Documentation Challenges in the Delivery of Healthcare

BCBS Kansas

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Nationally acclaimed for medical coding, many have called on her expertise to assist their practice in the area(s) of physician office compliance, medical chart audits, and provider and staff education. Jaci was recognized as Coder of the Year for the State of Virginia in 2006.

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Disclaimer

- Answers and comments are based on information that is available at this time
- The AMA , BCBS KS may provide additional information in the future that may contradict the interpretations provided in the presentation.
- Stay informed, ask questions!

AGENDA

Evaluation and Management

- Review of AMA documentation guidelines
- A reminder of what documentation is and how it can be used
- Review the definitions in the guidelines
- Critical Care

Diagnosis Coding

Modifiers

Split/Shared and I2

Scribes

E/M Guidelines
Challenges in Documentation

A few questions first…

Polling Questions

Complexity of Problems

The documentation requirements based on the definitions for ”problems addressed” , provide an understanding of which ICD10 codes may be reported. Are these the same rules we apply in Risk Adjustment or HCC coding models.

A. True
B. False
C. Do not care, N/A
D. What is HCC or RA?

Complexity of Problems

A patient presents with two acute uncomplicated problems and is also seen for a stable chronic condition.

What level of “problems addressed” would be selected?

A. Straightforward
B. Low
C. Moderate
D. High

Complexity of Problems

A patient presents with two acute uncomplicated problems and is also seen for a chronic condition that is not at goal and requires a medication adjustment.

What level of “problems addressed” would be selected?

A. Straightforward
B. Low
C. Moderate
D. High

Complexity of Problems

An oncologist seeing a patient with a current malignancy should consider that to be a high-level problem?

A. Yes
B. No

Counting Data

If a provider orders a lab (not performed in office) and the results are reviewed at a later date and reviewed at the next encounter, how does that count toward data?

A. One point at the encounter for the order and another point at the next encounter for the review
B. Two points on the date of the encounter (one for the order and one for the review)
C. No points at all because it was ordered by the reporting provider
D. One point for the order of the lab

Counting Data

A provider reads the results of a lab that was ordered by another provider in their group and billed out by the group how does this count toward data?

A. No points at all because it was already ordered in house and billed
B. One point for the review of the lab

Counting Data

A provider reviews notes from the referring physician two days before seeing the patient for the first time. The relevance of the information is documented in the visit note. Does this count as a data point for the date of the encounter?

A. Yes

B. No

Counting Data

If a provider orders a lab and the results are reviewed at later date and the results create the need to order more labs, will the order of more labs count as a data point(s)?

A. Yes

B. No

Leveling Risk

The documentation in the patient medical record states;

“Recommend patient continue on same regiment.” In the medical record it shows that the medication list has been reviewed by the M.A. The list contains names and doses of medications.

What level of Risk would be assigned?

A. Straightforward
B. Low
C. Moderate
D. High

Leveling Risk

It is decided that a diagnostic nasal endoscopy will be performed in the office. The provider documents “all risks and benefits were addressed with the patient and patient wishes to proceed with procedure.”

What level of risk would be assigned?

A. Straightforward

B. Low

C. Moderate

D. High

Leveling Risk

If an oncologist sees a patient who is currently undergoing chemotherapy, then the level of risk will be considered high due to the toxicity of the treatment?

A. Yes
B. No

What do you think?

Established patient being seen for new diagnosis of DM2. The complexity of the problem is moderate. The data is documented as low, and the risk is moderate. The provider documents 25 total minutes spent on that date of service. What level of established patient visit is reported?

A. 99212
B. 99213
C. 99214
D. 99215

What do you think?

Are the grids provided by the AMA enough to code, audit and educate?

A. Yes
B. No
C. I do not understand
D. What grids?

So now…

No matter how many changes to ”documentation” guidelines …what remains is

The medical record serves an important role in patient care and does it not still act in that same role even with different language in the E/M code descriptions?

The AMA E/M guidelines

Challenges and Definitions

Straightforward MDM

Any 2 of the 3 categories must be met

Number and Complexity of Problems Addressed	Amount or Complexity of Data to be Reviewed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complication and / or Morbidity or Mortality of Patient Management
Minimal • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

Low Complexity MDM

Any 2 of the 3 categories must be met

Number and Complexity of Problems Addressed	Amount or Complexity of Data to be Reviewed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complication and / or Morbidity or Mortality of Patient Management
Low **2** or more self-limited or minor problems; **or** **1** stable chronic illness; **or** **1** acute, uncomplicated illness or injury **1 stable, acute illness;** **1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care**	**Limited** (Must meet the requirements of at least 1 of the 2 categories) **Category 1: Tests and documents** • **Any combination of 2 from the following:** • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* **or** **Category 2: Assessment requiring an independent historian(s)** (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	**Low** **Low risk of morbidity from additional diagnostic testing or treatment**

Moderate Complexity MDM

- **Any 2 of the 3 categories must be met**

Number and Complexity of Problems Addressed	Amount or Complexity of Data to be Reviewed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complication and / or Morbidity or Mortality of Patient Management
Moderate **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** **2** or more stable chronic illnesses; **or** **1** undiagnosed new problem with uncertain prognosis; **or** **1** acute illness with systemic symptoms; **or** **1** acute complicated injury	**Moderate** (Must meet the requirements of at least 1 of the 3 categories) **Category 1: Tests and documents** • **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);** **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)	**Moderate** Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health (Z55 - Z65)

High Complexity MDM

- **Any 2 of the 3 categories must be met**

Number and Complexity of Problems Addressed	Amount or Complexity of Data to be Reviewed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complication and / or Morbidity or Mortality of Patient Management
High **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** **1** acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** (Must meet the requirements of at least 2 of the 3 categories) **Category 1: Tests and documents** **• Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **Or** **Category 2: Independent interpretation of tests** **• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);** **or** **Category 3: Discussion of management or test interpretation** • 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** Examples only • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision regarding hospitalization **or escalation of hospital level care** • Decision not to resuscitate or to deescalate care because of poor prognosis • **Parenteral controlled substances**

Documentation of Problems – Example

- Patient presents with hip pain that has been going on for the past month. No further details provided.
  - ***Acute uncomplicated problem 99203/99213***
- Patient presents with hip pain that has been going on for the past month. Patient has history of bursitis and associated hip pain for the past five years. Patient has tried multiple OTC options and PT with no relief of symptoms.
  - ***Chronic problem with exacerbation 99204/99214***

Number and Complexity of Problems Addressed at the Encounter

Definitions and Levels

Problems Addressed - Definition

A problem is addressed or managed when it is *evaluated or treated at the encounter* by the physician or other qualified health care professional reporting the service.

This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice.

Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service.

Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

Types of Problems

Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status. (Straightforward Complexity)

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness. (Low Complexity Problem)

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care

A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting. (Low complexity problem)

Stable, acute illness

A problem that is new or recent for which treatment has been initiated. The patient is improved and, while resolution may not be complete, is stable with respect to this condition. (Low Complexity Problem)

- ***Stable, chronic illness:*** A pro…r until the death of the patient. For the purpose of def…whether or not stage or severity changes (eg, uncontro…hronic condition). 'Stable' for the purposes of categorizing medical decision making …c treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short- term threat to life or function. The risk of morbidity with out treatment is significant.

1 = Low Complexity Problem
2 or more = Moderate Complexity Problem

1 = Moderate Complexity Problem

- ***Chronic illness with exacerbation, p…treatment*:** A chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and **requiring** additional supportive care or requiring attention to treatment for side effects.
- ***Chronic illness with severe exacerbation, progression, or side effects of treatment:*** The severe exacerbation or progression of a ch…ent that have significant risk of morbidity and may require escal…

1 = High Complexity Problem

Undiagnosed new problem with uncertain prognosis

Moderate complexity problem addressed

A problem in the differential diagnosis that represents a condition ***likely to result in a high risk of morbidity without treatment.***

Acute illness with systemic symptoms: Moderate complexity Problem Addressed

An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions ***for self-limited or minor problem*** or ***acute, uncomplicated illness or injury***. Systemic symptoms may not be general but may be single system.

Acute, complicated injury

An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity. (Moderate Complexity Problem)

Acute or chronic illness or injury that poses a threat to life or bodily function:
High complexity problem addressed

An acute illness with systemic symptoms, or an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment are consistent with this degree of potential severity.

From the AMA Definition of Morbidity

A state of illness or functional impairment that is expected to be of *substantial duration* during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

Is this clear in the documentation?

Problematic Scenerios

Start with the definition

- In the following example what was addressed?

Family Medicine

- This 80 year old female presents for fatigue and hyperlipidemia(lipid).
- History of Present Illness
- 1. fatigue
- 2. hyperlipidemia(lipid)
- The severity of the problem is moderate. The problem has not changed. Patient compliance with diet is fair, with exercise is fair, with medication is good and with follow up is good. Pertinent negatives include abdominal pain, chest pain, claudication and edema.

Constitutional	Normal	Well developed.
Eyes	Normal	Pupil - Right: Normal, Left: Normal.
Respiratory	Normal	Effort - Normal.
Psychiatric	Normal	Orientation - Oriented to time, place, person & situation.

The assessment

#	Detail Type	Description
1.	Assessment	Mixed hyperlipidemia (E78.2). Stable?
	Plan Orders	Active Medication: Crestor 5 mg tablet (who is managing?)
2.	Assessment	Transient cerebral ischemic attack, unspecified (G45.9). Not addressed, not current
3.	Assessment	Vitamin D deficiency, unspecified (E55.9). Not addressed
4.	Assessment	Body mass index (BMI) 22.0-22.9, adult (Z68.22). Z code not to used alone. What is the risk to patient if instructions not followed?
	Plan Orders	Today's instructions / counseling include(s) Dietary management education, guidance, and counseling.

Calculation of the Complexity of Data

Some Data Driven Definitions

Analyzed

- The process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter.
- Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter.
- Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Tests

- Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purpose of data reviewed and analyzed, pulse oximetry is not a test.

External

- ***External:*** External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.
- ***External physician or other qualified health care professional:*** An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.
- ***Discussion:*** Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Independent

- ***Independent historian(s):*** An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

- ***Independent Interpretation:*** The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the service test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Unique

- A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or other qualified health care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM.

Deducing Data

X-rays

- Medical decision making: X-ray: [Left toes] was obtained. I viewed the images myself on the hospital system. The interpretation of the study is: [No acute process]. [The interpretation was by the radiologist].

Review or independent interpretation.

What if reported with TC?

What if reported as global?

X-rays

Review or independent interpretation.

What if reported with TC?

What if reported as global?

- Chest x-ray: No acute infectious process as reviewed by myself and supervising physician, Dr. Super. Formal radiology read pending at the time of this dictation.

Risk

Definition and Documentation Requirements

Risk of Complications and/or Morbidity or Mortality of Patient Management

- One element used in selecting the level of service is the risk of complications and/or morbidity or mortality of patient management at an encounter. *This is distinct from the risk of the condition itself.*

Risk

- The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk.
- Definitions of risk are based upon the **usual behavior and thought processes** of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as *high, medium, low*, or *minimal* risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities).
- For the purpose of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

How Do We Measure Risk?

- Risk associated with the patient's problems, the diagnostic procedures, and treatments.
- Comorbidities/underlying diseases are not considered in selecting a level of E/M service unless;
  1. They are addressed
  2. Their presence increases the amount and/or complexity of data to be reviewed and analyzed

For purposes of the AMA guidelines Risk is defined as risk of complications and/or mortality of patient management

Risky Documentation

What level of risk?

Patient's symptomatic anemia, and exam findings today warrant a more thorough evaluation than that which can be provided within the scope of our urgent care setting. I have recommended patient report directly to Emergency Department for further evaluation. Patient declined EMS transport in favor of transporting himself by private vehicle. Patient left our facility in stable condition at approximately 1920 agreeable to going directly to the emergency department. I called Emergency Department and gave report to charge nurse at approximately 1940.

- No other treatment provided. Labs provided.

What level of risk would you assign?

- Straightforward
- Low
- Moderate
- High

Time Considerations

If time is documented, is that enough to select a level of service?

- Yes
- No

Think About It?

- If the time is documented on every note and on every note the time is either 25 or 40 minutes, do you give credit?

  - Yes
  - No

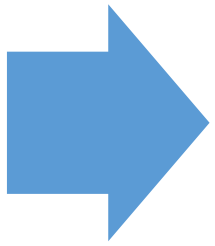
Date of Service and Time

Total time on the date of the encounter ***is by calendar date***. When using MDM or total time for code selection, a continuous service that spans the transition of two calendar dates is a single service and is reported on one calendar date. If the service is continuous before and through midnight, all the time may be applied to the reported date of the service. (May encounter this scenario in the hospital more than the office.)

The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional and the patient and/or family/caregiver.

Time Considerations

Total time includes both the face-to-face time with the patient and/or family/caregiver and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff).



It includes time regardless of the location of the physician or other qualified health care professional (eg, whether on or off the inpatient unit or in or out of the outpatient office). It does not include any time spent in the performance of other separately reported service(s).

Which Activities, when performed, count toward time

Counts toward time

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to
- the patient/family/caregiver
- care coordination (not separately reported)◄

Does not count toward time

- the performance of other services that are reported separately
- travel
- teaching that is general and not limited to discussion that is required for the management of a specific patient

Critical Care

CPT Definition and Documentation

Critical Care Guidance

- According to CPT® “A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition..”

Critical Care

Key CPT® Description Points:

- Must include high complexity decision-making.
- Critical care services must be provided at the bedside or immediately available.
- Time based codes
- Cannot be time spent performing separately billable procedures.

Documentation Challenges

PATIENT AND/OR CARE NOT OF A CRITICAL NATURE.

TIME NOT DOCUMENTED

PROCEDURE OVERLAP

MEDICAL NECESSITY

Often Performed and Separately Reportable

- CPR
- Central Venous Access
- Intubation

Time to perform, can not be included in CC time.

Diagnosis Coding = Medical Necessity

And Documentation Challenges and Reminders

Medical Necessity

With an even greater awareness of medical necessity and clinical documentation improvement it is more important than ever to audit and educate on correct diagnosis coding and reporting.

The AMA documentation guidelines and the definitions provided for assessing the problems addressed provide a good basis to help with the understanding of medical necessity and with determining which ICD10-CM codes should be reported for that encounter.

Diagnosis Coding

- Diagnostic codes are an important and sometimes misunderstood aspect of correct coding.
- They are a key element in all claims that support medical necessity and reflect severity.
- Improper ICD-10 diagnostic coding can lead to claim denials and other missed revenue opportunities. It can also make the practice a target for audits and expose it to risk.

ICD10-CM Official Guidelines Section IV.J.

- Code all documented conditions that coexist
- Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management.
- Do not code conditions that were previously treated and no longer exist.
- However, history codes (categories Z80- Z87) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Often Missed Opportunities

- Combination Codes (HTN,CKD,CHF) or those associated with DM
- Hyperglycemia codes for DM do not mean uncontrolled
- Chronic or acute being documented
- Additional codes to identify cause
- Adverse affects being documented and coded correctly
- SDOH not being reported

Diagnosis Coding Review

Patient presents to orthopedics with continued complaints for knee pain. Patient has tried OTC pain relief options and has been opposed to any other treatment options. Presents today to discuss alternatives in treatment. Following all details patient opts for a steroid injection. Risk benefits explained. Patient is a Type II diabetic controlled with diet. Patient has been made aware of possible change in blood sugar levels following the injection

Diagnosis(es) to report

A. knee pain
B. Drug induced diabetes mellitus with diabetic neuropathic arthropathy , knee pain
C. Type 2 diabetes mellitus with other diabetic arthropathy, knee pain
D. Knee pain, Type 2 diabetes mellitus without complications

Modifier Documentation

Why Must it Be So Hard?

One must start at the beginning…

The CPT definition of the surgical package.

It is the basis for understanding when and why to use a surgical modifier.

The Surgical Package

The term surgery means;

“Surgery: Branch of medicine dealing with manual and operative procedures for correction of deformities and defects, repair of injuries, and diagnosis and cure of certain diseases.”

Taber’s Cyclopedic Medical Dictionary

The Surgical Package

That is a clinical definition. For purposes of billing and coding we must consider what is meant when a particular surgical CPT code is billed. Remember, the CPT manual describes a *work product*. This is where we must start when understanding the information found in the guidelines. From a *work perspective* surgery consists of the following three main items;

1. The preoperative care
2. The intra-operative portion
3. The postoperative care

We will discuss each one separately.

Preoperative care

Before a surgeon will begin any surgical procedure it is important to verify that the patient is healthy enough to undergo the procedure. The patient normally has a preoperative physical for major surgeries where general anesthesia will be used.

For **minor procedures** (i.e. a simple stitch, draining an abscess), general anesthesia may not be needed, however it is still important to examine the procedure site as well as clean and prepare the site prior to any work beginning.

During **major surgery** where general anesthesia is used, the procedure site will be cleaned and the surrounding area draped or covered.

Intra-operative Time

The intra-operative portion refers to the surgical procedure, from the time the first cut or incision is made until the time of closure. If the procedure involves the use of a “scope” then the intra-operative portion includes the entry of the scope and the removal.

Postoperative care

After the surgery has been completed the patient requires a time to recover and heal from the procedure. Depending on the type and extent of the surgery the patient may remain in the hospital as an inpatient following the procedure or the patient may just stay in the recovery area for a few hours and then go home.

During the time of recovery, once the patient has returned home, the patient will have follow-up appointments in the physician's office to ensure that the healing from the procedure is progressing as planned.

The three parts of surgery are called the surgical package. The three parts of a surgery will always be performed and since each constitutes work, the provider does seek reimbursement as well. To simplify the payment the three parts are combined for payment and are referred to as, “The surgical package.”

The guidelines provided in the surgery section give us further definition to this package and list itemized detail as to what is included. This is an important point in surgical coding. Items that are listed as part of the package are all included in the reimbursement for the surgical CPT code and should not be coded separately.

“The Package”

The package is outlined and defined in the surgery guidelines of your CPT book.

The first important piece of information is a statement confirming what we all know to be true; which is that patients are different and even though many individuals will have the same surgical procedure performed the healing process for each may vary and the work required to accomplish the surgery may vary due to each patient’s clinical and anatomical presentation.

Key Note: Unbundling is the term used when a provider attempts to bill separately for the different parts of the surgical package.

The “Package”

List three reasons that could alter the work or recovery between different patients undergoing the same surgery.

1. health issues
2. altered anatomy
3. previous surgery

The “Package”

The bulleted list in CPT outlines those items which are considered **“bundled”** into the payment for the surgical CPT code billed.

Let’s review each one now.

Typical follow up care in the hospital or office would include inspection of the wound, removal of sutures, drains or staples.

Also included would be the removal of dressings and/or casts/splints and applying new dressing.

Educating the patient on any further care that they may need to do themselves at home, such as soaking in a tub after hemorrhoid surgery or using an ointment until a wound heals.

This concept of postoperative care is further defined in the guidelines. The notes found in CPT make it clear that “follow-up” or postoperative care is that care that is provided as a follow-up to the procedure. As mentioned above, this may include attention to wounds and dressings.

Any care provided to patients for complications from the procedure or exacerbation of the condition that created the need for surgery or any new problems should not be considered a part of normal postoperative care and may be coded and billed separately.

Key Note: not all insurance carriers will hold to this same thought on postoperative care. Many carriers, Medicare included, only reimburse for certain postoperative complications perhaps when it involves a trip back to the OR. Be sure to read contracts very closely.

Global Days and Global Package Concept

What does it all mean?

Concepts and real life

Global Days and the Surgical Package

As discussed already, the “package” defines a work product associated with a procedure. From a reimbursement perspective, time is a very essential factor as well. When does the package begin and when does it end? When is it appropriate to begin billing for services again?

For reimbursement purposes we use the term “Global Days” to represent the time associated with the “package.” Global days are set at either “0”, “10”, or “90” days.

The “package” begins 24 hours prior to surgery and the “global days” begin accruing the first day following the procedure. Minor procedures normally have a global period assigned as 0 or 10 days. Major surgeries are assigned a 90 day global time period.

Global Days and the Surgical Package

To determine the global period for *major surgeries*, carriers count 1 day immediately before the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery.

EXAMPLE:

Date of surgery - February 3

Preoperative period - February 2

Last day of postoperative period – May 3

Global Days and the Surgical Package

To determine the global period for *minor procedures*, carriers count the day of surgery and the appropriate number of days immediately following the date of surgery.

EXAMPLE:

Procedure with 10 follow-up days:

Date of surgery – February 3

Last day of postoperative period - February 13

Putting it All Together

The surgical package defines what items are bundled into payment of a surgical CPT code.

The global period defines for how many days this package is in effect.

Most importantly it defines for how many days following the procedure the follow up care visits are not to be billed.

Modifiers (A few, not all)

Think of scenarios, not memorizing modifiers

THE EXPLANATION FOR THE USE OF THE MODIFIER MUST BE DOCUMENTED!

Example #1 – Modifiers 25 and 57 – Decision for Surgery E/M modifiers only

We know that the surgical package includes the pre-operative visit which normally occurs the day of or the day before the surgery.

In the guidelines this visit is stated as occurring subsequent to the decision for surgery. What about if the decision for surgery occurs on the day of or the day before surgery? In some instances the surgery is considered an emergent need. If the E/M code for that decision was billed, it is quite possible the carrier would deny the visit code and consider the payment part of the payment for the surgical CPT code.

This would be neither fair nor appropriate considering the package does not include the decision for surgery. To let the carrier know that this was a visit for the decision for surgery, we have two modifiers that can be appended to the E/M code to indicate this scenario.

Modifier 25

- Medical documentation should clearly show that the E/M service performed was unique and distinct from the usual preoperative and postoperative care associated with the primary procedure performed on the same date of service.
- The NCCI manual does give one clinical example.
  - *Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.*

Modifier 25

- The procedure code includes typical pre and post work, not a significant and separate evaluation of a condition.
- Pre-work is site assessment, decision to perform the procedure, informed consent, obtaining information about allergies, obtaining information about immunization status, if relevant.
- Post-work includes post procedural instructions.
- When a physician/NP/PA needs to evaluate a condition and consider treatment options prior to the decision for surgery, bill for both.

Example #2 – Modifier 24 – Unrelated Postoperative Encounters E/M modifier only

From reading the guidelines we learned that all postoperative care E/M encounters are bundled into the payment for the surgery and are not separately reported for payment.

What about in those instances when a patient presents with a new problem that is not related to the surgery at all?

You may think that the diagnosis code would be enough indication that the service is unrelated to the surgery, but often it is not. This should be a billable as well as reimbursable encounter. Again, if the E/M code was billed, it would most likely be denied as already paid within the payment for the surgery. To explain this scenario Modifier -24 is used.

Modifier 25? Yes or No

- Patient presents today for complaints of left knee pain. It has been bothering him for several months now. He states it is painful with ambulation. He likes to stay fairly active. He ambulates with a cane. He has been taking anti-inflammatories with some relief. He has had his right knee replaced he said about 10 years ago and he has done well with that.
- The rest of his past medical, surgical, social, family history,medications, and allergies are otherwise documented in the nursing notes and have been reviewed.
- X-rays were taken in the office today and include multiple views of the left knee which show degenerative changes with bone-on-bone arthritis in the medial compartment.

Modifier 25? Yes or No

- Assessment: Left knee arthritis.
- Plan: I did discuss treatment options with him. He would like to try a steroid injection. Today in the office, we did prep the superolateral aspect of the left knee with Betadine and alcohol, and using sterile technique, we injected 80 mg of Depo-Medrol. The patient tolerated the procedure well. We will see him back in a month for recheck. He is in agreement with this treatment plan.

Example #3 Multiple Procedure Modifiers
50, 51, 59 (never appended to E/M codes)

The surgical package really defines the work for one procedure. What happens when more than one procedure/surgery takes place during the same session and by the same provider?

The patient still had just one pre-operative visit and one decision for surgery. The patient will still have one set of postoperative visits.

Still, work that is performed should be billed when it appropriate. Using modifiers appended to the surgical CPT code to convey the message of multiple procedures being performed is a way of telling the insurance carrier no *unbundling* is taking place and that the surgeon needed to perform more than one procedure.

Sometimes it takes more than one code to describe the total extent of the work performed.

Multiple Procedures

- **Modifier -51** appended to the subsequent surgical CPT code(s) billed states that multiple procedures had been needed. The -51 modifier normally implies that the provider is in the same body area for the second procedure and that the second procedure is treating the same condition as the first procedure.

- **Modifier -59 (MODIFIER 22 FOR BCBS KS) (PLEASE ATTACH RECORDS)** appended to the subsequent surgical CPT code(s) also billed indicates multiple procedures have been performed. However, the use of this modifier indicates that the additional procedure(s) was independent of and distinctly separate from the first or other procedure. This could mean a separate organ system or a separate incision or excision.

Split/Shared and I2

Documentation Challenges

CPT Description- Key elements

Page 6 in the 2024 CPT Professional Edition. Noted as a part of the E/M section Guidelines.

CPT

The guidelines and interpretations are provided to help determine which provider may report the E/M service.

The reporting provider has provided the substantive portion of the encounter.

Substantive has two distinct interpretations.

CPT – Substantive – Time Based E/M Services

Time

When the selection of the E/M code is based on total time on the date of the encounter, the services are reported by the professional who spent **the majority of the face to face or non face to face time** performing the service

Documentation

The documentation should reflect the individual time of each provider.

The documentation should reflect how time was spent.

CPT – Substantive – Medical Decision Making

When medical decision-making is used to determine the level of service when there is a team approach, the following criteria will apply.

1. Performance of a substantive part of the MDM requires that the physician(s) or QHP(s) made or approved the management plan for each condition in the assessment*(problems address)* ***and***
2. Takes responsibility for that plan including all risks *(risk of complications and/or morbidity or mortality of patient management)*

CPT – Substantive – Medical Decision Making

When medical decision-making is used to determine the level of service when there is a team approach, the following criteria will apply.

The problems and risk can determine the overall level of MDM, thus the level of service.

CPT – Substantive – Medical Decision Making

When data is used to determine the complexity of MDM, the reporting provider would need to document their own independent interpretation of a study for credit.

By agreeing to the plan of care, the reporting provider can get credit for tests/studies ordered.

CMS Definition- Key elements

MLN Matters MM13592
Update on Split or Shared E/M Visits

CMS

A split or shared visit is an E/M visit that both a physician or NPP in the same group perform in a facility setting, and in accordance with applicable law and regulations, either the physician or NPP can bill the service if they provide it independently.

CMS will pay the practitioner who performs the substantive portion of the visit.

CMS

Facility setting is an institutional setting in which payment for services and supplies provided incident to a physician or NPP’s professional services is prohibited under our regulations.

Split or shared services may be reported for services performed in the hospital or in a skilled nursing facility.

Office visits and nursing facility visits are not billable as split or shared services.

CMS

As of January 1, 2024, substantive portion means more than half of the total time spent by the physician and NPP performing the split or shared visit, or a substantive part of the MDM per the CPT E/M Guidelines. See the 2024 CPT Codebook.

CMS

Also starting in 2024, for prolonged visits, the substantive portion is more than half of the practitioners' total time. Only bill prolonged services when time is used to select visit level, and determination of who performed the substantive portion is based on time

For critical care visits and prolonged services which don't use MDM and only use time, substantive portion still means more than half of the total time spent by the practitioner performing the split or shared visit.

CMS

- In accordance with the CPT E/M Guidelines, only distinct time can be counted. When the practitioners jointly meet with or discuss the patient, only the time of one of the practitioners can be counted.

CMS

Practitioners cannot count time spent on the following:

- The performance of other services that are reported separately.
- Travel.
- Teaching that is general and not limited to discussion that is required for the management of a specific patient.

CMS

When MDM is used as the substantive portion, CMS believes each practitioner could perform certain aspects of MDM, but the billing practitioner must perform the substantive part of MDM laid out in the CPT E/M Guidelines in order to bill the shared visit.

CMS

For all split (or shared) visits, one of the practitioners must have face-to-face (in-person) contact with the patient, but it does not necessarily have to be the physician, nor the practitioner who performs the substantive portion and bills for the visit.

The substantive portion can be entirely with or without direct patient contact, and is determined by the proportion of total time, not whether the time involves patient contact.

CMS

Documentation in the medical record must identify the physician and NPP who performed the visit. The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record.

CMS

- Modifier -FS (Split or Shared E/M Visit) must be reported on claims for split (or shared) visits, to identify that the service was a split (or shared) visit.
- The modifier identified by CPT for purposes of reporting partial services (modifier -52 (reduced services)) cannot be used to report partial E/M visits, including any partial services furnished as split (or shared) visits. Medicare does not pay for partial E/M visits

Key elements (same)

The basic definition is the same. CMS just adds additional verbiage.

The reporting provider has provided the substantive portion of the encounter.

Substantive has two distinct interpretations.

Time and MDM are both appropriate for supporting the level of service.

The CMS definition of MDM does reference the E/M guidelines in CPT.

Key elements - Differences

CMS only allows split or shared services in the facility setting. Office would be considered “incident-to”.

CMS provides a very detailed expanded language of how the time should be documented.

CMS requires a modifier.

CMS provides documentation guidance and signature guidance.

What to do?????

Always follow the guidelines as presented from your payer.

Always keep informed and up to date!

Incident to

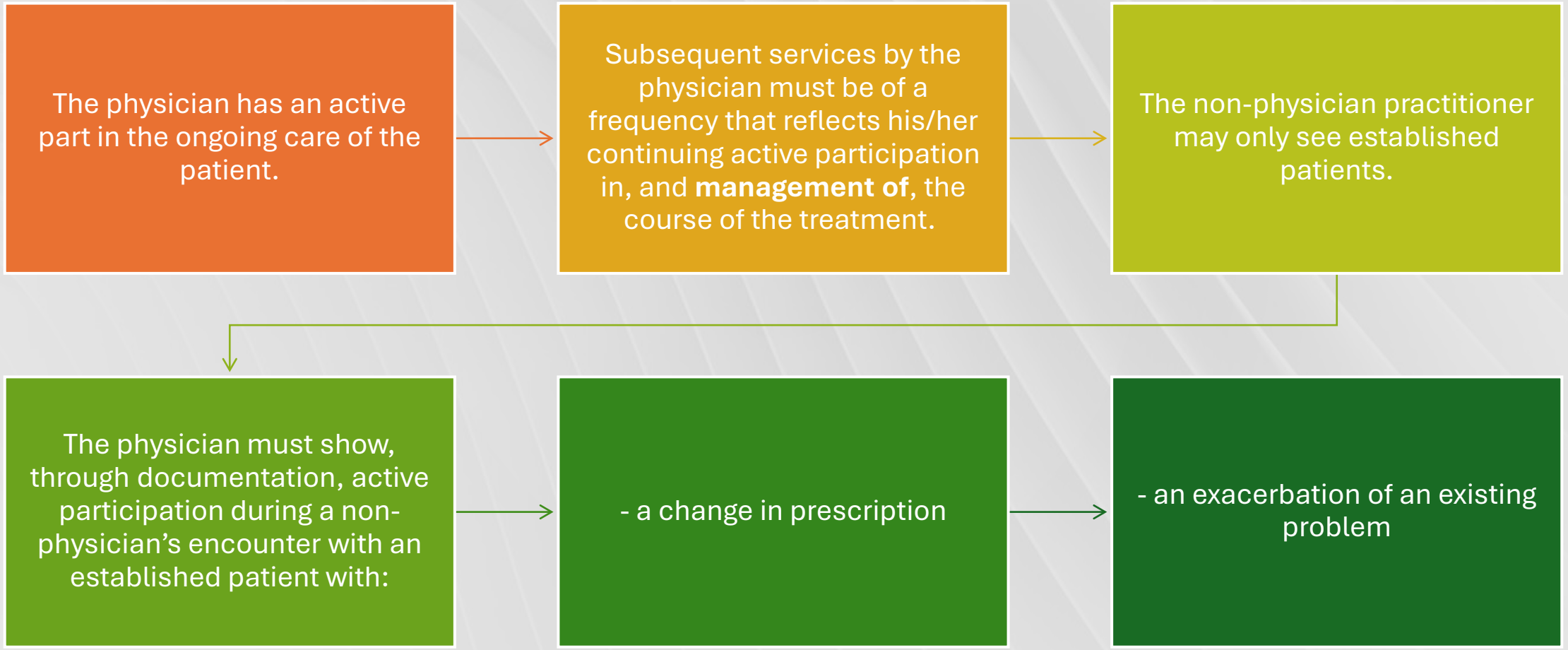
Began as a Medicare/CMS methodology for allowing NPPs to see patients on behalf of a physician who established the plan of care for that patient. Easy to understand, extremely difficult to implement.

This is a VERY payer specific guidelines now, as more non-Medicare payers are adopting the methodology as either I2 or split shared.

Basic Definition

Incident to a physician’s professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness.

A few basic rules of I2 (not a complete list)



Scribes

What/Who is a medical scribe?

- A medical scribe is someone who is trained to document physician-patient encounters quickly and accurately so that doctors do not have to. This allows doctors to spend more time face-to-face with patients and provide personalized care without getting caught up in charts.

Documentation Requirements

- Name of the scribe
- The provider **must attest** that the note has been documented by the scribe (by name).
- Date of service
- Signatures

Thank you, Questions?

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