policy Manual
100-03 Medicare National Coverage Determinations (NCD) Manual
100-04 Medicare Claims Processing Manual
100-05 Medicare Secondary Payer Manual
100-06 Medicare Financial Management Manual
100-07 State Operations Manual
100-08 Medicare Program Integrity Manual
100-09 Medicare Contractor Beneficiary and Provider Communications Manual
# CMS Manuals

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<td>State Medicaid Manual (The new manual is under development. Please continue to use the Paper-Based Manual to make your selection.)</td>
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<td>Medicare ESRD Network Organizations Manual</td>
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<td>Medicare Managed Care Manual</td>
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Chapter 13 - Radiology Services
Chapter 14 - Ambulatory Surgical Centers
Chapter 15 - Ambulance
Chapter 16 - Laboratory Services from Independent Labs, Physicians, and Providers
Chapter 17 - Drugs and Biologicals
Chapter 18 - Preventive and Screening Services
Chapter 19 - Indian Health Services
Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DME/POS), Parenteral and Enteral
Chapter 21 - Medicare Summary Notices
Chapter 22 - Remittance Notices to Providers
Chapter 23 - Fee Schedule Administration and Coding Requirements
Chapter 24 - EDI Support Requirements
Chapter 25 - Completing and Processing the Form CMS-1450 Data Set
Chapter 26 - Completing and Processing Form CMS-1500 Data Set
Chapter 27 - Contractor Instructions for CWF
Chapter 28 - Coordination With Medigap, Medicaid, and Other Complementary Insurers
Chapter 29 - Appeals of Claims Decisions
Chapter 30 - Financial Liability Protections
Chapter 31 - ANSI X12N Formats
Chapter 32 - Billing Requirements for Special Services
Chapter 33 - Miscellaneous Hold Harmless Provisions
Chapter 34 - Reopening and Revision of Claim Determinations and Decisions
Web Resources

**Manual - Chapter 12**

**CMS Transmittal 808** (January 6, 2006)- NH

**Medlearn Matter Articles**
- www.cms.hhs.gov/MLNGenInfo

**AMA Documentation Guidelines**
- www.cms.hhs.gov/MLNProducts/20_DocGuide.asp#TopOfPage
Chapter 12 - Physicians/Nonphysician Practitioners

- 10 - General
- 20 - Medicare Physicians Fee Schedule (MPFS)
- 30 - Correct Coding Policy
  - 30.1 - Digestive System (Codes 40000 - 49999)
  - 30.2 - Urinary and Male Genital Systems (Codes 50010 - 55899)
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  - 30.6 - Evaluation and Management Service Codes - General (Codes 99201 - 99499)
- 40 - Surgeons and Global Surgery
- 50 - Payment for Anesthesiology Services
- 60 - Payment for Pathology Services
Chapter 12 - Physicians/Nonphysician Practitioners

- 70 - Payment Conditions for Radiology Services
- 80 - Services of Physicians Furnished in Providers or to Patients of Providers
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  - 80.2 - Rural Health Clinic and Federally Qualified Health Center Services
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- 90 - Physicians Practicing in Special Settings
  - 90.1 - Physicians in Federal Hospitals
  - 90.2 - Physician Billing for End-Stage Renal Disease Services
  - 90.2.1 - Inpatient Hospital Visits With Dialysis Patients
  - 90.3 - Physicians’ Services Performed in Ambulatory Surgical Centers (ASC)
  - 90.4 - Billing and Payment in Health Professional Shortage Areas (HPSAs)
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Chapter 12 - Physicians/Nonphysician Practitioners

- 100 - Teaching Physician Services
- 110 - Physician Assistant (PA) Services Payment Methodology
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- 150 - Clinical Social Worker (CSW) Services
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  - 30.6.1 - Selection of Level of Evaluation and Management Service
    » 30.6.1.1 - Initial Preventive Physical Examination
  - 30.6.2 - Billing for Medically Necessary Visit on Same Occasion as Preventive Medicine Service
  - 30.6.3 - Payment for Immunosuppressive Therapy Management
  - 30.6.4 - Evaluation and Management (E/M) Services Furnished Incident to Physician’s Service by Nonphysician Practitioners
  - 30.6.5 - Physicians in Group Practice
  - 30.6.6 - Payment for Evaluation and Management Services Provided During Global Period of Surgery
  - 30.6.7 - Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits (Codes 99201 - 99215)
Chapter 12 - Physicians/Nonphysician Practitioners

- 30.6.8 - Payment for Hospital Observation Services (Codes 99217 - 99220)
- 30.6.9 - Payment for Inpatient Hospital Visits - General (Codes 99221 - 99239)
  » 30.6.9.1 - Payment for Initial Hospital Care Services (Codes 99221 - 99223)
  » 30.6.9.2 - Subsequent Hospital Visit and Hospital Discharge Management (Codes 99231 - 99239)
- 30.6.10 - Consultation Services (Codes 99241 - 99255)
- 30.6.11 - Emergency Department Visits (Codes 99281 - 99288)
- 30.6.12 - Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292)
Chapter 12 - Physicians/Nonphysician Practitioners

- 30.6.13 - Nursing Facility Services (Codes 99304 - 99318)
- 30.6.14 - Home Care and Domiciliary Care Visits (Codes 99324 - 99350)
  - 30.6.14.1 - Home Services (Codes 99341 - 99350)
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  - 30.6.15.3 - Physician Standby Service (Code 99360)
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- 30.6.16 - Case Management Services (Codes 99362 and 99371 - 99373)
Chapter 12 - Physicians/Nonphysician Practitioners

- **30.6 - Evaluation and Management Service Codes**
  
  – General - Codes 99201 - 99499
SEC. 30.6.1 - Selection of Level of Evaluation and Management Service

A. Use of CPT Codes

- “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.”
- “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.”

AMDA White Paper
• SEC. 30.6.1 - Selection of Level of Evaluation and Management Service

• B. Selection of Level Of Evaluation and Management Service
  – “Instruct physicians to select the code for the service based upon the content of the service.”
  – “The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care.”
Medically Necessary Visits

“Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B”
SEC. 30.6.1 - Selection of Level of Evaluation and Management Service

D. Use of Highest Levels of Evaluation and Management Codes

“Carriers must advise physicians that to bill the highest levels of visit and consultation codes, the services furnished must meet the definition of the code (e.g., to bill a Level 5 new patient visit, the history must meet CPT’s definition of a comprehensive history).”
• SEC. 30.6.1 - Selection of Level of Evaluation and Management Service

• D. Use of Highest Levels of Evaluation and Management Codes
  - “The comprehensive history must include a review of all the systems and a complete past (medical and surgical) family and social history obtained at that visit.
  - In the case of an established patient, it is acceptable for a physician to review the existing record and update it to reflect only changes in the patient’s medical, family, and social history from the last encounter, but the physician must review the entire history for it to be considered a comprehensive history.”

Medicare Claims Processing Manual, Pub.100-04
Chapter 12 - Physicians/Nonphysician Practitioners

• 30.6 - Evaluation and Management Service Codes
  – General - Codes 99201 - 99499

• 30.6.13 - Nursing Facility Services
  – Codes 99304 - 99318
30.6.13 - Nursing Facility Services

A. Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

B. Visits to Comply With Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF

C. Visits by Qualified Nonphysician Practitioners

D. Medically Complex Care
30.6.13 - Nursing Facility Services

E. Incident to Services

F. Use of the Prolonged Services Codes and Other Time-Related Services

G. Multiple Visits

H. Split/Shared E/M Visit

I. SNF/NF Discharge Day Management Service
DOCUMENTATION GUIDELINES

• **DO NOT UNDERDOCUMENT**
  – OVERALL STATUS OF THE PATIENT

• MULTIPLE DIAGNOSES
• CO-MORBIDITIES
• OTHER COMPLICATING ISSUES
• FAMILY ISSUES
• FACILITY ISSUES
A. **Visits to Perform the Initial Comprehensive Assessment and Annual Assessments**

B. Visits to Comply With Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF

C. Visits by Qualified Nonphysician Practitioners

D. Medically Complex Care
30.6.13 A Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

- Definition of Initial Federally Mandated Visit is:
  - “the initial comprehensive visit during which the physician:
    - completes a thorough assessment,
    - develops a plan of care, and
    - writes or verifies admitting orders for the nursing facility resident.”
30.6.13 A Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

- Prior to/after Initial Federally Mandated Visit:
  - “other medically necessary E/M visits may be performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit.”
  - “Qualified NPP may perform.”
  - “Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B.”
30.6.13 A Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

• “The principal physician of record must append the modifier “-AI”, Principal Physician of Record, to the initial nursing facility care code.”

• “This modifier will identify the physician who oversees the patient’s care from other physicians who may be furnishing specialty care.”
30.6.13 A Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

• **WHO CAN PERFORM?**

  – The initial federally mandated comprehensive visit in a SNF and NF must be performed by the physician except as otherwise permitted (42 CFR 483.40 (c) (4)).

  – **SNF**
    
    • “the physician may not delegate initial federally mandated comprehensive visit in a SNF.”

  – **NF**
    
    • “In the NF setting, a qualified NPP (i.e., a nurse practitioner (NP), physician assistant (PA), or a clinical nurse specialist (CNS), who is not employed by the facility, may perform the initial federally mandated comprehensive visit when the State law permits this.”
30.6.13 A Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

• READMISSION
  – “A readmission to a SNF or NF shall have the same payment policy requirements as an initial admission in both the SNF and NF settings.”
  – Definition of “readmission” unclear
  – ? Patient needs to be officially discharged from the facility to be able to use another Initial Visit code, otherwise a Subsequent Visit code should be used.
30.6.13 A Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

• **ANNUAL ASSESSMENT (99318)**
  
  – “An annual nursing facility assessment visit code may substitute as meeting one of the federally mandated physician visits if the code requirements for CPT code 99318 are fully met and in lieu of reporting a Subsequent Nursing Facility Care, per day, service (codes 99307 - 99310).
  
  – It shall not be performed in addition to the required number of federally mandated physician visits.”
Medicare Claims Processing Manual, Pub.100-04

• 30.6.13 - Nursing Facility Services

A. Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

B. Visits to Comply With Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF

C. Visits by Qualified Nonphysician Practitioners

D. Medically Complex Care
B. Visits to Comply With Federal Regulations (42 CFR 483.40)

“Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial federally mandated visit by the physician, or qualified NPP where permitted, payment shall be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.”

“Subsequent Nursing Facility Care, per day, (99307 - 99310) shall be used to report federally mandated physician E/M visits and medically necessary E/M visits.”
• 30.6.13 - Nursing Facility Services

B. Visits to Comply With Federal Regulations (42 CFR 483.40)

“Carriers shall not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service.”

• The federally mandated E/M visit may serve also as a medically necessary E/M visit if the situation arises (i.e., the patient has health problems that need attention on the day the scheduled mandated physician E/M visit occurs). The physician/qualified NPP shall bill only one E/M visit.
B. Visits to Comply With Federal Regulations
(42 CFR 483.40)

“Medicare Part B payment policy does not pay for additional E/M visits that may be required by State law for a facility admission or for other additional visits to satisfy facility or other administrative purposes.”
“E/M visits, prior to and after the initial federally mandated physician visit, that are reasonable and medically necessary to meet the medical needs of the individual patient (unrelated to any State requirement or administrative purpose) are payable under Medicare Part B.”
30.6.13 - Nursing Facility Services

A. Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

B. Visits to Comply With Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF

C. Visits by Qualified Nonphysician Practitioners

D. Medically Complex Care
30.6.13 C Visits by Qualified Nonphysician Practitioners

- **State Regulations, State Scope of Practice**
  
  “All E/M visits shall be within the State scope of practice and licensure requirements where the visit is performed and all the requirements for physician collaboration and physician supervision shall be met when performed and reported by qualified NPPs.”

  “General physician supervision and employer billing requirements shall be met for PA services in addition to the PA meeting the State scope of practice and licensure requirements where the E/M visit is performed.”
Visits by Qualified Nonphysician Practitioners

• **Medically Necessary Visits**

  “Qualified NPPs may perform medically necessary E/M visits prior to and after the physician’s initial visit in both the SNF and NF.

  Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B.

  A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit.”
• Federally Mandated Visits
  – SNF (31)
  – “Following the initial federally mandated visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.”
Federally Mandated Visits

- NF (32)

- “Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial federally mandated visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.”
Visits by Qualified Nonphysician Practitioners

“Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.”
• 30.6.13 - Nursing Facility Services

A. Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

B. Visits to Comply With Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF

C. Visits by Qualified Nonphysician Practitioners

D. Medically Complex Care
D. Medically Complex Care

“Payment is made for E/M visits to patients in a SNF who are receiving services for medically complex care upon discharge from an acute care facility when the visits are reasonable and medically necessary and documented in the medical record.”
D. Medically Complex Care

“Physicians and qualified NPPs shall report initial nursing facility care codes for their first visit with the patient.”

“The principal physician of record must append the modifier “-AI” Principal Physician of Record, to the initial nursing facility care code when billed to identify the physician who oversees the patient’s care from other physicians who may be furnishing specialty care.”

Physicians and qualified NPPs shall report E/M visits using the Subsequent Nursing Facility Care, per day (codes 99307 - 99310) for follow-up visits
E. Incident to Services
F. Use of the Prolonged Services Codes and Other Time-Related Services
G. Multiple Visits
H. Split/Shared E/M Visit
I. SNF/NF Discharge Day Management Service
60.1-60.3 - Services of Nonphysician Personnel Furnished Incident to Physician’s Services

“the service can be billed under the Physicians UPIN/PIN, and payment will be made at the appropriate physician fee schedule payment.”
30.6.13 E Incident To Services in the Nursing Home

- Where a physician establishes an office in a SNF/NF, the “incident to” services and requirements are confined to this discrete part of the facility designated as his/her office.

- “Incident to” E/M visits, provided in a facility setting, are not payable under the Physician Fee Schedule for Medicare Part B.
30.6.13 - Nursing Facility Services

E. Incident to Services

F. Use of the Prolonged Services Codes and Other Time-Related Services

G. Multiple Visits

H. Split/Shared E/M Visit

I. SNF/NF Discharge Day Management Service
30.6.13 F Use of the Prolonged Services Codes and Other Time-Related Services

- Prolonged Services
- Counseling and Coordination of Care Visits

99356-99357

- Will discuss later in lecture
• **30.6.13 - Nursing Facility Services**

  E. Incident to Services
  
  F. Use of the Prolonged Services Codes and Other Time-Related Services

  **G. Multiple Visits**

  H. Split/Shared E/M Visit

  I. SNF/NF Discharge Day Management Service
30.6.13 G Multiple Visits

“Claims for an unreasonable number of daily E/M visits by the same physician to multiple patients at a facility within a 24-hour period may result in medical review to determine medical necessity for the visits.”

Not quantified

“The medical record must be personally documented by the physician or qualified NPP who performed the E/M visit and the documentation shall support the specific level of E/M visit to each individual patient.”
Medicare Claims Processing Manual, Pub.100-04

- 30.6.13 - Nursing Facility Services
  
  E. Incident to Services
  F. Use of the Prolonged Services Codes and Other Time-Related Services
  G. Multiple Visits
  H. **Split/Shared E/M Visit**
  I. SNF/NF Discharge Day Management Service
30.6.13 H Split/Shared Visits

- **Definition**
  - “a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service.”
  - “The physician and the qualified NPP must be in the same group practice or be employed by the same employer”
  - **Can** be used for hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non facility clinic visits, and prolonged visits associated with these E/M visit codes

- **Nursing Facility**
  - “A split/shared E/M visit **can not** be reported in the SNF/NF setting.”

- Also does not apply to critical care services or procedures
E. Incident to Services
F. Use of the Prolonged Services Codes and Other Time-Related Services
G. Multiple Visits
H. Split/Shared E/M Visit
I. **SNF/NF Discharge Day Management Service**
30.6.13 | SNF/NF Discharge Day Management

- Requires a face-to-face visit
- Reported for the date of the actual visit by the physician or qualified NPP even if the patient is discharged from the facility on a different calendar date.
- 99315-99316
Death

“may be reported using CPT code 99315 or 99316, depending on the code requirement, for a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement.”
QUESTIONS
MEDICARE CLAIMS PROCESSING MANUAL

CHAPTER 12
OTHER ISSUES / SECTIONS
MULTI-SITE SAME DAY VISITS
MULTI-SITE SAME DAY

Office/Outpatient/Emergency Department Visit w/Nursing Facility Admission

Same MD, Same date

- Medicare does not pay for the office or ED visit
- Medicare will pay only Initial Nursing Facility Care code
- Bundle E/M visits on the same date provided in sites other than the nursing facility into the initial nursing facility care code
- 30.6.7 - Payment for Office or Other Outpatient Evaluation and Management (E/M) Visits
MULTI-SITE SAME DAY

Nursing Facility Visit
w/
Hospital Visit or Admission

Same MD, Same date

- Medicare does not pay for the NH visit
- Medicare will pay only Initial Hospital Care code

- 30.6.9.1 - Payment for Initial Hospital Care Services
MULTI-SITE SAME DAY
Hospital Discharge Management w/
Nursing Facility Admission

Same MD, Same date

- Medicare **does** pay for the Hospital Discharge visit (99238, 99239)
- Medicare will **also** pay Initial Nursing Facility Care code

**30.6.9.2 - Subsequent Hospital Visit and Hospital Discharge Management**
Consultations
99241-99255

• 30.6.10 - Consultation Services
Consultations - Gone With the Wind

• Consultation codes no longer recognized by CMS effective 1/1/10 (except telehealth codes)

• Fiscal Effect
  – Increase the work relative value units (RVUs) for new and established office visits
  – Increase the work RVUs for initial hospital and initial nursing facility visits
  – Incorporate the increased use of these visits into the practice expense (PE) and malpractice calculations
  – Increase the incremental work RVUs for the codes that are built into the 10-day and 90-day global surgical codes

Revised Consultation Policy

• Inpatient hospital setting and nursing facility setting

• “All physicians (and qualified nonphysician practitioners where permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 - 99223) or nursing facility care codes (99304 - 99306).”

• AMDA clarified language re: initial evaluation in SNF and NPP: MLN MATTERS SE 1010

• 30.6.10 - Consultation Services
Use of initial nursing facility (NF) care codes for E/M services that could be described by CPT consultation codes

• “Physicians may bill an initial NF care CPT code for their first visit during a patient’s admission to a NF in lieu of the CPT consultation codes these physicians may have previously reported, when the conditions for billing the initial NF care CPT code are satisfied.

• The initial visit in a skilled nursing facility (SNF) and nursing facility must be furnished by a physician except as otherwise permitted as specified in CFR Section 483.40(c)(4).

• The initial NF care CPT codes 99304 through 99306 are used to report the initial E/M visit in a SNF or NF that fulfills federally-mandated requirements under Section 483.40(c)”

MLN MATTERS NUMBER: SE1010
Initial E/M service that could be described by a CPT consultation code not meeting the requirements for reporting an initial NF care CPT code

• May bill a subsequent NF care CPT code in lieu of the CPT consultation codes they may have previously reported.
• Otherwise, the subsequent NF care CPT codes 99307 through 99310 are used to report either a federally-mandated periodic visit under Section 483.40(c), or any E/M service prior to and after the initial physician visit that is reasonable and medically necessary to meet the medical needs of the individual resident.
Revised Consultation Policy

• Principal physician of record is identified in Medicare as the physician who oversees the patient’s care from other physicians who may be furnishing specialty care.

• Only the principal physician of record shall append modifier “-AI”, Principal Physician of Record, in addition to the E/M code.

• Follow-up visits in the facility setting shall be billed as subsequent hospital care visits and subsequent nursing facility care visits.
DOCUMENTATION

• “Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient.

• In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician.

• This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes.”
Physicians in Group Practice
30.6.5

• Same Group - Same Specialty
  • Bill and be paid as though they were single MD
  • One E&M code per day per problem
  • Can combine same day visits and submit appropriate code
  • Unrelated problems: can submit different bills

• Same group - Different Specialty
  • Bill and be paid without regard to membership in group
Prolonged Care  30.6.15.1  
99354-99357

- Medicare does pay for these codes
- Rare
- Need another E&M code as stipulated
Prolonged Care  30.6.15.1
99354-99357

• 99356-99357 - inpatient and NH
• 99354-99355 - office, outpatient setting
• Documentation not required to be sent w/ bill, but is required in record as to duration and content of svc
• 99356 - First 30 min of prolonged service
• 99357 - each additional 30 minutes beyond the first hour
Prolonged Care  30.6.15.1
99354-99357

• “Physicians may count only the duration of \textbf{direct face-to-face contact} between the physician and the patient (whether the service was continuous or not) beyond the typical/average time of the visit code billed to determine whether prolonged services can be billed and to determine the prolonged services codes that are allowable.”
“In the case of prolonged hospital services, time spent reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient, or waiting for test results, for changes in the patient’s condition, for end of a therapy, or for use of facilities cannot be billed as prolonged services.”
H. Prolonged Services Associated With Evaluation and Management Services Based on Counseling and/or Coordination of Care (Time-Based)

• “In those evaluation and management services in which the code level is selected based on time, prolonged services may only be reported with the highest code level in that family of codes as the companion code.”
OTHER BILLING/CODING TOPICS
Transitional Care Management Services Codes (99495 and 99496)

- As of January 1, 2013, Medicare pays for combined face to face and non-face to face physician and staff service of complex patients recently discharged from hospital, LTAC, or skilled nursing facility.
- Medicare will pay between $164 and $231, depending on the complexity of the patient, for care during the 29 days after the discharge date.
Transitional Care Management Services Code 99495

- 99495 - Moderate complexity patients
  - Requires physician / staff to make direct contact, by phone or electronically, with the patient or caregiver within 2 business days of discharge.
  - A face-to-face visit with the patient is required within 14 calendar days of discharge.
Transitional Care Management Services Code 99496

- 99496 - High-complexity patients
  - Requires direct contact with the patient or caregiver within 2 business days
  - Face-to-face visit within 7 calendar days

- Both codes billable by only one party (PCP or specialist) in the outpatient setting

- Requires medication reconciliation and any needed coordination of care
Transitional Care Management Services Codes (99495 and 99496)

• Non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his/her direction:
  – Staff services: medication adherence, education of patients / caregivers e.g. self-management, HHA communication, facilitating access to care.
  – Physician services: discharge information review, diagnostic test follow up, community resources referrals, educating patients / families, interaction with other health professionals
Complex Chronic Care Coordination

- CPT codes established and will be paid for in 2015 at present - *details still not set*
- Home, AL and residential based codes
- Patient has at least 2 chronic condition placing them at risk higher level of care, requires significant services and coordination of care
- Includes non-face to face physician & staff work
- Not billed with care plan or TCM codes
Advance Care Planning Code

• CPT has made code / RUC has set value, but CMS has not decided whether to pay for it (death squad part 2)
• One-half hour practitioner time to discuss ACP, ensure appropriate forms filled out
• Only for complicated cases requiring practitioner (not staff time)
• 2016 payment at earliest, all sites of service eligible
Telehealth

- Telehealth NOW allowed under distinct conditions - most still not billable
- ONLY regulatory required subsequent visits are allowed (99307-10)
- ONLY can be made every 30 days
- MUST be located in a rural health professional shortage area or in a county outside of a Metropolitan Statistical Area
Telehealth continued

• As a condition of payment, an interactive audio and video telecommunications system must be used that permits real-time communication between a physician or practitioner at the distant site and the beneficiary at the originating site
• Will be expanded to Annual Wellness exam - *may set a trend*
Employment and Medicare Billing

- “A physician who is employed by the SNF/NF may perform the E/M visits and bill independently to Medicare Part B for payment.

- An NPP who is employed by the SNF or NF may perform and bill Medicare Part B directly for those services where it is permitted.

- The employer of the PA shall always report the visits performed by the PA.

- A physician, NP or CNS has the option to bill Medicare directly or to reassign payment for his/her professional service to the facility.”

- 30.6.13 - Nursing Facility Services
PER DAY SERVICE

– “The Nursing Facility Services codes represent a “per day” service.”

– “Carriers shall not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service.”

– 30.6.13 - Nursing Facility Services
Face-to-Face Encounter vs. Physical Exam

- All E&M codes require a face to face contact (Including NF Discharges)
- Physical exam not required for all E&M codes
  - 2 of 3 (Hx, Exam, Medical decision making) for subsequent NF visits
- Still need face to face contact
Assuming Care from Another Provider

- Need to use appropriate E&M code
- Usually 99309 level
- Need to document appropriately
- Can not use 99304-6 codes unless newly admitted into facility
Use of Templates for Visits

- Acceptable
- Caveat: must perform all items checked or delineated in chart record
- Suggestion: have nurses document briefly extent of your visit
Medical Director Covering of Patient Visits

- Regulatory issues – need to have visits performed in timely manner
- Emergency care
- Liability issues – knowledge of patient, malpractice vs. administrative?
- Payment issues – Medical Director not Attending or “Consultant”
- Administrative function covered under contract?
QUESTIONS
CODING:

AMA

CPT
NH CPT CODES  2006 AMA

- INITIAL
  - 99304
  - 99305
  - 99306

- SUBSEQUENT CARE
  - 99307
  - 99308
  - 99309
  - 99310

- DISCHARGE SERVICES
  - 99315
  - 99316

- ANNUAL
  - 99318
DOCUMENTATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network

Official CMS Information for Medicare Fee-For-Service Providers

Evaluation and Management Services Guide

December 2010 / ICN: 006764
WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

• Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes.

• The medical record chronologically documents the care of the patient and is an important element contributing to high quality care.
WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?

• The medical record facilitates:
  – the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time.
  – communication and continuity of care among physicians and other health care professionals involved in the patient's care;
WHAT DO PAYERS WANT AND WHY?

• Because payers have a contractual obligation to enrollees, they may require reasonable documentation that services are consistent with the insurance coverage provided.

• They may request information to validate:
  – the site of service;
  – the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
  – that services provided have been accurately reported.
GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
   – reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   – assessment, clinical impression or diagnosis;
   – plan for care; and
   – date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION

5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
LEVEL OF E/M SERVICE
LEVEL OF E/M SERVICE
7 COMPONENTS

• HISTORY
• EXAMINATION
• MEDICAL DECISION MAKING
• Counseling
• Coordination of care
• Nature of presenting problem
• TIME
LEVEL OF E/M SERVICE
3 Key Components

• HISTORY

• EXAMINATION

• MEDICAL DECISION MAKING
“When counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient, NF services), time is the key or controlling factor in selecting the level of service.

Document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided.”

30.6.1 C. - Selection of Level of Evaluation and Management Service
Selection Of Level Of Evaluation and Management Service Based On Duration Of Coordination Of Care and/or Counseling

TIME

“The physician need not complete a history and physical examination in order to select the level of service.

Documentation must be in sufficient detail to support the claim.

The time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time.”

30.6.1 C. - Selection of Level of Evaluation and Management Service
Time spent counseling the patient or coordinating the patient’s care after the physician has left the patient’s floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.

The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded.

30.6.1 C. - Selection of Level of Evaluation and Management Service
CPT defines counseling as a discussion with a 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 and 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
7. Patient and family education

The types of discussions listed in the definition of counseling should be documented.
TIME

- PRE-SERVICE
- INTRA-SERVICE
- POST-SERVICE

- Each code has associated pre, intra, and post service times
NH CPT CODES

TIMES

- INITIAL
  - 99304 25 minutes
  - 99305 35 minutes
  - 99306 45 minutes

- SUBSEQUENT CARE
  - 99307 10 minutes
  - 99308 15 minutes
  - 99309 25 minutes
  - 99310 35 minutes

- DISCHARGE SERVICES
  - 99315 <30 minutes
  - 99316 >30 minutes

- ANNUAL
  - 99318 30 minutes
Training Tools/Grids

• Most CMS contractors have developed grids/training tools to help review charts

• Next few slides show the 6 page Training Tool for NGS Services, Inc.
# Evaluation & Management Documentation Training Tool

## 1—History

Refer to the data section (below) in order to quantify. After referring to data, circle the entry farthest to the RIGHT in the table, which best describes the history of present illness (HPI), review of system (ROS), and past medical, family, social history (PFSH). If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the LEFT, identifies the type of history. After completing this table which classifies the history, circle the type of history within the appropriate grid in Section 5. Minimum requirements for each level of history are listed directly above each level in the grid. CHIEF COMPLAINTS REQUIRED FOR ALL HISTORY LEVELS.

### HPI Elements

<table>
<thead>
<tr>
<th>Location</th>
<th>Quality</th>
<th>Severity</th>
<th>Duration</th>
<th>Timing</th>
<th>Contact</th>
<th>Modifying factors</th>
<th>Associated signs and symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Brief (1)</td>
<td>□ Brief (1–3)</td>
<td>□ Extended (4 or more)</td>
<td>□ Extended (4 or more)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HPI: Status of Chronic Conditions

| □ 3 conditions | □ N/A | □ Status of 3 chronic conditions | □ Status of 3 chronic conditions |

### ROS: (Review of System)

<table>
<thead>
<tr>
<th>Constitutional (weight loss, etc.)</th>
<th>Eyes</th>
<th>Ear, nose, mouth, and throat</th>
<th>Card/Vascular</th>
<th>Respiratory</th>
<th>GI</th>
<th>GU</th>
<th>Musc/Skeletal</th>
<th>Integumentary (Skin, breast)</th>
<th>Neuro</th>
<th>Psych</th>
<th>Endo</th>
<th>Ham Lymph</th>
<th>All/immune</th>
<th>All others negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ None</td>
<td>□ Pertinent to problem (1 system)</td>
<td>□ Extended (2–9)</td>
<td>□ Complete</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Complete ROS: Ten or more systems, or some systems with statement “all others negative.”

### PFSH (past medical, family, social history) areas

<table>
<thead>
<tr>
<th>□ Past history (patient’s past experiences with illnesses, operations, injuries and treatments)</th>
<th>□ Family history (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk)</th>
<th>□ Social history (an age-appropriate review of past and current activities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ None</td>
<td>□ None</td>
<td>□ Pertinent to problem (1 history area)</td>
</tr>
</tbody>
</table>

Complete PFSH
Two history areas: a) Established patients – office (outpatient) care; b) Emergency dept.
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.

### Final Results

<table>
<thead>
<tr>
<th>Final Results</th>
<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
</table>
## 2—Examination

Refer to data section (table below) in order to quantify. After referring to data, identify the type of examination. Circle the type of examination within the appropriate grid in Section 5. Note: Choose 1995 or 1997 rules, but not both.

<table>
<thead>
<tr>
<th>Examination</th>
<th>Calculation — Choose either 1995 or 1997 rules to calculate result</th>
<th>1995</th>
<th>1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body areas:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head, including face</td>
<td>One body area or system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest, including breast and axillae</td>
<td>2–7 areas or systems (Minimal detail for areas and/or systems examined; check list type documentation without any expansion of documentation of findings)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td>8 or more systems only</td>
</tr>
<tr>
<td>Neck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back, including spine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia, groin, buttocks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Each extremity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organ systems:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constitutional (e.g., vitals, gen app)</td>
<td>1–5 bullets (1 or more body areas or system)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears, nose, mouth, throat</td>
<td>6 bullets (1 or more body areas or system)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GU</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neuro</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psych</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemat/lymph/imm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final Results</td>
<td>Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Detailed</td>
</tr>
</tbody>
</table>
3—Medical Decision Making

**Number of Diagnoses or Treatment Options**

Identify each problem or treatment option mentioned in the record. Enter the number in each of the categories in Column B in the table below. (There is a maximum number in two categories.)

<table>
<thead>
<tr>
<th>A—Problem(s) Status</th>
<th>B—Number</th>
<th>C—Points</th>
<th>D—Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor (stable, improved, or worsening)</td>
<td>Max = 2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. problem (to examiner); stable, improved</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Est. problem (to examiner); worsening</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner); no additional workup planned</td>
<td>Max = 1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>New problem (to examiner); add workup planned</td>
<td></td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

**Amount and/or Complexity of Data Reviewed**

For each category or reviewed data identified, circle the number in the Points column. Total the points.

<table>
<thead>
<tr>
<th>Reviewed Data</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>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.</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself (not simply review of report)</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Risk of Complications and/or Morbidity or Mortality

Use the risk table below as a guide to assign risk factors. It is understood that the table below does not contain all specific instances of medical care; the table is intended to be used as a guide. Circle the most appropriate factor(s) in each category. The overall measure of risk is the highest level circled. Enter the level of risk identified in “Final Result for Complexity” table below.

#### Table 3C

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One self-limited or minor problem, e.g., cold insect bite, tinea corporis</td>
<td>Laboratory tests requiring venipuncture, Chest X-rays, EEG, Urinalysis, Ultrasound, e.g., echo, KOH prep</td>
<td>Kast, Gargles, Elastic bandages, Superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>Two or more self-limited or minor problems, One stable chronic illness, e.g., well controlled hypertension or, noninsulin dependent diabetes, cataract, BPH, Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>Physiologic tests not under stress, e.g., pulmonary function tests, Noncardiovascular imaging studies with contrast, e.g., barium enema, Superficial needle biopsies, Clinical laboratory tests requiring arterial puncture, Skin biopsies</td>
<td>Over-the-Counter drugs, Minor surgery with no identified risk factors, Physical therapy, Occupational therapy, IV fluids without additives</td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more chronic illness 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, pneumonia, colitis, Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>Physiologic tests under stress, e.g., cardiac stress test, vital 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, angiocardiogram, cardiac catheter, Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</td>
<td>Minor surgery with identified risk factors, Elective major surgery (open, percutaneous or endoscopic with no identified risk factors), Prescription drug management (continuation &amp; new prescription), Therapeutic nuclear medicines, IV fluids with additives, Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td>High</td>
<td>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</td>
<td>Cardiovascular imaging studies with contrast with identified risk factors, Cardiac electrophysiological tests, Diagnostic endoscopies with identified risk factors, Discography</td>
<td>Elective major surgery (open, percutaneous or endoscopic with identified risk factors), Emergency major surgery (open, percutaneous or endoscopic), Parental controlled substances, Drug therapy requiring intensive monitoring for toxicity, Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>

### Final Result for Complexity

#### Table 3D

<table>
<thead>
<tr>
<th></th>
<th>A Number diagnoses or treatment options</th>
<th>B Amount and Complexity of Data</th>
<th>C Highest Risk</th>
<th>Type of decision making</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>≤ 1 Minimal</td>
<td>≤ 1 Minimal</td>
<td>Minimal</td>
<td>Straight Forward</td>
</tr>
<tr>
<td></td>
<td>2 Limited</td>
<td>2 Limited</td>
<td>Low</td>
<td>Low Complexity</td>
</tr>
<tr>
<td></td>
<td>3 Multiple</td>
<td>3 Moderate</td>
<td>Moderate</td>
<td>Moderate Complexity</td>
</tr>
<tr>
<td></td>
<td>≥ 4 Extensive</td>
<td>≥ 4 Extensive</td>
<td>High</td>
<td>High Complexity</td>
</tr>
</tbody>
</table>

Draw a line down any column with 2 or 3 circles to identify the type of decision making in that column. Otherwise, draw a line down the column with the second circle from the left. After completing this table, circle the type of decision making within the appropriate grid in Section 5.
4—Time

If the physician documents total time and indicates that counseling or coordinating care dominates (more than 50%) the encounter, time may determine level of service. Documentation may refer to: prognosis, differential diagnosis, risks, benefits of treatment, instructions, compliance, risk reduction and/or discussion with another healthcare provider.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does documentation reveal total time?</td>
<td>☐ Yes  ☐ No</td>
</tr>
<tr>
<td>Does documentation describe the content of counseling or coordinating care?</td>
<td>☐ Yes  ☐ No</td>
</tr>
<tr>
<td>Does documentation reveal that more than half of the time was counseling or coordinating care?</td>
<td>☐ Yes  ☐ No</td>
</tr>
</tbody>
</table>

   If all answers are “yes,” you may select level based on time.

5—Level of Service

**Outpatient and Emergency Room (ER)**

<table>
<thead>
<tr>
<th>History</th>
<th>New Office/ER—Requires three components within shaded area</th>
<th>Established Office—Requires two components within shaded area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complexity of medical decision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average time (minutes) (ER has no average time)</td>
<td>10 New (99201)</td>
<td>5 (99211)</td>
</tr>
<tr>
<td>Level</td>
<td>1</td>
<td>10 (99212)</td>
</tr>
<tr>
<td></td>
<td>II</td>
<td>15 (99213)</td>
</tr>
<tr>
<td></td>
<td>III</td>
<td>23 (99214)</td>
</tr>
<tr>
<td></td>
<td>IV</td>
<td>40 (99215)</td>
</tr>
<tr>
<td></td>
<td>V</td>
<td></td>
</tr>
</tbody>
</table>

**Inpatient**

<table>
<thead>
<tr>
<th>History</th>
<th>Initial Hospital/Observation—Requires three components within shaded area</th>
<th>Subsequent Hospital—Requires two components within shaded area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complexity of medical decision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average time (minutes) (Initial observation care has no average time)</td>
<td>30 Init hop (99221)</td>
<td>15 Subsequent (99231)</td>
</tr>
<tr>
<td>Level</td>
<td>I</td>
<td>I</td>
</tr>
<tr>
<td></td>
<td>II</td>
<td>II</td>
</tr>
<tr>
<td></td>
<td>III</td>
<td>III</td>
</tr>
</tbody>
</table>
### Nursing Facility Care

<table>
<thead>
<tr>
<th>History</th>
<th>Initial Nursing Facility—Requires three components within shaded areas</th>
<th>Subsequent Nursing Facility—Requires two components within shaded areas</th>
<th>Other Nursing Facility (Annual Assessment)—Requires three components within shaded areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>D/C</td>
<td>C</td>
<td>C interval</td>
</tr>
<tr>
<td>Complexity of medical decision</td>
<td>SF/L</td>
<td>M</td>
<td>D interval</td>
</tr>
<tr>
<td>Average time (minutes) (Initial observation care has no average time)</td>
<td>25</td>
<td>35</td>
<td>45</td>
</tr>
<tr>
<td>Level</td>
<td>I</td>
<td>II</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>(99304)</td>
<td>(99305)</td>
<td>(99306)</td>
</tr>
<tr>
<td></td>
<td>PF interval</td>
<td>EPF interval</td>
<td>D interval</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>EPF interval</td>
<td>C interval</td>
</tr>
<tr>
<td></td>
<td>SF</td>
<td>L</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>(99307)</td>
<td>(99308)</td>
<td>(99309)</td>
</tr>
<tr>
<td></td>
<td>I</td>
<td>II</td>
<td>III</td>
</tr>
<tr>
<td></td>
<td>(99310)</td>
<td>(99311)</td>
<td>IV</td>
</tr>
</tbody>
</table>

### Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care and Home Care

<table>
<thead>
<tr>
<th>History</th>
<th>New—Requires 3 components within shaded area</th>
<th>Established—Requires 2 components within the shaded area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>PF</td>
<td>EPF</td>
</tr>
<tr>
<td>Complexity of medical decision</td>
<td>SF</td>
<td>L</td>
</tr>
<tr>
<td>Average time (minutes)</td>
<td>20 Domiciliary (99324)</td>
<td>30 Domiciliary (99325)</td>
</tr>
<tr>
<td></td>
<td>Domiciliary (99341)</td>
<td>Domiciliary (99327)</td>
</tr>
<tr>
<td>Level</td>
<td>I</td>
<td>II</td>
</tr>
<tr>
<td></td>
<td>(99342)</td>
<td>(99343)</td>
</tr>
<tr>
<td></td>
<td>PF interval</td>
<td>EPF</td>
</tr>
<tr>
<td></td>
<td>D</td>
<td>EPF</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>SF</td>
<td>L</td>
</tr>
<tr>
<td></td>
<td>15 Domiciliary (99335)</td>
<td>25 Domiciliary (99336)</td>
</tr>
<tr>
<td></td>
<td>Domiciliary (99348)</td>
<td>Domiciliary (99349)</td>
</tr>
<tr>
<td></td>
<td>Domiciliary (99347)</td>
<td>Home Care (99348)</td>
</tr>
<tr>
<td></td>
<td>Domiciliary (99334)</td>
<td>Home Care (99348)</td>
</tr>
<tr>
<td></td>
<td>Domiciliary (99336)</td>
<td>Home Care (99348)</td>
</tr>
<tr>
<td></td>
<td>Domiciliary (99349)</td>
<td>Home Care (99348)</td>
</tr>
<tr>
<td></td>
<td>Domiciliary (99337)</td>
<td>Home Care (99348)</td>
</tr>
<tr>
<td></td>
<td>Domiciliary (99338)</td>
<td>Home Care (99348)</td>
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<tr>
<td></td>
<td>Domiciliary (99340)</td>
<td>Home Care (99348)</td>
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<tr>
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<tr>
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<td>Domiciliary (99342)</td>
<td>Home Care (99348)</td>
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<td>Domiciliary (99343)</td>
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<tr>
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</tr>
<tr>
<td></td>
<td>Domiciliary (99345)</td>
<td>Home Care (99348)</td>
</tr>
</tbody>
</table>

PF = Problem Focused  |  EPF = Expanded Problem Focused  |  D = Detailed  |  C = Comprehensive  |  SF = Straightforward  |  L = Low M = Moderate  |  H = High

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.

Resource: Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1

### References
- Current Procedural Terminology, American Medical Association
BOTTOM LINE

KNOW THE RULES

FOLLOW THE RULES

GO SEE YOUR PATIENTS