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Third Party billing and reimbursement of professional medical services is based on a translation of medical record documentation into a series of codes. There are three coding systems utilized for physician services. These coding systems are ICD-10-CM, CPT-4, and HCPCS level II. The ICD-10-CM coding system is used to translate diagnostic information into numerical and alphanumerical codes. CPT-4 is used to translate procedural or evaluation services into five digit numerical codes. HCPCS level II codes are 5-digit alphanumeric codes used to report supplies and drugs as well as medical services that are not identified in CPT-4. Medical chart documentation in the form of dictated notes, handwritten notes or electronic medical record system entries must thoroughly and accurately support the ICD-10-CM, CPT and/or HCPCS codes selected for billing. In particular the following items should be documented for each service provided and billed:

- Clear and accurate indication of the degree of involvement on the part of the faculty physician;
- A complete description of any procedures performed; and
- All relevant diagnoses for the service being provided. When multiple diagnoses exist, the most important diagnosis to support the level of care should be identified.

Note: Qualified diagnoses are not acceptable for billing purposes. A qualified diagnosis, or working diagnosis, is one that is not yet proven. Examples of qualified diagnoses are those documented as “probable”, “rule out”, or “suspected,” etc. With the help of insurance company computers, a qualified diagnosis can result in inaccurate information becoming part of the patient’s permanent health profile. If the provider has not made a definitive diagnosis, the patient’s symptoms, signs, and/or abnormal test results should be identified and reported as the diagnosis, e.g., “abdominal pain.”

EPIC charge capture process is used to capture charges in the ECU Physician ambulatory setting. Physicians and/or clinical staff will complete their documentation and then pick E/M levels, labs, procedures, etc. Once the pertinent items are selected for billing and the note is closed, then the ambulatory charges can drop into the billing system.

A variety of methods and formats are used to capture charges for physician services rendered in the inpatient setting. In general, faculty physicians complete an inpatient billing sheet or pocket card to record services and diagnostic information for each inpatient encounter in narrative form. Professional coding staff converts the narratives to CPT and ICD-10-CM codes for billing purposes. In a few instances, coders abstract from the chart documentation and create the billed service.

Federal Programs have especially strict documentation and billing standards for professional care provided by physicians affiliated with teaching institutions. These standards require that services only be billed when direct patient care (identifiable as a personal service) has been rendered and documented by the attending faculty physician. For ECU Physicians’ billing purposes, this standard is strictly adhered to as policy for the following patient populations:

- All Tricare
- All Medicare
- All patients 65 years of age and older (i.e. Medicare eligible)

To clarify many of the issues unique to patient care rendered in a teaching institution, please refer to the section in this booklet covering Teaching Physician Guidelines. Failure to comply with the guidelines both in practice and in chart documentation can have significant adverse effects on the School’s professional service billings and reimbursement.
It is the responsibility of the provider, physician or other clinical staff, to document every patient encounter. On October 5, 2000, the Office of Inspector General (OIG) issued guidance to physicians relative to documentation that should appear in a patient’s medical record. The intent of this guidance is to facilitate high quality patient care by identifying the precise services rendered to a patient as documented by a physician/clinical staff in any location of care.

The elements of thorough documentation as identified by the OIG:
- The medical record is complete and legible
- The reason for the encounter
- Any relevant history
- Physical examination findings
- Prior diagnostic test results as applicable
- Assessment/Clinical impression or diagnosis
- Plan of care
- Date and legible identity of the observer/clinician
- Rationale for ordering diagnostic and other ancillary services must be easily inferred, if not documented
- ICD-10-CM, CPT-4 and HCPCS II codes submitted for reimbursement must be supported by documentation in the medical record
- Health risk factors are identified
- Progress of the patient to any treatment/plan of care
- Changes/revisions to any treatment/plan of care
- Any revisions in diagnosis should be documented

It is expected that all of the above elements are to be documented in the patient’s medical record as applicable.
BACKGROUND

Evaluation and Management Coding or E/M Coding was introduced by the American Medical Association in 1992. E/M codes (99201-99499) are designed to classify medical services provided by physicians and other health care providers performed in various clinical settings. Services are classified by considering the following:

- amount of skill of the practitioner
- effort
- time
- responsibility
- medical knowledge

E/M codes reflect the medical services that are provided by a clinician in the diagnosis and treatment of illness or injury, in the prevention of disease or in the health maintenance of a patient.

E/M codes are the most commonly billed professional service and can be billed by any specialty. The following terms and definitions are used throughout the E/M section of the CPT manual.

- **Chief complaint:** A concise statement of the reason for the encounter. Generally this statement is provided in the patient’s own words. All medical record documentation must reflect the chief complaint.
- **Concurrent care:** Services provided by more than one physician to the same patient on the same day. Generally these services are limited to inpatient services in which providers of differing specialties or subspecialties are managing different aspects of a patient’s care. Medical record documentation should specifically address the care being provided by each respective physician.
- **Transfer of care:** Process of the physician or other qualified health care professional who is providing management for some or all of a patient’s problem relinquishes this responsibility to another physician or other qualified health care professional. This person explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services.
- **Counseling:** Discussion between the provider and patient/family regarding but not limited to: diagnosis, treatment, prognosis, risk factor reduction, patient/family education, compliance with treatment. Medical record documentation should specifically outline any counseling of a patient and/or family, including the amount of time spent.
- **Established patient:** Any patient who has had a face-to-face encounter with a physician or another physician of the same specialty within the same group practice within the last 3 years.
- **New patient:** Any patient who has not had a face-to-face encounter with a physician or another physician of the same specialty within the same group practice within the last 3 years.
- **Modifier:** A 2-digit numeric or alpha-numeric suffix that is added to a CPT code. The intent of a modifier is to notify a payer that the basic service surrounding the CPT code it is attached to, has been altered in some manner.
The E/M section of the CPT manual is divided into several broad categories such as office visits, hospital visits and consultations. Subcategories further divide the categories to identify more specific characteristics such as initial visits, subsequent visits and discharge services. Specific E/M code selection for patient encounters may be billed at 1 of 5 levels for some services and 1 of 3 for some others. The appropriate selection of the E/M code is based on the documentation of the following components:

1. Extensiveness of the medical history
2. Extensiveness of the medical examination, and
3. Complexity of the medical decision making
   4. Counseling of patient/family/caregiver
   5. Coordination of care
   6. Nature of the presenting problem
   7. Time¹

The first three items in this list (history, exam and medical decision making) are the key components when selecting a level of E/M service.

Please refer to the following pages for more information on the above 7 components.

¹ Time as a key or controlling factor only becomes relevant if more than 50% of the encounter is dominated by counseling/coordination of care.
The levels of E/M services are based on four levels of history (Problem Focused, Expanded Problem Focused, Detailed, and Comprehensive). Each type of history includes some or all of the following elements:

- Chief complaint (CC)
- History of present illness (HPI)
- Review of systems (ROS) and
- Past, family, and/or social history (PFSH).

The extent of the history of present illness, review of systems, and past, family and/or social history that is obtained and documented is dependent upon clinical judgment and the nature of the presenting problem(s).

The chart below shows the progression of the elements required for each type of history. To qualify for a given type of history all three elements in the table must be met. (A chief complaint is indicated at all levels.)

<table>
<thead>
<tr>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems (ROS)</th>
<th>Past, Family, and/or Social History (PFSH)</th>
<th>Type of History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
<td>Problem Focused</td>
</tr>
<tr>
<td>Brief Problem</td>
<td>Problem Pertinent</td>
<td>N/A</td>
<td>Focused Expanded Problem</td>
</tr>
<tr>
<td>Extended</td>
<td>Extended</td>
<td>Pertinent</td>
<td>Detailed</td>
</tr>
<tr>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
<td>Comprehensive</td>
</tr>
</tbody>
</table>

- DG: The CC, ROS and PFSH may be listed as separate elements of history, or they may be included in the description of the history of the present illness.

- DG: A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his/her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:
  - describing any new ROS and/or PFSH information or noting there has been no change in the information; and
  - note the date and location of the earlier ROS and/or PFSH.

- DG: The ROS and/or PFSH may be recorded by ancillary staff or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.
• DG: If the physician is unable to obtain a history from the patient or other source, the record should describe the patient’s condition or other circumstance that precludes obtaining a history.

Definitions and specific documentation guidelines for each of the elements of history are listed below.

**CHIEF COMPLAINT (CC):**

The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient’s own words.

• DG: The medical record should clearly reflect the chief complaint.

**History of present illness:**

The HPI is a chronological description of the development of the patient’s present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

• location
• quality
• severity
• duration
• timing
• context
• modifying factors
• associated signs and symptoms

Brief and extended HPIs are distinguished by the amount of detail needed to accurately characterize the clinical problem(s).

A brief HPI consists of one to three elements of the HPI.

• DG: The medical record should describe one to three elements of the present illness (HPI).

An extended HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

• DG: The medical record should describe at least four elements of the present illness (HPI), or the status of at least three chronic or inactive conditions.
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- location
- quality
- severity
- duration
- timing
- context
- modifying factors
- associated signs and symptoms

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- DG: The medical record should describe one to three elements of the present illness (HPI).

An extended HPI consists of at least four elements of the HPI or the status of at least three chronic or inactive conditions.

- DG: The medical record should describe at least four elements of the present illness (HPI), or the status of at least three chronic or inactive conditions.
Review of Systems:

A ROS is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.

For purposes of ROS, the following systems are recognized:
- Constitutional Symptoms (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

A problem pertinent ROS inquiries about the system directly related to the problem(s) identified in the HPI.
- DG: The patient’s positive responses and pertinent negatives for the system related to the problem should be documented.

An extended ROS inquiries about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.
- DG: The patient’s positive responses and pertinent negatives for two to nine systems should be documented.

A complete ROS inquiries about the system(s) directly related to the problem(s) identified in the HPI, plus all additional body systems.
- DG: At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.
PAST, FAMILY AND/OR SOCIAL HISTORY (PFSH):

The PFSH consists of a review of three areas:

- past history (the patient’s past experiences with illnesses, operations, injuries and treatments)
- family history (a review of medical events in the patient’s family, including diseases which maybe hereditary or place the patient at risk)
- social history (an age appropriate review of past and current activities)

For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care.

A pertinent PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

- DG: At least one specific item from any of the three history areas must be documented for a pertinent PFSH.

A complete PFSH is a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

- DG: At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; domiciliary care, established patient; and home care, established patient

- DG: At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; home care, new patient.
Examination: documentation of a close inspection of one or more of the following body areas or organ systems that are determined to be relevant in making a diagnosis and subsequent treatment of a patient’s condition.

BODY AREAS: (For purposes of examination, the following body areas are recognized:

- Head, including face
- Neck
- Chest, including breast and axilla
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

ORGAN SYSTEMS: (For purposes of examination, the following organ systems are recognized:

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

CPT identifies 4 types of examinations:

- Problem focused: limited exam of a single affected body area or organ system.
- Expanded problem focused: a limited exam of the affected body area or organ system and other symptomatic or related organ system(s). This exam has been defined as requiring documentation of 2-4 body areas or organ systems.
- Detailed: an extended exam of the affected body area(s) and other symptomatic or related organ systems. This exam has been defined as requiring documentation of 5-7 body areas or organ systems.
- Comprehensive: a general multi-system exam is one that includes a minimum of 8 organ systems OR a complete examination of a single organ system. Note: a comprehensive examination performed as part of the Preventive Medicine Evaluation services is multisystem, but its extent is based on age and risk factors.
**Number of diagnoses or management options** – The number of possible diagnoses and/or the number of management options that must be considered is based on the number of type of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

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

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

There are four types of medical decision making recognized:

- Straightforward
- Low complexity
- Moderate complexity
- High complexity

The table on the following page may be used to help to determine whether the risk of significant complications, morbidity, and/or mortality is minimal, low, moderate or high.
<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>
</table>
| Minimal       | One self-limited or minor problem, (e.g., cold, insect bite, tinea corporis) | • Laboratory tests requiring venipuncture  
• Chest x-rays  
• EKG/EEG  
• Urinalysis  
• Ultrasound, (e.g., echocardiography)  
• KOH prep | • Rest  
• Gargles  
• Elastic bandages  
• Superficial dressings |
| Low           | • Two or more self-limited or minor problems  
• One stable chronic illness, (e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH)  
• Acute uncomplicated illness or injury, (e.g., cystitis, allergic rhinitis, simple sprain) | • Physiologic tests not under stress, (e.g., pulmonary function tests)  
• Non-cardiovascular imaging studies with contrast, (e.g., barium enema)  
• Superficial needle biopsies  
• Clinical laboratory tests requiring arterial puncture  
• Skin biopsies | • Occupational therapy  
• IV fluids without additives  
• Over-the-counter drugs  
• Minor surgery with no identified risk factors  
• Physical therapy |
| Moderate      | • One or more chronic illnesses with mild exacerbation, progression or side effects of treatment  
• Two or more stable chronic illnesses  
• Undiagnosed new problem with uncertain prognosis, (e.g., lump in breast)  
• Acute illness with systemic symptoms, (e.g., pyelonephritis, pneumonitis, colitis)  
• Acute complicated injury, (e.g., head injury with brief loss of consciousness) | • Physiologic tests under stress, (e.g., cardiac stress test, fetal contraction stress test)  
• Diagnostic endoscopies with no identified risk factors  
• Deep needle or incisional biopsy  
• Cardiovascular imaging studies with contrast and no identified risk factors, (e.g., arteriogram, cardiac catheterization)  
• Obtain fluid from body cavity, (e.g.: lumbar puncture, thoracentesis, culdocentesis) | • Minor surgery with identified risk factors  
• Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors  
• Prescription drug management  
• Therapeutic nuclear medicine  
• IV fluids with additives  
• Closed treatment of fracture or dislocation without manipulation |
| High          | • One or more chronic illnesses with severe exacerbation, progression or side effects of treatment  
• Acute or chronic illnesses or injuries that pose a threat to life or bodily function, (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, sensory loss) | • Cardiovascular imaging studies with contrast with identified risk factors  
• Cardiac electrophysiological test  
• Diagnostic endoscopies with identified risk factors  
• Discography | • Elective major surgery (open, percutaneous or endoscopic) with identified risk factors  
• Emergency major surgery (open, percutaneous or endoscopic)  
• Parenteral controlled substances  
• Drug therapy requiring intensive monitoring for toxicity  
• Decision not to resuscitate or to de-escalate care because of poor prognosis |
4. Counseling

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

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management/treatment options
- Instructions for management/treatment and/or follow-up
- Importance of compliance with chosen management/treatment options
- Risk factor reduction
- Patient and family education

5. Coordination of Care

Coordination of care may include arranging for further services and communicating with providers such as nursing homes or health agencies through written reports and/or telephone contact. Coordination of care that is provided but does not occur on the same date as a face to face encounter should be billed utilizing the Case Management codes.
The E/M codes recognize five types of presenting problems that are defined as the following:

1. **Minimal problem**: May not require the presence of the physician, but the service is provided under the physician’s supervision.

2. **Self-limited or minor problem**:  
   - Runs a definite and prescribed course.  
   - Is transient in nature, and is not likely to permanently alter health status.  
   - It has a good prognosis with management/compliance.

3. **Low severity problem**:  
   - Low risk of morbidity without treatment.  
   - Little to no risk of mortality without treatment.  
   - An expected full recovery without functional impairment.

4. **Moderate severity problem**:  
   - Moderate risk of morbidity and/or mortality without treatment.  
   - Uncertain prognosis.  
   - An increased probability of prolonged functional impairment.

5. **High severity problem**:  
   - High to extreme risk of morbidity and/or mortality without treatment.  
   - High probability of severe, prolonged functional impairment.
For E/M services, time is a determining factor for E/M level of service only when COUNSELING and COORDINATION OF CARE dominates the patient/family encounter (more than 50% of total patient encounter time). Both total patient/family encounter time and time spent counseling or coordinating care must be documented in the medical record. Time spent by non-physician providers may not be counted in time used for determining E/M code selection.

Time is not a descriptive component for the emergency department levels of E/M services. Emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. This makes it difficult to estimate the amount of time spent face-to-face with a patient.

Time is defined differently for outpatient and inpatient services.

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

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

**UNIT/FLOOR TIME (Observation and inpatient hospital services):**

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

Time must also be documented in the medical record when codes are billed which include a time descriptor such as critical care, prolonged services and hospital discharge.
### E/M Chart Review Worksheet

**REVIEWER:**

**DATE OF REVIEW:**

<table>
<thead>
<tr>
<th>Physician:</th>
<th>Specialty:</th>
<th>DOS:</th>
<th>MR#:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewers Code(s):</td>
<td>Code(s) Billed:</td>
<td>Dx:</td>
<td></td>
</tr>
</tbody>
</table>

#### HPI

<table>
<thead>
<tr>
<th>Location</th>
<th>Area of body, localized, unilateral, bilateral, fixed, migratory, radiate, referred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Specific pattern, sharp, dull, throbbing, stabbing, constant, intermittent, acute, chronic, stable, improving, worsening, laceration is jagged or straight</td>
</tr>
<tr>
<td>Severity</td>
<td>Severity itself is considered a quality, scale of 1 to 10, compared to ..., pt. feels really well, observation, functional status</td>
</tr>
<tr>
<td>Duration</td>
<td>Onset 3 days ago, since last Monday, for about 2 mos., in the last 2 wks., yesterday</td>
</tr>
<tr>
<td>Timing</td>
<td>Onset of problem or symptom and progression, recurrent, comes and goes, continuous, never really goes away, seldom, frequently, time of day, pattern</td>
</tr>
<tr>
<td>Context</td>
<td>Associated with activity, aggravated by activity, improves w/ activity, stress rel.</td>
</tr>
<tr>
<td>Modifying Factors</td>
<td>Steps the pt. has taken to alleviate the symptoms, what exacerbates symptoms, is helped by, is hindered by</td>
</tr>
<tr>
<td>Associated Signs &amp; Sx</td>
<td>Clinical impressions, direct physician questioning: specific symptoms, generalized symptoms “pertinent positives and negatives”</td>
</tr>
</tbody>
</table>

#### REVIEW OF SYSTEMS

<table>
<thead>
<tr>
<th>Const</th>
<th>Eyes</th>
<th>ENMT</th>
<th>Cardio</th>
<th>Resp</th>
<th>GI</th>
</tr>
</thead>
<tbody>
<tr>
<td>GU</td>
<td>Musc</td>
<td>Integ</td>
<td>Psych</td>
<td>Neuro</td>
<td>Endo</td>
</tr>
<tr>
<td>Hem/Lymph</td>
<td>All/Immun</td>
<td>All others negative</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unable to obtain - reason:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### PFSH

- Past History (Meds, Allergy, Surg, Hosp, Diet, Illness, Inj, Immuno)
- Family History (Medical events in pts. family, hereditary diseases)
- Social History (Marital, Employ, Occup, Living, Alcohol, Education, Sex Hx)

**Must Document ALL 3 PFSH elements to qualify for a Comp. History for NEW patients. (Office, OBS, IP, Consult, & Nursing facility)**

### HISTORY

<table>
<thead>
<tr>
<th>HPI</th>
<th>PR. FOCUSED</th>
<th>EXP. PR. FOC.</th>
<th>DETAILED</th>
<th>COMP.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 3</td>
<td></td>
<td></td>
<td>≥ 4</td>
<td>≥ 4</td>
</tr>
<tr>
<td>ROS</td>
<td>0</td>
<td>1</td>
<td>2 – 9</td>
<td>10</td>
</tr>
<tr>
<td>PFSH</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2 – 3</td>
</tr>
</tbody>
</table>

### EXAM

(Comp exam may be based on 8+ organ systems or 8+ body systems* or a complete single organ system)

**BODY AREAS: *Palmetto Medicare ONLY will allow 8+ body systems = Comp Exam**

- Head/Face
- Neck
- Chest
- Abdomen
- Back/Spine
- Gent/Groin/Buttocks
- Rt. Upper Ext.
- Lt. Upper Ext.
- Rt. Lower Ext.
- Lt. Lower Ext.

**ORGAN SYSTEMS:**

<table>
<thead>
<tr>
<th>Const.</th>
<th>Eyes</th>
<th>ENMT</th>
<th>Cardio</th>
<th>Respiratory</th>
<th>GI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musc</td>
<td>Skin</td>
<td>Neuro</td>
<td>Psych</td>
<td>Hem/Lymph/Imm</td>
<td>GU</td>
</tr>
</tbody>
</table>

### EXAM

<table>
<thead>
<tr>
<th>(Physical)</th>
<th>PR. FOCUSED</th>
<th>EXP. PR. FOC.</th>
<th>DETAILED</th>
<th>COMP.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2 – 4</td>
<td>5 – 7</td>
<td>8+</td>
</tr>
</tbody>
</table>

Final audit_template_update/Compliance.
<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>NUMBER</th>
<th>POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited / minor stable, improving, or worsening (max 2)</td>
<td></td>
<td>X1</td>
</tr>
<tr>
<td>Established Dx/Prob. Stable/improved</td>
<td></td>
<td>X1</td>
</tr>
<tr>
<td>Established Dx/Prob. Worsening</td>
<td></td>
<td>X2</td>
</tr>
<tr>
<td>New Prob. / No additional workup planned (1)</td>
<td></td>
<td>X3</td>
</tr>
<tr>
<td>New Prob. / Addl. workup planned, consultation</td>
<td></td>
<td>X4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Possible Points</th>
<th>POINTS</th>
<th>TYPE OF DATA (AMOUNT AND COMPLEXITY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>Review and/or order of clinical lab tests</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Review and/or order of tests in the radiology section of CPT (7xxxx Series) (nuclear medicine and all imaging except echocardiography and cardiac cath)</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Review and/or order of tests in the medicine section of CPT (9xxxx Series) (EEG, EKG, echocardiography, cardiac cath, non-invasive vascular studies, pulmonary function studies)</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Discussion of test results with performing physician</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Independent review of image, tracing or specimen</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>Decision to obtain old records and/or history from others</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Review &amp; summarize old records and/or history obtained from others</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL OF RISK</th>
<th>PRESENTING PROBLEM</th>
<th>DIAG. PROC. ORDERED</th>
<th>MGMT. OPTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Minimal</strong></td>
<td>1 self-limited or minor problem, e.g. cold, bite</td>
<td>*Lab tests w/ venipuncture, *Chest x-rays, *EKG/EEG, *Urineanalysis, *Ultrasound, e.g., Echocardiography, *KOH prep</td>
<td>Rest, Gargles, Elastic Bandages, Superficial Dressings</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>*2 or more self-limited or minor problems</td>
<td>*Physiologic tests not under stress, e.g., pulmonary function tests</td>
<td>*Over the counter drugs</td>
</tr>
<tr>
<td></td>
<td>*1 stable chronic illness, e.g. well controlled HTN or NIDDM, cataract, BPH</td>
<td>*Non-cardiovascular imaging studies with contrast, e.g., barium enema</td>
<td>*Minor surgery w/ no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>*Acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, sprain</td>
<td>*Superficial needle biopsies</td>
<td>*Physical Therapy</td>
</tr>
<tr>
<td></td>
<td>*Acute complicated injury e.g., head injury w/ brief loss of consciousness</td>
<td>*Clinical lab tests w/ arterial puncture *Skin biopsies</td>
<td>*Occupational Therapy</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>*1 or more chronic illnesses w/ mild exacerbation, progression or side effects of treatment</td>
<td>*Physiologic tests under stress, e.g., cardiac stress test, fetal stress test</td>
<td>*IV fluids w/ additives</td>
</tr>
<tr>
<td></td>
<td>*2 or more stable chronic illnesses</td>
<td>*Diagnostic endoscopies w/ no identified risk factors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>*Undiagnosed new prob. w/ uncertain prognosis e.g., lump in breast</td>
<td>*Deep needle or incision biopsy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>*Acute illness w/ systemic symptoms e.g., pyelonephritis, pneumonitis, colitis</td>
<td>*Cardiovascular imaging studies w/ contrast &amp; no risk factors e.g., arteriogram, cardiac catheterization</td>
<td></td>
</tr>
<tr>
<td></td>
<td>*Acute complicated injury e.g., head injury w/ brief loss of consciousness</td>
<td>*Obtain fluid from body cavity e.g., LP</td>
<td></td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>*1 or more chronic illnesses w/ severe exac., progression, or side effects of treatment</td>
<td>*Cardiovascular imaging studies w/ contrast w/ identified risk factors</td>
<td>*Minor surgery w/ identified risk</td>
</tr>
<tr>
<td></td>
<td>*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/others, peritonitis, acute renal failure</td>
<td>*Cardiac electrophysiological tests</td>
<td>*Elective major surgery (open, percutaneous or endoscopic) w/ identified risk factors</td>
</tr>
<tr>
<td></td>
<td>*An abrupt change in neurologic status, e.g., seizure, TIA, weakness, sensory loss</td>
<td>*Diagnostic endoscopies w/ identified risk factors</td>
<td>*Emergency major surgery (open, percutaneous or endoscopic)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>*Discography</td>
<td>*Drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Decision not to resuscitate (DNR) or to de-escalate care because of poor prognosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Parenteral controlled substance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MDM</th>
<th>STFWD</th>
<th>LOW</th>
<th>MOD</th>
<th>HIGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>DX / MGMT.</td>
<td>0 – 1</td>
<td>2</td>
<td>3</td>
<td>≥4</td>
</tr>
<tr>
<td>DATA</td>
<td>0 – 1</td>
<td>2</td>
<td>3</td>
<td>≥4</td>
</tr>
<tr>
<td>RISK</td>
<td>MIN</td>
<td>LOW</td>
<td>MOD</td>
<td>HIGH</td>
</tr>
</tbody>
</table>

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The following categories and codes are the E/M services most frequently billed by ECU Physicians. Each category listed includes general guidelines for use of any code from that category range. Please be advised that this is not an all-inclusive list. For detailed information on utilizing a specific E/M code listed or one that is not listed in the below information, please contact your departments Billing Manager, one of the individuals or departments listed in the “Need Help?” section of this document and/or appropriate staff within Clinical Financial Services.

Office or Other Outpatient Services
99201-99215

- Services provided billed as either New patient (99201-99205) or Established patient (99211-99215).
- New patient defined as “one who has not received any professional services from the physician personally or the physician’s specialty group within the past 3 years.”
- New patient services (99201-99205) require documentation of all 3 key components: history, exam, and medical decision making; OR complete documentation relative to counseling/coordination of care with the amount of time spent by the provider.
- Established patient services (99211-99215) require documentation of 2 of the 3 key components: history, exam, and medical decision making; OR complete documentation relative to counseling/coordination of care with the amount of time spent by the provider.
- Established patient 99211 services do not require the face to face presence of an attending physician in order to bill the service. This is also known as a “nurse visit.”
- This category of CPT codes is used to bill for services in the office setting or other ambulatory facility.

Preventive Medicine Services
99381-99397

- These CPT codes are used to bill for the preventive medicine evaluation of New or Established patients from birth through adulthood.
- CPT codes are selected according to the type of patient, New vs. Established, and according to the age of the patient.
- Identification of medical problems during a preventive medicine service that warrant additional work above and beyond that normally associated with a wellness visit should be separately reported using an Office/Outpatient code (99201-99215) with an attached modifier 25.
- An insignificant problem/abnormality that does not require additional work or evaluation should not be separately reported.
- Immunizations, laboratory, radiology services or screening tests identified by a specific CPT code should be separately reported.
- ow-up consultation codes.
Prolonged Services (Office/Outpatient Setting)

99354-99355 (face-to-face patient contact)

- These codes are used to report the total amount of face-to-face patient contact with an attending physician performing prolonged care in the Office or Outpatient Setting.
- The amount of time provided by an attending physician performing prolonged care must exceed 30 minutes to qualify billing this service.
- These codes are designated as “add-on” codes and may not be billed independently. They are required to be billed with a basic Office/ Outpatient Evaluation and Management service.
- Documentation must include the total time spent by the attending physician providing prolonged care. Time in the performance of the basic E/M service should be excluded from the prolonged care.
- Insurance companies routinely request copies of medical charts as a prerequisite to reimbursing prolonged attendance codes.
- Time spent does not need to be continuous on a particular date in order to bill prolonged service.
- Below is an example grid that outlines the time factor in using prolonged services codes 99354 and 99355 for office/outpatient services.
- A discussion of prolonged services in the inpatient setting, 99356 and 99357 occurs later in this document.

<table>
<thead>
<tr>
<th>Code</th>
<th>Typical Minutes for code</th>
<th>Threshold Minutes to bill code 99354</th>
<th>Threshold Minutes to bill codes 99354 and 99355</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10</td>
<td>40</td>
<td>85</td>
</tr>
<tr>
<td>99202</td>
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<td>50</td>
<td>95</td>
</tr>
<tr>
<td>99203</td>
<td>30</td>
<td>60</td>
<td>105</td>
</tr>
<tr>
<td>99204</td>
<td>45</td>
<td>75</td>
<td>120</td>
</tr>
<tr>
<td>99205</td>
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<td>99214</td>
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<td>99242</td>
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<td>99341</td>
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<td>50</td>
<td>95</td>
</tr>
<tr>
<td>99342</td>
<td>30</td>
<td>60</td>
<td>105</td>
</tr>
</tbody>
</table>
Care Plan Oversight Services

99374-99380

- Identify Care Plan Oversight Services for patients under the care of a home health agency, hospice or nursing facility.
- Services include development/revision of patient care plans, review of patient status, communication with other health care professionals involved in the patient’s care and or adjustment in the patient’s treatment regimen.
- Attending physician presence with the patient face to face is not required.
- Time spent performing this service must be performed by the attending physician and included in documentation in the patient’s medical record.
- Medicare requires use of G0181 to bill for Care Plan Oversight, 30 minutes or more, for a Home Health Patient.
- Medicare requires use of G0182 to bill for Care Plan Oversight, 30 minutes or more, for a Medicare covered Hospice Service.
- Medicare identifies that Home Health/Hospice services are to be billed with the following stipulations:
  - The attending physician must spend at least 30 minutes
  - Can only be billed once every 30 days
  - Requires interdisciplinary team involvement such as Physical therapy, Occupational therapy, etc. to be eligible for this service.
Physician Certification/Re-certification of Home Health Plan of Care
G0179 and G0180

- Specific to Medicare beneficiaries that are under a Home Health Plan of Care.
- G0180 identifies the initial creation and implementation of a Home Health Plan of Care per certification period (patient should not have received home health services within the last 60 days unless, on a rare occasion, a new plan of care has been implemented).
- G0179 identifies the recertification of the Home Health Plan of Care during the re-certification period (the patient should have received at least 60 days of service under the initial plan of care).
- Billing of this service must be by the attending physician who signs the certification/re-certification of the plan of care.
- Copies of the signed certification/re-certifications should be maintained as documentation of the provided service.

Consultations
99241-99255

- Consultative services are categorized according to the location of the patient.
- Characteristics of a consultation:
  - A formal request for an opinion from one provider to another
  - A written report of the findings, including any diagnostic/therapeutic services ordered
  - Communication of the findings, services and recommendations reported back to the ordering source.
- The request for the consult and reason should be documented in the patient’s medical chart.
- The consult report should also be in the patient’s medical record and communicated to the requesting provider. The report should include:
  - An explanation of the medical necessity for the consult
  - The name of the physician who requested the consult
  - The name of the physician providing the consult
  - A report of findings and recommendations
- Diagnostic and/or therapeutic procedures performed by the consultant are also billable in addition to the consultation itself, provided they are recorded in the patient’s chart.
- In a hospital setting, a consultant who assumes responsibility for management of a portion or all of the patient’s condition(s) following an initial consult service must bill using the subsequent hospital care codes (99231-99233) as opposed to follow-up consultation codes.
- Follow-up services occurring post discharge in the office setting should be billed with the appropriate established patient code (CPT codes 99211–99215)
- Referral to a specialist in which the intent is to treat an established or diagnosed problem does not represent a consultative service for the specialist and should be reported using the appropriate E/M service (New vs. Established patient, subsequent hospital care, etc.).
Hospital Observation Services
99217-99220; 99224-99226, 99234-99236

- These CPTs represent services rendered to patients designated/admitted as “observation status” regardless of physical location within the hospital.
- Observation designation should be clearly documented in the hospital chart preferably at the time of admission.
- E/M services rendered in other sites (example: ED, office, nursing facility, etc) related to the observation admission is considered to be part of the initial observation care service and not reported separately.
- Admission to the inpatient level of care following observation status occurring on the same date should be reported using the hospital admission E/M codes (99221-99223). Observation E/M services should not be reported separately on the same date as inpatient admission services.
- Observation care that continues on subsequent days following Observation admission services but are not occurring on the date of discharge are reported with an appropriate code from the Established Office/Outpatient Services Category (99211-99215).
- Observation care discharge (99217) should be utilized to report all E/M services provided to a patient including final examination, preparation of discharge records, instructions of continuing care, etc.
- Admission/Discharge Observation services that occur on the same date should be billed utilizing a code from Observation or Inpatient Care Services (Including Admission and Discharge Services) CPT 99234-99236.

Hospital Inpatient Services
Initial Care 99221-99223
Subsequent Care 99231-99233
Discharge Day Management 99238-99239

- Initial hospital care (99221-99223) provided to a patient is billed only once per admission.
- Initial inpatient encounters by physicians other than the admitting physician should be reported as Subsequent Hospital Care codes (99231-99233) or Consultation services (99251-99255) as applicable. Do not code 99221-99223.
- All evaluation and management services that occur in another site of service that are in conjunction with or leading up to an inpatient admission should not be separately coded. These E/M services are to be combined with the admission and the level of service should be selected based on all documentation for that date of service.
- E/M services occurring in another site of service totally unrelated to an inpatient admission occurring on the same date may be separately coded.
- Recording of daily progress notes by a teaching physician should be billed as subsequent care visits (99231-99233) with the exception of services requested in a consultative capacity.
- The final examination of the patient, discussion of the hospital stay, instructions for continuing care to all relevant caregivers and preparation of discharge records, prescriptions and referral forms are billed as discharge day management (99238 or 99239).
- The Discharge Day Management service more than 30 minutes, 99239, must be time spent by the teaching physician. The documentation in the medical record must reflect the total time spent.
As with Initial Hospital Care, Discharge Day management may be billed only once per admission. Discharge of care from a particular specialty service during a hospitalization does not represent a discharge day management service. Such discharges from a specialty service should be billed using a code from the Subsequent Hospital Care (99231-99233) category.

Emergency Care 99281-99288

- Reportable for services performed in a hospital based facility setting open 24 hours a day.
- Emergency care services may be billed by any physician specialty for services rendered in the Emergency Department setting.
- For services requested by an ED physician and performed by another specialty physician in which an opinion or advice for the care or treatment of a patient in the Emergency Department, use the Consultation service codes 99241-99245.
- Service provided to a critically ill patient performed in the Emergency Department should be billed using the Critical Care codes 99291-99292.
- Emergency care does not make a distinction between new and established patients. All patients are treated as “new patients.”

Critical Care 99291-99292

- A critical illness or injury is defined as one that 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 services include but are not limited to the treatment or prevention of further deterioration of central nervous system failure, circulatory system failure, shock-like conditions, renal, hepatic, metabolic or respiratory system failure, post-operative complications, or overwhelming infection.
- Cumulative time spent during a particular date by any and all Teaching Physicians performing Critical Care is utilized to calculate the billing of this time based service.
- Work performed by residents independently, without the presence of a Teaching Physician is excluded from Critical Care time calculation.
- Critical care is considered to be a package of services and as such the following services are included and should not be billed separately during the critical care period:
  - interpretation of cardiac output measurement (CPT codes 93561-93562)
  - chest x-rays (71010-71020)
  - pulse oximetry (94760-94762)
  - blood gases and information stored in computers (CPT code 99090)
  - gastric intubation (CPT code 43752 and 43753)
  - temporary transcutaneous pacing (CPT code 92953)
  - ventilation management (CPT codes 94002-94004, 94660, 94662)
  - vascular access procedures (CPT codes 36000, 36410, 36415, 36591, 36600)
- Critical care services may be billed from any location.
• Documentation should specify the critical nature of the service and provide a record of all procedures performed and time involved.
• Circumstances may warrant the separate billing of an E/M service in addition to Critical Care if a separately identifiable service is rendered. The separate E/M service would be submitted with a modifier 25. An example: The patient is seen in the morning and an appropriate E/M service is billed as documented for the service. Later in the day, the patient becomes critically ill and is seen for Critical Care. This service may be billed in addition to the E/M service that would be reported for earlier that day. The modifier 25 should be added to the E/M service performed earlier in the day.

Inpatient Neonatal and Pediatric Critical Care 99468-99476
Initial and Continuing Intensive Care Services 99477-99480
• The same definitions for critical care services apply for the adult, child and neonate.
• Codes 99468 and 99469 are used to report the services of directing the inpatient care of a critically ill neonate or infant 28 days of age or younger. They represent care starting with the date of admission (99468) to a critical care unit and subsequent day(s) (99469) that the neonate remains critical. These codes may be reported only by a single individual and only once per day, per patient, per hospital stay in a given facility.
• Codes 99471-99476 are used to report direction of the inpatient care of a critically ill infant or young child from 29 days of postnatal age of 5 years of age.
• Services for the critically ill or critically injured child 6 years of age or older would be reported with the time-based critical care codes (99291-99292).
• Bundled services as addressed in the above Critical Care guidelines are also included in Pediatric/Neonatal Critical Care Codes. Additionally, the following services are also bundled and should not be separately coded:

  - Vascular Access procedures:
    - Peripheral vessel catheterization (36000)
    - Other arterial catheters (36140, 36620)
    - Umbilical venous catheters (36510)
    - Central vessel catheterization (36555)
    - Vascular access procedures (36400, 36405, 36406)
    - Vascular punctures (36420, 36600)
    - Umbilical arterial catheters (36660)
  - Airway and ventilation management:
    - Endotracheal intubation (31500)
    - Ventilatory management (94002 – 94004)
    - Bedside pulmonary function testing (94375)
    - Surfactant administration (94610)
    - Continuous positive airway pressure (CPAP) (94660)
  - Lumbar puncture (62270)
  - Suprapubic bladder aspiration (51000)
  - Bladder catheterization (51701, 51702)
- Invasive/non-invasive electronic monitoring of vital signs, bedside pulmonary function (94375)
- Monitoring or interpretation of blood gases or oxygen saturation (94760-94762)
- Oral or nasogastric tube placement (43752)
- Transfusion of blood components (36430, 36440)
- Car Seat Evaluation (94780 – 94781)

- Performance of minor procedures/services not specifically listed as bundled according to the Critical Care Guidelines or as mentioned above, may be separately reported.

Prolonged Attendance (Inpatient Setting)
99356-99357 (face-to-face patient contact)

- Codes 99356-99357 are used to report prolonged service in an inpatient setting.
- Insurance companies routinely request copies of medical charts as a prerequisite to reimbursing prolonged attendance codes.
- This service should only be billed when it is clearly documented that the patient’s condition requires physician presence in the hospital or direct attendance to the patient, and when such attendance keeps the physician away from other duties.
- The codes should not be used for time spent in other functions during normal working hours.
- These codes are designated as “add-on” codes and may not be billed independently. They are required to be billed with a basic Inpatient Evaluation and Management service.
- Documentation must include the total time spent by the attending physician providing prolonged care. Time in the performance of the basic E/M service should be excluded from the prolonged care.
- Time spent does not need to be continuous on a particular date in order to bill prolonged service.
The surgical package or “global surgical package” is the coding concept commonly applied to CPT codes within the range 10000-69990. The purpose of this surgical global package is to ensure that services are consistently coded and reimbursed. It should be stressed that many health insurance companies have varying definitions of what may or may not be included in the global surgical package.

The following services, at a minimum, have been identified as included in the Global Surgical Package:
- Anesthesia services such as topical, local and regional anesthetics. Many payers include conscious sedation in the global surgical package.
- One related E/M preoperative visit after the decision is made to operate.
- Intraoperative services that are a normal, usual and necessary part of a surgical procedure.
- Postoperative care required by the surgeon
- Routine supplies that are considered integral to performing the procedure

From a reimbursement perspective, it should be noted that health insurance payers assign a “global period” to each surgical procedure. A global period is the length of time prior to, during and following a procedure in which services provided by the surgeon or specialty group can be considered as part of the surgical service and separate payment would not be allowed. There are three defined global periods:

**Minor** - Zero (0) postoperative days, pre-op begins the day of the surgery. To determine the global period for a minor surgery with a postoperative period of zero, count the day of surgery only. Services prior to the date of surgery and following the date of surgery are separately coded.

**Minor Surgery** – 10 postoperative days, pre-op begins the day of surgery. To determine the global period for a 10-day minor surgery, count the day of surgery and 10 days immediately following the date of surgery. Services prior to the date of surgery and following the date of surgery are separately coded.

**Major Surgery** – 90 postoperative days, pre-op begins the day prior to the surgery. To determine the global period for a major surgery, count the day prior to the date of surgery, the day of surgery and 90 days immediately following the date of surgery. Services preceding the day prior to surgery and following the 90th post-op day should be separately coded and billed.
As noted in the E/M section of this manual, a CPT modifier is a 2-digit suffix added to a CPT code to notify a payer that the service it is attached to have been altered in some way. The following are the most commonly used modifiers when billing surgical services.

**Payment Modifiers**

The following modifiers have been identified as those that describe additional work, decreased work or generally effect reimbursement. The modifier with a brief description is listed below:

- **22 - Unusual procedure:** This modifier designates a service requiring more than described by the 5 digit CPT code. The provider is asking for additional reimbursement for the service. Many payers require the submission of documentation to justify additional payment.

- **50 - Bilateral procedure:** This modifier identifies the exact same service performed bilaterally during the same operative session.

- **51 - Multiple procedures:** This modifier is attached to identify more than one procedure performed during the same operative session. The highest valued procedure should be coded first and subsequent procedures should have the modifier 51 attached, with the exception of those codes with the add-on designation within CPT.

- **59 - Distinct procedural service:** This modifier identifies a service that is distinct or independent from other services performed on the same day. These are services that are not normally reported together but are appropriate under the circumstances. This may represent a separate site, lesion, incision/excision, etc. not normally encountered.

**Global Modifiers**

The following modifiers identify services that represent exception reporting of the global surgical package.

- **54 - Surgical care only:** The provider using this modifier did not provide the pre-operative or post-operative care. Reimbursement for this service is for the procedure only.

- **55 - Postoperative management only:** The provider using this modifier performed only the postoperative care of the patient. Reimbursement is for postoperative care only. This modifier is attached to the CPT code for the surgical procedure.

- **56 - Preoperative management only:** The provider using this modifier performed only the preoperative care of the patient. Reimbursement is for the preoperative care only. This modifier is attached to the CPT code for the surgical procedure.
58- Staged or related procedure/service by the same physician during the post-op period (of another procedure): This modifier identifies a service performed during the post-op period of another procedure. Characteristics for using this modifier are that the secondary procedure was planned prospectively at the time of the initial procedure (staged), more extensive than the original procedure, or for therapy following a diagnostic surgical service.

Special Surgical Events Modifiers:

76- Repeat procedure by same physician
77- Repeat procedure by different physician
78- Return to the operating room during the post-operative period This identifies a return to the operating room during the post-op period of a procedure such as the return to the OR to treat a complication.
79- Unrelated procedure during post-op period This service represents a return to the OR during the post-operative period of an unrelated procedure.

Multiple Surgical Providers:

62- Two surgeons required This modifier identifies a service in which two primary surgeons are required to perform distinct parts during an operative session. Generally the two surgeons are of differing specialties. Each surgical CPT is reported on a claim for each physician with the modifier attached.
66- Surgical team required This modifier is reported when the service requires a skilled team of 3 or more physicians. The surgical CPT of each team member is reported with the team modifier attached.
82- Assistant surgeon when qualified resident not available In the circumstance when a qualified resident is not available to assist with a procedure, a second faculty provider can be utilized as an assistant. The operative documentation should reflect that a qualified resident was not available. The assisting provider will submit the same surgical procedure as the primary surgeon with modifier 82 attached.
The following bulleted items are critical elements in the documentation of a surgical procedure:

- Identification of all procedures performed, primary and secondary, during the operative episode.
- Presence/extent of involvement of the teaching faculty.
  - **Major procedures**: teaching faculty must be present during key portions of the procedure.
  - **Endoscopic procedures**: must be present during the entire viewing including scope insertion/removal. Real time viewing in another room is not allowed.
  - **Minor procedures**: procedures ≤ 5 minutes. Require the teaching faculty to be present for the entire procedure.
- Medical necessity for the procedure should be clearly identified.
- Dictation of the operative report by the resident is acceptable and the report should be signed by the resident.
- Operative reports dictated by residents should be reviewed by teaching faculty involved, making revisions as needed, and co-signed by the teaching faculty.
- Presence of additional faculty during the procedure should be noted with documented medical necessity.
- Teaching faculty acting as assistant at surgery when a qualified resident is not available should be clearly stated in the operative report.
- Lesion excision requires specific documentation of the size of the lesion. Record the length, depth and site of any and all lacerations that require repair.
• Many major payers (Medicare, Medicaid, TriCare, BCBS) do not allow separate reimbursement in the treatment of post-op complications unless the situation requires a return trip to an OR.

• “Return to an OR” is defined as a place of service specifically equipped/staffed for the sole purpose of performing procedures.

• Postoperative evaluation and management services provided by the surgeon but not related to the surgery may be separately coded and billed. Documentation should distinguish the service from the procedure and the E/M service would be reported with a modifier -24.

• Modifier -25 should be used when the surgeon is billing an unrelated E/M service on the same date as a procedure. Documentation should reflect that the E/M service was not related to the procedure.
Other medical and diagnostic services (CPT code ranges 70010-79999, 80047 – 89398, and 90281- 99199) include, among others, such categories as psychiatry, therapeutic and diagnostic cardiology, allergy and immunology, chemotherapy administration, radiology, and laboratory. These areas are not individually addressed in this booklet because unique, and often complex, criteria may apply to each procedure within the service groupings. Please address any questions regarding the documentation or billing of these services to the Office of Institutional Integrity and/or the Clinical Financial Services Department as listed in the “Need Help?” section at the end of this document.

CPT Modifier 26
CPT modifier 26 is often necessary to properly bill diagnostic medical, radiology, and laboratory studies and is worthy of attention. It is used to inform third party payers that only the professional component of a diagnostic service was rendered. This modifier is only appended to a CPT code when there is no specific 5 digit code for physician interpretation and report of the test. It is particularly applicable to services rendered in an inpatient or outpatient hospital location because the technical portion of the service (i.e. facility, equipment, and clinical/technical support staff) is reimbursed to the hospital. When performing these diagnostic services, documentation should include an explanation of the procedure, a description of the findings, and an interpretation of results and their relevance to the patient’s medical condition. In this age of automation, insurance companies will not accept a computer printout with physician notes of “agree with above”, “normal”, or “abnormal” as adequate documentation that a billable professional service was rendered. For further information on the Teaching Physician’s role when billing the professional portion of a diagnostic service, please refer to the section of this document entitled “Billing Other Unique Services” of this document.
The services of non-physician providers (NPPs) are generally considered to be an extension of a physician’s professional service. First and foremost, a billable service performed by a NPP must be within the scope of the NPP’s licensure. Multiple mechanisms are utilized to bill the NPP service. A brief description of each follows:

A. “Incident to” is a billing mechanism defined by governmental payers that allow services of a NPP to be billed in the name of a supervising attending physician. “Incident to” is specifically defined as those services “that are furnished as an integral, although incidental, part of the physician’s personal professional service in the course of the diagnosis or treatment of an injury or illness.” Services billed in accordance with this guideline are reimbursed by the payer at 100% of the physician’s allowed amount.

B. Independent practitioners are NPPs employed by a physician group that are recognized as credentialed providers and can be enrolled with a particular payer. Primarily Medicare, Medicaid and Tricare recognize and accept billings by certain types of NPPs provided they have met the enrollment requirements specified by the payer. Generally, reimbursement rates for a NPP will be at a lesser rate than that of a physician and can range anywhere from 65% to 85% of the physician reimbursed fee schedule.

MEDICARE/TRICARE “INCIDENT TO” POLICY:
Services that are billed as “incident to” a physician’s personal service are paid at 100% of the Medicare Physician’s Fee Schedule, i.e. as if the physician actually performed the service personally. As such, the following stipulations must be met in order for a service to be billed to Medicare as “incident to”:

- The initial visit must be with a physician of the specialty group and a treatment regimen established.
- The service is directly supervised by a physician/provider of that specialty group. Direct supervision means that the supervising/billing physician must be present in the clinic suite and readily available to direct or assist the NPP throughout the encounter.
- The service is in a facility owned or leased by ECU
- The NPP providing the “incident to” service must represent an expense incurred by the supervising physician or the practice that employees/contracts with the supervising physician.
- The physician must show active participation in the management of the patient. This does not imply that the physician must see the patient during each visit, but at a frequency that proves involvement on the part of the physician in the patient’s care.
- New problems or conditions that result in a change in the patient’s treatment regimen require physician involvement.
- Documentation relative to physician supervision, i.e. identification of the supervising physician/provider is encouraged. Co-signature of the supervising physician is also encouraged.
MEDICAID “INCIDENT TO” POLICY:
Medical Services:
Medical services meeting “incident to” requirements as specified by Medicaid policy may be billed in the supervising attending physician’s name if the following guidelines are met:
- The service must be provided by an employee of the physician or of the same physician group.
- Direct personal supervision of the service must be met as follows:
  - The supervising physician may be available in the clinic or be accessible via direct communication by radio, telephone or other telecommunication for Nurse Practitioners, Physician Assistants or Nurse Midwives.
- The supervision requirements for NPPs is required for all Medicaid recipients, whether the encounter is an initial or subsequent service.
- Services must be of the kind that is typically performed in a physician’s office.
- Documentation relative to physician supervision, i.e. identification of the supervising physician/provider is encouraged. Co-signature of the supervising physician is also encouraged.

Behavioral Health Services:
Medicaid has identified a separate “incident to” policy for individuals receiving behavioral health services from a recognized mid-level provider employed by a physician group practice. The following lists requirements for billing Medicaid behavioral health “incident to” services:
- The services being rendered are the kind that are commonly furnished in a physician’s office or clinic.
- The encounter is occurring under direct physician supervision defined as follows:
  1. The physician has initially seen the patient.
  2. The physician should be present in the office suite in which the practitioner is providing the service and
  3. Immediately available in the event of an emergency.
  4. The physician must be able to provide evidence of management of the patient’s care.

COMMERCIAL INSURANCE “INCIDENT TO” POLICY:
Commercial insurance companies typically do not enroll NPPs who are employed by a group practice. ECU Physicians generally bills services of NPPs to commercial insurance companies in accordance with the previous section titled “Medicaid Incident To Medical Services” unless the specific commercial plan has an identified “incident to” policy regarding the recognition and coverage of the NPP.

NOTE: “Incident to” and independent practitioner billing can be complex. It is suggested that prior to billing for these services, contact the Office of Institutional Integrity and/or the Provider Enrollment Department of the Clinical Financial Services Department as listed in the “Need Help?” section at the end of this document for current and specific information regarding billing procedures.
Background

Different third-party payers have established different rules and regulations regarding the documentation required to support billing. Federal and state regulatory agencies have also issued guidelines regarding documentation of medical services. ECU Physicians has developed policies and procedures to insure compliance with these requirements. This document describes the obligations of teaching physicians in providing the necessary documentation.

For the purpose of this policy, the following definitions apply:

**Resident**: A resident is an individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting.

**Fellow**: An individual in an ACGME or non-ACGME subspecialty training program. Services rendered by ACGME Fellows (referred to as residents by the ACGME) are the equivalent to resident services and are treated as such. Non-ACGME Fellows are generally fully licensed and credentialed as appropriate for their specialty and are treated as Attendings for billing purposes. There are rare Fellows in non-ACGME programs who cannot bill as Attendings. These situations will be clarified by the individual training programs.

**Medical Student**: A medical student is an individual who is enrolled in a program culminating in a doctoral degree in medicine. Any contribution of a medical student to the performance of a billable E/M service can be documented by the student as long as the teaching physician or resident personally performs (or re-performs) the physical exam and medical decision making activities. The teaching physician or resident can verify any medical student documentation rather than re-documenting the work.

**Teaching Physician**: A teaching physician is an individual who, while functioning within the teaching activities of an official residency program, involves residents and/or medical students in the care of his or her patients or supervises residents in the care of patients.
Claims for ANY service may be submitted to Medicare/Tricare when one of the following has been met and appropriate documentation is completed:

- Services are independently furnished by a physician who is not a resident; or
- The teaching physician was physically present during the critical/key portion of the service (provided in conjunction with a resident); or

The provision of general supervision of residents by teaching physicians as identified in locations granted by Medicare (see “Primary Care Exception” later in this document).
1. Documentation by the Teaching Physician (TP) must reflect the following:
   A. personal performance by the TP as an independent service –OR-
   B. both physical presence during the key/critical portions when the service was
      performed (resident collaboration) –AND-
   C. participation of the TP in the management of the patient.

2. Documentation of both the resident and TP service will be combined to determine the
   level of care assigned if the service is documented as outlined in (B) and (C) above.
   
   \[(A) = \text{Billable Service} \]
   \[(B)+(C) = \text{Billable Service} \]

3. Combined documentation (TP + resident) must demonstrate the medical necessity of the
   service.

4. Evaluation and Management services selected based on time is discussed in section “D.
   Billing Other Unique Services.”

5. Documentation by the resident of teaching physician presence/supervision alone without
   supporting notation of same from the teaching physician is insufficient for billing
   purposes.

6. Medical student participation in a service must be performed in the physical presence of a
   TP or resident.

7. Students may document services in the medical record. However, the teaching physician
   must verify all the student documentation or findings, including History, Physical exam
   and/or Medical Decision Making. The teaching physician must personally perform (or
   re-perform) the physical exam and medical decision making. Student documentation
   may be reviewed and verified rather than re-documenting the work. Here is the
   suggested attestation statement for the student work sign off:

   “I saw, examined and evaluated the patient and discussed the case with the medical
   student. I have reviewed the note and agree with the content and plan as written. I have
   verified all sections documented by the medical student as noted.”

8. For services that involve more than one resident, the TP note should clearly identify
   which resident the TP is referencing/linking to.

9. Resident supervision statements in the form of stickers or stamps utilized by teaching
   faculty must include additional documentation in the form of the TP’s personal findings
   relative to the applicable E&M service (i.e. history, exam, medical decision making)
   made by the teaching physician. Use of stickers or stamps that only state that the resident
   was supervised without further documentation by the teaching physician will be
   considered a non-billable service.
Teaching Physician Statements

Acceptable examples for Initial services (I) and Subsequent services (S):
Acceptable scenario for teaching physicians providing E/M services:

Following are three common scenarios for teaching physicians providing E/M services:

Scenario 1:
The teaching physician personally performs all the required elements of an E/M service without a resident. In this scenario the resident may or may not have performed the E/M service independently.
In the absence of a note by a resident, the teaching physician must document as he/she would document an E/M service in a nonteaching setting.
Where a resident has written notes, the teaching physician’s note may reference the resident’s note. The teaching physician must document that he/she performed the critical or key portion(s) of the service, and that he/she was directly involved in the management of the patient. For payment, the composite of the teaching physician’s entry and the resident’s entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Scenario 1 Language:
Admitting Note: “I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident’s note and agree with the documented findings and plan of care.”

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

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

(Note: In this scenario if there are no resident notes, the teaching physician must document as he/she would document an E/M service in a non-teaching setting.)

Scenario 2:
The resident performs the elements required for an E/M service in the presence of, or jointly with, the teaching physician and the resident documents the service. In this case, the teaching physician must document that he/she was present during the performance of the critical or key portion(s) of the service and that he/she was directly involved in the management of the patient. The teaching physician’s note should reference the resident’s note. For payment, the composite of the teaching physician’s entry and the resident’s entry together must support the medical necessity and the level of the service billed by the teaching physician.
Scenario 2 Language:
Initial or Follow-up Visit: “I was present with the resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident’s note.”

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

Scenario 3:
The resident performs some or all of the required elements of the service in the absence of the teaching physician and documents his/her service. The teaching physician independently performs the critical or key portion(s) of the service with or without the resident present and, as appropriate, discusses the case with the resident. In this instance, the teaching physician must document that he/she personally saw the patient, personally performed critical or key portions of the service, and participated in the management of the patient. The teaching physician’s note should reference the resident’s note. For payment, the composite of the teaching physician’s entry and the resident’s entry together must support the medical necessity of the billed service and the level of the service billed by the teaching physician.

Scenario 3 Language:
Initial Visit: “I saw and evaluated the patient. I reviewed the resident’s note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs.”

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

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

Follow-up Visit: “I saw and evaluated the patient. Agree with resident’s note but lower extremities are weaker, now 3/5; MRI of L/S Spine today.”

I: “I was present with the resident during the history and exam. I discussed with Dr. Resident and agree with findings and plan as documented.”

I: “I performed the hx and exam of the patient and discussed management options with Dr. Resident. Reviewed resident’s note and agree with findings and plan.”

I or S: “I saw and examined/evaluated the patient. I agree with the resident’s note except ______________________________.”

S: “I saw and examined the patient. I agree with the findings and plan of care as documented by the resident.”

S: “I saw the patient with the resident and agree with the resident’s findings and plan.”

S: “See the resident’s note for details. I saw and evaluated the patient and agree with the resident’s findings and plan.”
Unacceptable examples of documentation:

Following are examples of unacceptable documentation:

“Agree with above.”, followed by legible countersignature or identity;

“Rounded, Reviewed, Agree.”, followed by legible countersignature or identity;

“Discussed with resident. Agree.”, followed by legible countersignature or identity;

“Seen and agree.”, followed by legible countersignature or identity;

“Patient seen and evaluated.”, followed by legible countersignature or identity; and
A legible countersignature or identity alone.

Such documentation is not acceptable, because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had evaluated the patient, and/or had any involvement with the plan of care.
1. Allows TPs working within a clinic that is granted a primary care exception due to residency training activities to bill Medicare/Tricare for lower and mid-level Evaluation and Management services provided by the resident. The types of clinics eligible for this exception are clearly defined by the federal payers.

2. Primary Care Exceptions identified at ECU Physicians:
   - Family Medicine Clinic
   - General Internal Medicine Clinic
   - Geriatrics Clinic
   - General Pediatrics Clinic
   - General OB/Gyn Clinic

3. Teaching physician to resident supervision ratio is 1 TP for up to 4 residents (1:4).

4. The TP cannot have other supervision responsibilities while precepting the residents, i.e., cannot also simultaneously supervise nurses, MOAs, mid-level providers, medical students etc.

5. Level of service allowed under primary care exception:

<table>
<thead>
<tr>
<th>New patient</th>
<th>Established patient</th>
</tr>
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<tbody>
<tr>
<td>99201</td>
<td>99211</td>
</tr>
<tr>
<td>99202</td>
<td>99212</td>
</tr>
<tr>
<td>99203</td>
<td>99213</td>
</tr>
</tbody>
</table>

For any service billed at a higher level of 99203 or 99213, the precepting TP is required to make a personal evaluation of the patient and document those findings.

Other services, such as minor procedures performed in the exception clinic, require supervision and documentation of such as outlined in the Medicare Minor Procedure policy outlined in item C 12. “Supervision and Documentation Requirements for Billing Surgical Services (including Endoscopic Operations).”

6. Effective January 1, 2005, Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first 12 months of Medicare enrollment are included under the primary care exception. (HCPCS code G0402)

7. Effective January 1, 2011, Annual wellness visit, including personal preventive plan service, first visit/subsequent visit are included under the primary care exception. (HCPCS codes G0438 and G0439)
1. Teaching physicians are required to review the following when provided by a resident during or immediately after each patient’s visit:
   - Medical history
   - Diagnosis
   - Physical exam
   - Record of tests/therapies

2. Teaching physicians must document a review of the residents’ plan of care, including any participation/discussion that was necessary for continuity of care, and their agreement/disagreement with the resident’s assessment and plan.

3. Resident documentation that is not available for the TP to review at the time of the encounter must be reviewed by the TP when the resident documentation becomes available. TP documentation should reflect the same information as outlined in number 9 above.
1. The teaching surgeon must be immediately available to furnish services during the entire procedure.
2. The teaching surgeon must be physically present during the procedure for all critical and key portions of the procedure (as defined by the teaching surgeon).
3. The teaching surgeon is responsible for the pre-operative, operative and post-operative care of the patient.
4. Physical presence during the opening and closing of the surgical field is not required unless considered key (but immediate availability must still be met).
5. The teaching surgeon determines which post-operative visits are considered key/critical and require his/her presence.
6. Specific documentation of teaching surgeon presence during a single procedure may be made by the resident without specific separate documentation from the teaching surgeon.
7. Overlapping surgeries require the teaching surgeon to be present during the critical or key portions of both operations.
8. Critical or key portions of overlapping surgery may not take place at the same time.
9. With overlapping procedures, the teaching surgeon may become involved in the second procedure only if the key/critical portion of the initial procedure has passed.
10. Non-critical/Non-key portions of overlapping procedures require that the teaching surgeon make arrangements for another qualified surgeon to be available to immediately assist should the need arise.
11. Three concurrent procedures: the role of the teaching surgeon in each case is classified as supervisory to the hospital rather than a direct physician service and is not billable under the Medicare/Tricare physician fee schedule.
12. Minor procedures taking less than 5 minutes to complete require the teaching surgeon/physician to be present during the entire procedure in order to bill for the procedure.
13. Medical student notes relative to performing minor procedures cannot be used as the documentation to justify a billable service. Teaching surgeons/physicians must document personal presence during the procedure and document a procedure note to outline the service provided.
14. Examples of minor procedures include but are not limited to the following: line removals and placements, minor sutures, drain insertions, aspirations, lumbar punctures, etc.
15. Endoscopic surgery requires the teaching surgeon to be present during the entire viewing which is defined as “from the insertion to the removal of the endoscope.” Viewing of the endoscopic procedure via a monitor in another room does not meet the teaching physician presence policy as defined by Medicare/Tricare.
Diagnostic Services

Interpretation of diagnostic radiology/tests: Medicare/Tricare pays for the interpretation if performed or reviewed by the TP.

Teaching physician signature on an interpretation without any other signature is assumed to be the interpretation performed by the TP and payment will be made.

Interpretations prepared and/or signed by residents require a statement from the TP indicating that the image and interpretation was personally reviewed, as well as agreement or edit of the interpretation, and a legible countersignature.

Interpretations prepared by residents with a TP co-signature only are not acceptable for billing purposes.

Psychiatric Services

General TP rules as previously discussed apply to many psychiatry services such as consultations, initial and subsequent hospital visits etc.

The requirement for the TP presence during a particular psychiatric service may be met by concurrent observation of the service through the use of a one-way mirror or video equipment.

Audio-only equipment does not satisfy the physical presence requirement as outlined in 1 and 2 above.

Visualization of a recorded videotape by the TP after the encounter does not satisfy the supervision requirements and does not justify a billable service.

The TP supervising the resident must be a physician. Psychologists who supervise residents as part of a GME approved program does not satisfy the resident supervision required for a billable service.
Time Based Services

Services that are selected based on time specifically require the TP be present for the period of time as described by the CPT code.

Time spent by the resident in performing the service without the presence of the teaching physician cannot be included in a time-based code.

Teaching physician presence with the resident during the performance of the service can be counted toward the total time of the service.

The following services are examples of CPT codes selected based on time:

- Critical care services (99291-99292)
- Hospital discharge day management (99238-99239)
- Prolonged services (99354-99359)
Services provided by residents under the direct supervision of a teaching physician are billable to most payers. For billing purposes, direct supervision means that the teaching physician is accessible, as defined in Subsection I (below), when the services being billed are provided by the resident. The teaching physician is responsible for all services rendered, fees charged, and reimbursements received. The services must be documented, as defined in Subsection II, in the patient’s medical record. The supervising physician must sign the patient’s medical record indicating that he or she accepts responsibility for the services rendered.

**SUBSECTION I**

Accessibility of the teaching physician while the resident is providing services is defined as follows:

**A. Ambulatory**

Accessibility of the teaching physician for supervision of ambulatory services requires the teaching physician to be present in the clinic or office setting while the resident is treating patients. The physician is thus immediately available to review the patient’s history, personally examine the patient, as needed, review the records of the encounter and laboratory tests, confirm or revise the diagnoses, and determine the course of treatment.

**B. Inpatient**

Accessibility of the teaching physician for supervision of non-procedural inpatient services requires that the teaching physician evaluate the patient within 24 hours of admission and on each day thereafter for which services are billed. The teaching physician must review the patient’s history, personally examine the patient, as needed, review the records of the encounter and laboratory tests, confirm or revise the diagnoses, and determine the course of treatment.

**C. Procedures**

1. **Minor Procedures**

Accessibility of the teaching physician for supervision of procedures that take only a few minutes to complete or involve relatively little decision making once the need for the procedure is determined requires that the teaching physician be on the premises and immediately available to provide services during the entire procedure.

2. **All Other Procedures**

Accessibility for supervision of all other procedures requires that the teaching physician be physically present during all critical and key portions of the procedure and be immediately available to provide services during the entire procedure.

**SUBSECTION II**

Documentation for services must include a description of the presence and/or participation of the teaching physician. In the absence of specific documentation of presence by the teaching physician, the resident may document the encounter to include the involvement and participation of the teaching physician. The teaching physician’s signature is then adequate to confirm agreement. Reference by a TP to a medical student’s note is limited to documentation related to the ROS or past family/social history only. Medical student notes with a co-signature of the TP only without further elaboration from either the resident or the TP is not acceptable for billing purposes. The combined entries of the medical student, resident, and teaching physician must be adequate to substantiate the level of service required and billed. Documentation must include the teaching physician’s signature for each encounter.
Definitions, roles and responsibilities

- Third party payers and other bodies have provided specific guidelines and expectations for how a scribe functions, documents in the records, and for how the provider must provide a signature.

- A scribe is an individual who enters information into the EHR exactly as dictated by a provider. A scribe’s role is purely clerical in nature. Scribes are responsible for capturing an accurate and detailed description of the patient encounter in words supplied by the provider.

- The provider must be present in the room with the scribe at all times. Scribes accompany the provider into the exam room, using their individually assigned security rights to access the EHR, and enter information in real time.

- Scribes are not permitted to make independent decisions or chart entries while capturing or entering information into the health record or EHR beyond what is specifically dictated by the provider.

- The EHR should clearly identify whether a note is scribed, or, whether it has been written as part of his/her educational experience.

- The medical record must clearly reflect:
  - The provider who performed the service
  - The individual who scribed the service
  - A notation from the provider that he/she reviewed the documentation for accuracy
  - Dated signature by the provider

Examples of required appropriate documentation:

- Identification of scribe:
  “________ scribing for Dr.________

- Notation from provider that he/she reviewed for accuracy:
  “I agree with the above documentation' or 'I agree the documentation is accurate and complete”

References

http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Railroad%20Medicare~EM%20Help%20Center~General%20Articles~8EE18V4524?open&navmenu=EM*Help*Center

American Health Informatics Management Association (AHIMA) “Using Medical Scribes in a Physician Practice”
http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_049807.hcsp?dDocName=bok1_049807#appendixA
NEED HELP?
If you have questions about documentation, coding, or any other aspect of the billing process, please feel free to contact us. The Office of Institutional Integrity staff will be glad to assist with any questions.

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