



UNIVERSITY OF NEVADA  

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SCHOOL *of* MEDICINE

# **BILLING COMPLIANCE HANDBOOK**

**UNIVERSITY OF NEVADA SCHOOL OF  
MEDICINE**

**Original: September 1, 1997  
Revised: October 1, 2004**

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## **PROGRAM OVERVIEW**

This billing compliance program consists of audit procedures and tools, documentation standards and quality improvement reporting mechanisms. Audit procedures and tools have been developed to assist with implementation of the program. Documentation standards have been developed using professional billing criteria as defined by CPT and Medicare. This program was designed to follow Medicare Carrier Manual Billing Guidelines.

## **POLICY STATEMENT**

The University of Nevada School of Medicine Integrated Clinical Services North and South, Inc. ("Corporation") requires all its representatives to act in a legal manner consistent with all applicable governmental standards and requirements.

- This Compliance Program is designed to enhance and further demonstrate the Corporation's commitment to achieve the highest level of awareness of governmental and legal requirements.
- The Corporation's goals are to provide effective training and education programs, audit and monitor the Corporation's claim development and submission process and develop effective communications concerning compliance.
- The purpose of the Plan is to provide the overall framework of the Corporation's compliance program.
- The goal of the Corporation's compliance program is to help the Corporation comply with all applicable federal and state laws, rules and regulations to prevent improper conduct and to promote quality, integrity and honesty in all our dealings with third party payers.
- It is the responsibility of each clinical faculty member to the University of Nevada School of Medicine and each employee of the Corporation to read and understand the policies and obligations described in this compliance plan.
- It is the responsibility of each representative of this Corporation to comply with this compliance program and with all health care laws, and the provisions of the Institutional Compliance Agreement between the South Practice Corporation and the Office of the Inspector General.
- The Corporation will provide representatives with all relevant materials including guidelines regarding the justification and documentation requirements for Medicare and Medicaid billing and submission of claims and provide educational opportunities through meetings, seminars and written correspondence.

**RESOLUTION OF THE BOARD OF DIRECTORS REGARDING  
CORPORATE COMPLIANCE PROGRAM**

WHEREAS the policies of Integrated Clinical Services have always been that compliance federal with federal and state laws and adherence to the Corporations' own ethical standards is of primary importance.

WHEREAS the Board of Directors have continually strived to promote and enforce, in whatever way possible, adherence to this corporate policy by the Corporations' faculty physicians and employees.

WHEREAS the Board of Directors believe that adoption of a formal corporate compliance program is an additional means to foster adherence to the Corporations' policy.

WHEREAS the Board of Directors have considered and evaluated recommendations regarding development of a comprehensive corporate compliance program.

NOW THEREFORE IT IS HEREBY RESOLVED that the Board of Directors approve the development of a comprehensive corporate compliance program consistent with the Corporations' policy of compliance with federal and state laws and its own ethical standards.

UNANIMOUSLY ADOPTED this first day of September 1997 upon motion duly made and seconded.

Revisions approved by Board.



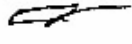
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John M. Lilley  
President

May 1, 2002

MEMORANDUM

TO: Steve McFarlane  
Faculty, staff, residents and students of the  
University of Nevada School of Medicine

FROM: John Lilley 

SUBJECT: Code of Conduct for the University of Nevada  
School of Medicine

I have read and hereby approve the Code of Conduct for the University of Nevada School of Medicine. From this date forward, any violation of the Code of Conduct may give rise to disciplinary action pursuant to the UCCSN Code, chapter 6, under section 6.2.2(t).

Attachment

## **Code of Conduct for University of Nevada School of Medicine**

To fulfill its health care mission of education, research and service to patients, UNSOM adopts the following standards of ethics and conduct, which shall be followed by each member of the UNSOM community. In this Code of Conduct, the term “staff/faculty” includes all UNSOM staff and faculty members, MedSchool Associates North and MedSchool Associates South employees, independent contractors of MedSchool Associates North and MedSchool Associates South including residents and medical students that are involved in the delivery of professional medical services to patients or are involved in the preparation or submission of claims to third party payers, relevant independent contractors, that deliver care to UNSOM’s patients or are involved in the preparation or submission of claims to third party payers, directors and officers of MedSchool Associates North and MedSchool Associates South.

### **Quality of Care**

The UNSOM health care professionals will provide quality health care in a manner that is appropriate, medically necessary, and efficient.

1. All patients of UNSOM will be afforded quality clinical services.
2. Urgent and/or emergent services will be provided independent of payment methodology.
3. To the extent possible, UNSOM health care professionals will involve patients, and family members in decisions regarding the care delivered.
4. UNSOM recognizes the right of patients to make choices about their own care, including the right to do without recommended care or to refuse treatment.
5. UNSOM personnel, generally the patient’s health care provider or knowledgeable designee, will inform patients about the therapeutic alternatives and risks associated with the care they are seeking and obtain the informed consent of the patient or their representative.

### **Fair Treatment of Personnel**

UNSOM is committed to providing equal employment opportunity and a work environment where each employee is treated with dignity and respect.

### **Compliance and the Law**

It is the responsibility of UNSOM and each member of the UNSOM community, including the University’s staff and faculty and relevant agents, representatives, contractors and vendors, to follow all applicable laws and regulations, and to maintain a health care and business environment that is committed to integrity and ethical conduct. Any one who becomes aware of a violation of the law or the compliance policies set forth in the Code of Conduct is responsible to report it to his/her supervisor and the Compliance Officer.

Physicians, billing representatives, and relevant independent contractors must abide by all laws and regulations governing financial and billing transactions. These regulations include rules against mishandling billing and claims, offering or receiving kickbacks, conflicts of interest, making inappropriate patient referrals, destroying the environment, and unfairly influencing market competition. Further information regarding specific laws and regulations can be obtained from the Billing Compliance Office at (702) 671-6447 in Las Vegas or (775) 784-6317 in Reno.

## **Code of Conduct cont...**

Anyone who wants to make a report of a potential problem may contact the Compliance Officer by calling an anonymous, confidential Billing Compliance Hotline at 866-671-2230, or by sending an email to Jeff Wyatt at [JWyatt@med.unr.edu](mailto:JWyatt@med.unr.edu) or Tammy Boring at [tboring@med.unr.edu](mailto:tboring@med.unr.edu) in Las Vegas or Cynthia Brown, M.D. at [cmb@med.unr.edu](mailto:cmb@med.unr.edu) in Reno.

### **Billing and Claims**

UNSOM is committed to charging, billing and submitting claims for reimbursement only when professional services and supervision of resident services have been provided and documented in the manner required by laws and regulations. Employees, faculty, staff, directors, officers, agents and independent contractors either providing professional services or involved in billing for such services should know and carefully follow the applicable rules for submission of bills and claims for reimbursement on behalf of UNSOM. If you know or suspect that a bill or claim for reimbursement is incorrect, you are required to report it immediately to your supervisor and to the Compliance Officer.

### **Documentation of Health Care Services and Research**

It is essential that the delivery of health care services and the conduct of research activities be documented as required by laws and regulations. It is only through good documentation that the nature, quantity, and quality of services and activities can be communicated to third party payers, granting agencies and other health care providers. All physicians and independent contractors providing resident attending services must follow the documentation rules in the Medicare Teaching Physician guidelines as well as all applicable Nevada Medicaid guidelines, other federal healthcare program guidelines and the guidelines established by Medicare.

### **Anti-Kickback Policy**

When someone who can influence purchasing decisions at UNSOM, takes money or anything of value from a vendor, it can be considered a kickback. It can also be considered a kickback if someone refers a patient to another provider or a hospital and receives something of value in exchange. No one working at UNSOM or immediate family members of a UNSOM employee can take a kickback. If there is a concern about a potential kickback violation such as group purchasing arrangements and price reductions for health care plans, the Compliance Officer should be consulted before entering into any transaction to which this rule may apply. If you know of or suspect a kickback arrangement, you should report it to your supervisor and the Compliance Officer. These anti-kickback rules also apply to the recruitment of physicians, recruitment of research subjects, and the acquisition of physicians' practices.

### **Patient Referrals**

Referrals of patients to services outside of UNSOM are important to the delivery of appropriate patient care. If a referring physician, or his or her immediate family member, has an ownership or financial interest in the entity to which a patient is referred, and payment for the referred services will be made from a federal or state health care program, (such as Medicare, and Medicaid), a federal law, commonly referred to as the "Stark Law," may prohibit the referral.

## **Code of Conduct cont...**

No UNSOM physician shall refer a patient for services in violation of the law. If a physician has questions about referrals, he/she should consult with the Compliance Officer.

### **Market Competition**

To insure compliance, UNSOM prohibits various practices, including setting charges in collusion with competitors, certain exclusive arrangements with vendors and the sharing of confidential information with competing providers (such as current information of future plans regarding salaries or charges for services provided). UNSOM faculty, staff, directors, agents and relevant contractors must comply with all state and federal antitrust (monopolies) laws and regulations.

### **Purchasing**

All purchasing decisions must be made without any conflicts of interest that could affect the outcome. Any concerns about the legality of a proposed transaction, such as inducements offered by a vendor or supplier, must be discussed with the supervisor or the Compliance Officer. Purchasing policies established by MedSchool Associates North, MedSchool Associates South and the University of Nevada School of Medicine provide additional guidance and should be consulted prior to any purchasing decision.

### **Conflicts of Interest**

UNSOM faculty/staff must avoid potential or perceived conflicts of interest. This includes gifts from patients and gifts or entertainment received from vendors. A violation of a conflict of interest policy may also constitute a violation of the anti-kickback rules. The Faculty/staff shall be familiar with and adhere to the anti-kickback rules and regulations.

### **Federally Funded Grants**

UNSOM faculty/staff shall follow all applicable federal regulations relating to accurate reporting and appropriate expenditure of grant funds. Questions concerning grants should be directed to the UNR Office of Grants and Contracts or the Compliance Officer to ensure that all regulations are observed.

### **Scientific Integrity**

UNSOM participates in research grants and clinical trial studies. UNSOM faculty, staff, directors, agents and relevant contractors must follow all laws and regulations related to scientific research. UNSOM faculty/staff who have information about inappropriate activities connected with research should contact the Compliance Officer.

In the interest of maintaining the highest standards of patient care and scientific integrity, researchers and physicians must familiarize themselves with all federal and state laws governing their activities. Regulations relating to documentation of all medical services and research, federally funded grants, and scientific integrity can be obtained by contacting the UNR Office of Sponsored Projects Administration or the Compliance Office.

### **Environment**

UNSOM is committed to complying with all laws and regulations respecting the conservation and protection of the environment, including laws requiring the safe disposal of all waste,

## **Code of Conduct cont...**

including hazardous waste. UNSOM will cooperate with appropriate authorities to remedy environmental contamination for which UNSOM is found to be responsible. Regulations and procedures regarding environmental safety and compliance can be obtained by contacting the University's Office of Environmental Health and Safety (EH&S) at 775-327-5040.

### **Safety**

The UNSOM supports the University's goal to ensure the safe and healthy learning, research, work and student living environments for faculty, staff, students, residents, and visitors. As such, all faculty, staff, students and residents must be vigilant in order to avoid unsafe acts which could jeopardize their own health and safety, or which could put others at risk. All persons are expected to learn and follow approved safety standards and procedures which apply to their activities, and to check with their supervisors, MedSchool Associates South Director of Human Resources, MedSchool Associates North Director of Human Resources, or the University's Office of Environmental Health and Safety (EH&S) when they have any questions concerning potential hazards or individual obligations to protect the environment.

### **Confidentiality**

UNSOM staff and faculty do have access to sensitive, confidential information about patient care and research records. UNSOM prohibits the unauthorized seeking, disclosing, or giving of confidential information, particularly information contained in a patient's medical record related to a patient's care. UNSOM faculty/staff who know of any unauthorized release of confidential patient information should report the matter immediately to his or her supervisor, the Compliance Officer, and the Privacy Officer.

### **Controlled Substances**

UNSOM prohibits the unlawful possession, use, manufacture or distribution of illicit and illegal drugs on its property or as part of any UNSOM sponsored activity. All healthcare professionals, including those who maintain Drug Enforcement Agency (DEA) registration, must comply with all federal and state laws regulating controlled substances. Any staff member who knows or suspects the unlawful or unauthorized possession, use, manufacture or distribution of illicit drugs must immediately notify his or her supervisor and the Compliance Officer.

### **Discrimination**

UNSOM is committed to equal employment and educational opportunity. In conformity with federal and state law, and university policy and policies of MedSchool Associates North and MedSchool Associates South, we are guided by the principle that there shall be no discrimination against individuals because of race, color, creed, religion, national origin, sex, age, disability, veteran status, or sexual orientation. Equal opportunity and access to programs shall be available to all members of the UNSOM community and to employees, agents, directors and relevant contractors of Medschool Associates North and Medschool Associates South and, both students and employed personnel at every level, and to all units, facilities and services of UNSOM..

### **Response to Investigation**

It is the obligation of UNSOM to cooperate with government investigators as required by law. If an employee receives a subpoena, search warrant or other similar document, before taking any action, the employee will immediately contact the Compliance Officer at (702) 671-2230 in

## **Code of Conduct cont...**

Las Vegas and (775) 784-1128 in Reno who will then notify legal counsel. The Compliance Officer or its legal representative is responsible for authorizing the release or copying of documents. If a government investigator, agent or auditor comes to UNSOM, the Compliance Officer and the Office of the Dean must be contacted immediately before discussing any matters with such investigator, agent, or auditor.

### **Disciplinary Action**

All UNSOM employees, officers, directors, staff and faculty as well as independent contractors and agents of UNSOM that deliver care to UNSOM's patients or are involved in the preparation or submission of claims to third party payers must carry out their duties for UNSOM as stated in these policies. Any violation of applicable law or violation of this code will subject such individual (s) or group (s) to disciplinary action in accordance with the University and Community College System of Nevada (UCCSN) code, UCCSN Board of Regents policies, and or policies and procedures established by the University of Nevada School of Medicine Multi-Specialty Group Practice South, Inc. These disciplinary actions also may apply to a supervisor who directs or approves the person's improper actions, is aware of those actions but does not act appropriately to correct them, or who otherwise fails to exercise appropriate supervision.

### **Obligation to Report Violations**

If at any time any member of UNSOM's staff/faculty, as well as UNSOM's independent contractors and agents becomes aware of any apparent violation of UNSOM's legal compliance policies, he/she must report it to his/her supervisor and to the Compliance Officer. Be assured that these reports will be treated as confidential and will be shared with others only on a bona fide need-to-know basis. UNSOM will take no adverse action against anyone making these reports in good faith, whether or not the report ultimately proves to be well founded. If a staff/faculty member or independent contractor or agent does not report conduct violating UNSOM's legal compliance policies, the staff/faculty member may be subject to disciplinary actions, in accordance with UCCSN Code, UCCSN Board of Regents policy and/or policies and procedures established by the University of Nevada School of Medicine Multi-specialty Group Practice South, Inc., and may be terminated from employment and the independent contractors/agent's contracts with UNSOM may be immediately terminated.

### **Independent Contractors, Vendors and Agents**

All contractors and vendors who provide services to UNSOM must comply with all applicable laws, UNSOM policies, and the provisions contained on this code of conduct..

This provision supersedes any statements to the contrary contained in the agreement between the independent contractor and agent. The independent contractor and agent hereby agree that this Code of Conduct becomes an amendment to the agreement between UNSOM and the independent contractor/agent upon independent contractor/agent signing the Code of Conduct receipt and acknowledgement.

## **Code of Conduct cont...**

Anyone wanting to make a report of a suspected wrongdoing or a potential problem may contact the Compliance Officer at (702) 671-2230 in Las Vegas or (775) 784-1128 in Reno, or call an anonymous, confidential Compliance Hotline at 866-671-2230 or send an email to Jeffrey Wyatt at [jwyatt@med.unr.edu](mailto:jwyatt@med.unr.edu) or Tammy Boring at [tboring@med.unr.edu](mailto:tboring@med.unr.edu) in Las Vegas or Cynthia Brown, M.D. at [cmb@med.unr.edu](mailto:cmb@med.unr.edu) in Reno.

Date Created: March 8, 2002

Date Revised: May 11, 2004

## **PURPOSE AND OBJECTIVES OF PROGRAM**

The purposes and objectives of this Program are to:

- 1.** Establish standards and procedures to be followed by all Corporations Representatives to effect compliance with applicable federal, state and local health care laws, regulations and ordinances.
- 2.** Designate a Corporation Representative responsible for directing the effort to enhance compliance, including implementation of this Program.
- 3.** Document the Corporation's compliance efforts.
- 4.** Ensure Discretionary Authority is not given to inappropriate person.
- 5.** Provide a means for communicating to all Corporation Representatives the standards and procedures all are expected to follow.
- 6.** Establish minimum standards for billing and collection activities, including a system of monitoring and oversight of billing activity to ensure adherence to the standards and procedures established.
- 7.** Provide a means for reporting questionable billing activities to the Corporation.
- 8.** Provide for the verification of compliance with this Program including audit performed through corporate legal counsel.
- 9.** Provide a mechanism to investigate any alleged violations and to prevent violations in the future.
- 10.** Increase training of Corporation Representatives concerning applicable billing requirements.
- 11.** Provide for regular review of overall Corporation compliance efforts to ensure that practices reflect current requirements and other adjustments are made to improve this program.

## **SCOPE AND IMPLEMENTATION OF THE PROGRAM**

This Program shall be adopted by the Board of Directors ("Integrated Clinical Services") of the Corporation. The Vice Dean of the Corporation or his/her designee shall be designated as Chair of the Compliance Committee and shall report to the Dean of the School of Medicine as stated in this Program. All Corporation Representatives are required to participate in this Program. The Chief Compliance Officers of the Practice Corporations will be designated by the Dean of the University of Nevada School of Medicine to serve terms at the full discretion of the Dean.

A Compliance Committee will be established by the Board of Directors and consist of faculty representatives from various departments and Board appointed administrative representatives. The committee will be chaired by the Vice Dean and will meet on a monthly basis. Compliance Committee members are charged with establishing standards for documentation and dictation of physician's progress notes, as well as with the ongoing process of monitoring and evaluating the quality and appropriate use of ICD-9 & CPT codes and the billing of codes related to those standards.

The Compliance Committee and will be responsible for implementing and sustaining the compliance program. The Committee members are expected to understand the seriousness of non-compliance, the vulnerability of the auditor's position, and the confidential nature of the information collected on each physician. The Compliance Committee shall ensure that guidelines for implementation of and compliance with this Program are adopted and that copies of all relevant materials are provided to all Corporation Representatives. In particular, guidelines regarding the justification and documentation requirements for Medicare and Medicaid billing, and submission of claims, shall be provided to all Corporation Representatives.

## **Duties and Responsibilities of the Compliance Committee**

In addition, with the assistance of the Compliance Committee the Compliance officer shall:

1. Be responsible for the functioning of this Program in his/her area of responsibility and ensure communication of the standards and procedures of this Program to each Corporation Representative.
2. Ensure that every Corporation Representative involved in the billing process attends presentations regarding this Program at least annually.
3. Encourage every Corporation Representative to report all possible illegal conduct to the Compliance Officer.
4. Assure compliance with this Program.
5. Promptly investigate any reports of possible illegal conduct received.
6. Ensure that all audits, investigations, records and proceedings of the Corporation is reported or available to the Compliance Officer.
7. As the designated representative of the Corporation, make reports from and to each entity in a manner that, to the extent practical, is only on a need to know basis; and as appropriate, provide information directly to the Dean or the legal counsel for the Corporation.
8. Acting on behalf of the Corporation, give annual certification of substantial compliance with this Program to the Compliance Officer's best knowledge.
9. Be responsible for the direction of the Compliance Program and ensure adherence of the plan.

## **Duties & Responsibilities of the Compliance Officer**

The Compliance Officer shall monitor the compliance efforts of the Corporation to implement the provisions of this Program. The Compliance Officer shall verify annually in writing to the Board that the Corporation has:

1. Established compliance standards and procedures that are reasonably capable of reducing the prospect of illegal conduct.
2. Designate specific individuals with a sufficient level of authority to oversee compliance with the compliance standards and procedures adopted by the corporation.
3. Not appoint any person who the Corporation knows has intentionally engaged in illegal billing activities to a position in which the person will have Discretionary Authority, and the Corporation shall take reasonable steps to verify that applicants for positions requiring the exercise of Discretionary Authority have no history of illegal activity.
4. Communicate effectively the standards and procedures to be followed by Corporation Representatives, and establish a mechanism to report possible illegal conduct without retribution.
5. Use monitoring and auditing systems reasonably designed to detect illegal activities; and achieve substantial compliance with the applicable standards and procedures to the best of the Compliance Officer's knowledge.
6. Consistently enforce appropriate disciplinary mechanisms for responsible individuals who commit illegal acts or who are responsible to and fail to detect illegal conduct.
7. Implement effective compliance practices to prevent reoccurrence of illegal conduct; responded appropriately to any reports of possible illegal conduct; and modified standards and procedures as necessary to achieve compliance.
8. Substantially comply with its approved audit plan as submitted.

If the Corporation fails to substantially comply with the provisions of the above paragraph, the Dean may require the engagement of an independent external organization with appropriate expertise to conduct an audit of specific activities of the Corporation. Any such required audit is to be conducted through legal counsel for the Corporation under the protection of attorney-client privilege and will be paid for by the Corporation. The required audit and, if so indicated, appropriate corrective action will be promptly taken by the Corporation.

## **TRAINING AND EDUCATION**

Training is recognized as a critical part of this compliance program. In addition to the rules and regulations specific to the Corporation, faculty positions and employee positions, training in billing compliance issues are deemed to be a key element to be addressed by the Corporations training programs.

The Compliance Officer, or his/her designee and the Compliance Committee will be responsible for developing and monitoring ongoing education relating to billing compliance. Initial educational sessions will focus on introducing Medicare compliance to all new employees, emphasizing their responsibilities. The Compliance Committee and the Compliance Officer will coordinate the integration of compliance training into the orientation process for new faculty and employees including providing a copy of this manual and acquiring the signature of all faculty and employees on the attestation to compliance form.

Some employees may receive specialized training tailored for their respective responsibilities. Annual Billing Compliance training will be conducted and required for all established and new faculty. Education may be provided through a variety of means, including orientation, written materials, newsletters, staff meetings, and formal internal and external education. This specialized training may focus on complex areas or on areas for which the Compliance Officer or Compliance Committee have deemed as high risk.

The Compliance Officer will oversee the establishment and maintenance of a mechanism to monitor continuing education specific to the individual employee's position and responsibilities.

## **PREVENTION OF IMPROPER INDUCEMENTS, KICKBACKS AND SELF-REFERRALS**

All faculty, staff, agents, vendors and independent contractor's of Integrated Clinical Services must not accept or offer, (for themselves or for Integrated Clinical Services), anything of value in exchange for referrals of business or the referral of patients to Integrated Clinical Services.

In general, all business arrangements where faculty, staff, agents and independent contractors of Integrated Clinical Services refer patients or other business to outside agencies or where these 3 entities receive patient referrals or other business from third parties, should be conducted on the basis of fair market value for services rendered. In all situations where business opportunities result in referrals from or to Integrated Clinical Services, the proposed documents supporting the business arrangements must be reviewed and approved by the Chief Business Officers of the practice corporations and/or the Dean's Office of Integrated Clinical Services (depending upon the entity engaged) and legal counsel for the practice corporations and Integrated Clinical Services, if appropriate.

Joint ventures and partnerships with outside/third party entities can create potential compliance problems. The nature of the relationship and the transfer of consideration between partners can create inappropriate incentive or inducement arrangements. Therefore, all joint ventures and partnership proposals must be reviewed and approved by the respective Chief Business Officers of the practice corporations and/or the Dean's Office of Integrated Clinical Services (and legal counsel, if appropriate). In addition, medical directorship contracts and consulting contracts can create compliance issues. Any proposed medical direction contracts and consulting contracts must be reviewed and approved by the Chief Business Officers of the Practice Corporations and/or the Dean's Office of Integrated Clinical Services (and legal counsel, if necessary).

All faculty, staff, agents and independent contractors of Integrated Clinical Services may not offer or receive any item or service of value as an inducement for the referral of business or patients to or from the Practice Corporations or the Integrated Clinical Services.

The Practice Corporations and Integrated Clinical Services maintain policies that prohibit the waiver of coinsurance or deductible amounts that are due from patients unless bona fide financial hardship is displayed. All faculty, staff, agents and contractors providing health care services or who are involved in processing or submitting bills for services are required to read, understand and abide by the financial hardship procedures developed by the Practice Corporations.

## **REDUCING THE RISK OF IMPROPER CODING AND IMPROPER BILLING; DOCUMENTING MEDICAL NECESSITY AND COVERED BENEFITS**

Integrated Clinical Services are committed to ensuring that claims submitted for payment to all payers, including Federal, State and local government agencies, private insurers and individuals, are accurate, appropriately reflect the actual services that were delivered and are submitted in conformity with all rules, regulations and requirements established by the individual payers. Accordingly, all faculty, staff, agents and independent contractors who are responsible for providing healthcare services and for documenting, coding, billing and accounting for patient care services must comply with all applicable Federal, State and other third party payer regulations and all Practice Plan and School of Medicine procedures and relevant activities and programs.

To protect against improper coding and billing, all staff, faculty, agents and independent contractors providing healthcare services or who are involved in submitting claims for those services must adhere to the following guidelines and procedures:

1. Familiarize themselves with Federal, State, local and other third party payer billing rules and regulations by reviewing Medicare Part B News distributions, the Medicare Part B Billing Manual, the Nevada Medicaid Billing Manual and billing provider manuals promulgated by private third party payers. A compendium containing these documents must be retained in each department and each departmental clinical site as a reference tool. Additionally, these individuals are required to read, understand and comply with all billing and collection rules, regulations, policies and procedures promulgated by the Practice Corporations and Integrated Clinical Services.
2. Under no circumstances will Integrated Clinical Services or the Practice Corporations tolerate the submission of bills that misrepresent the services that were delivered. All faculty and staff involved in the coding of services and the submission of bills have a duty to ensure the accuracy of the claims submitted through all reasonable processes including, but not limited to, review of the supporting documentation, consultation with the treating healthcare provider, consultation with coding specialists employed or contracted by the Practice Corporations, consultation with the Director of Billing Compliance and/or the Chief Compliance Officer and direct contact with the billing support staff of the involved payer.
3. Supporting medical documentation must be completed for all services rendered and maintained in the medical chart for all patient encounters. That documentation must be legible and in conformity with all requirements established by applicable Federal, State and local governmental agencies and all other third party payers. All faculty, staff, agents and independent contractors providing healthcare services or who are involved in billing for those services shall perform their duties based on the principle that services that are not completely, accurately and legibly documented have not been provided and cannot be billed. Additional guidance on correct.

## **REDUCING THE RISK OF IMPROPER CODING AND IMPROPER BILLING; DOCUMENTING MEDICAL NECESSITY AND COVERED BENEFITS cont....**

documentation can be found in the sections titled, “Documentation Standards,” “General Principles of Medical Record Documentation”, and “Standards for Documentation” in this Compliance Handbook.

4. Billed charges for all services provided will be consistently and uniformly applied to all accounts through consistent use of the approved fee schedules for the Practice Corporations. Discounts from billed charges will be applied in accordance with approved contracts with payers, approved financial hardship and other processes established by the Practice Corporations and Integrated Clinical Services.
5. Services that are delivered to patients that are not covered by Federal, State, or local governmental healthcare programs or by private third party payers cannot be billed to the third party payers. Additionally, these services cannot be billed to the individual patients unless the patients agree to pay for the services and have been advised of their payment responsibilities in writing, in advance of the services being rendered through the use of the Advance Beneficiary Notice (ABN) for Medicare patients and a modified ABN form for all other payers. The forms must be maintained in the patient’s medical records with copies maintained with the billing records.
6. All charge data, charge adjustment/write off data, and all collection data will be accurately recorded and maintained in the appropriate accounts. Credit balances in patients accounts must be reviewed, researched and processed in a timely manner in accordance with applicable rules and regulations. Any duplicate payments or overpayments resulting in credit balances require immediate processing with immediate refund of any overpayment to the payer or patient.
7. All faculty, staff, agents and independent contractors providing healthcare services or items to patients shall do so only if those services or items are consistent with generally accepted medical standards for diagnosis or treatment of disease and are determined by the provider to be medically necessary and medically appropriate in the particular case. This requirement also extends to any tests, including screening tests that providers may request. Governmental and private third party payers will only reimburse for services and items that meet the relevant payers’ definition of reasonable and necessary. Hence, the Practice Corporations shall only bill for services that meet the relevant payers’ standard of being reasonable and necessary for the diagnosis and treatment of a patient. The Practice Corporations can bill in order to receive a denial for services, but only if the denial is needed for reimbursement from a secondary payer.

**REDUCING THE RISK OF IMPROPER CODING AND IMPROPER BILLING; DOCUMENTING MEDICAL NECESSITY AND COVERED BENEFITS cont....**

8. Under no circumstances will any faculty member, staff member, agent or independent contractor providing healthcare services knowingly use his or her provider number, or another provider's number, in a manner that results in improper billing. This prohibition includes, but is not limited to, using another provider's identification number to bill for services rendered by the provider during the period before the provider has been issued his or her own billing provider number. Additionally, these individuals will use all means reasonably necessary to protect against the misuse of their provider identification numbers.
9. Providers and others involved in the submission of bills for payment by third party payers shall not knowingly unbundled services by billing for multiple components of a service that must be billed as a single fee.
10. Providers and others involved in the submission of bills for payment by a third party payer shall not knowingly select a CPT-4 code for a service rendered that is higher than the level of service that is supported by the documentation for the service (up-coding) and shall not select one or two mid-level codes exclusively for all of a similar type services provided under the philosophy that some would be higher, some lower, and the charges would average out over time (clustering).
11. Appropriate coding modifiers, designed to accurately reflect the services rendered by providers, will be correctly applied to all bills submitted for reimbursement to all third party payers. Independent contractor billing agencies and all internal billing staff shall contact the relevant providers to determine whether appropriate modifiers were used or whether a modifier should be added in all circumstances where the addition of modifiers or the correct use of a modifier by a provider is questioned. Additional guidance on the correct use of modifiers is provided in the section entitled, "CPT Definitions", under the sub paragraphs titled, "Modifiers".

## **Creation and Retention of Compliance and Medical Records Delivered, Owned or Operated by the Practice Plan and Integrated Clinical Services**

All patient records reflecting healthcare services delivered by faculty, staff, agents and independent contractors of the Practice Plans and Integrated Clinical Services are the property of the Practice Plans and Integrated Clinical Services. Additionally, compliance records and institutional records are the property of the Practice Plans and Integrated Clinical Services. All individuals responsible for the preparation and retention of patient, compliance and institutional records shall ensure that those records are accurately prepared and maintained in accordance with applicable laws and policies and procedures established by the Practice Plans and Integrated Clinical Services.

Specifically:

1. Faculty, staff, agents and independent contractors will not knowingly create records that contain any misleading, false, deceptive or fraudulent information.
2. No faculty member, staff member, agent or independent contractor is authorized to delete any information from a record. Additionally, no party listed above is authorized to destroy any record or any portion of any record unless that destruction is in accordance with policies established by the Practice Plans and/or Integrated Clinical Services and such destruction is not in violation of any law or regulation promulgated by any entity having authority over the Practice Plans and/or the School of Medicine.
3. No faculty member, staff member, agent or independent contractor is authorized to sign a record on behalf of another person or affix the initials of another person to any records. Electronic signatures and signature stamps can be utilized in accordance with policies established by the Practice Plans and Integrated Clinical Services. Electronic signatures and signature stamps must be protected at all times and access must be limited to authorized users.
4. All records that are the property of the Practice Plans and the Integrated Clinical Services must be maintained in accordance with accepted standards and principles established within the particular profession and in accordance with applicable policies and procedures adopted by the Practice Plans and Integrated Clinical Services. These policies and procedures must be consistent with Federal, and State requirements regarding the appropriate time period for maintenance and location of records.
5. All medical records in the possession of the Practice Plans or Integrated Clinical Services must be secured against loss, destruction, unauthorized access, unauthorized reproduction, corruption or damage in accordance with applicable Federal and State laws and the policies and procedures of the Practice Corporations and Integrated Clinical Services.

**Creation and Retention of Compliance and Medical Records Delivered,  
Owned or Operated by the Practice Plan and Integrated Clinical Services**

cont...

6. All billing, compliance records, including but not limited to evidence of educational activities, documents outlining internal investigations and internal audit activities and results, must be maintained in the office of the Director of Billing Compliance for a minimum of 7 years established by the Practice Corporations and Integrated Clinical Services.

## **REPORTING AND INVESTIGATION OF POTENTIAL VIOLATIONS OF THE COMPLIANCE PROGRAM**

The Corporation is committed to investigating all potential violations of Federal healthcare program standards and requirements; violations of state and local healthcare program requirements, violations of the Institutional Compliance Agreement between the South Practice Corporation, and the OIG, violations of the Compliance Handbook and Code of Conduct. Adherence with these standards and requirements is of paramount importance, as the consequences to both the Practice Corporations and individual faculty, employees, agents and independent contractors can include but is not limited to, fines, penalties, treble damage, assessments, debarment or exclusion from participation in Federal healthcare programs and criminal prosecution. Therefore, faculty, employees, agents and independent contractors must remain steadfast in reporting potential violations and the corporations, the Compliance Officers and the Compliance Committee must diligently pursue and investigate all potential violations and act to implement corrective actions.

### **A. Reporting Violations**

Any Corporation Representative may report instances of possible illegal conduct directly to the Compliance Officer by calling the Hotline Number at 866-671-2230. The Corporation shall establish a mechanism to receive reports establish a mechanism to receive reports of possible illegal conduct from any Corporation Representative or other persons, as well as provide an access point for persons to receive information or ask questions concerning the Program. Such reports may be anonymous; however, informants are encouraged to provide as much information as possible, including their names, in order to facilitate investigation of all allegations. Each Corporation Representative involved in the billing process will be required to sign an annual verification as to his/her knowledge of any possible illegal conduct. Failure to report knowledge of wrongdoing may, itself result in disciplinary action. Any manager or supervisor receiving a report of possible illegal conduct must immediately advise the Compliance Officer.

### **B. No Retaliation**

No adverse action or any form of retaliation shall be taken by the Corporation against any person because of that person's good faith report of possible illegal conduct.

### **C. Investigating Reports of Possible Illegal Conduct**

1. Upon receiving a report of possible illegal conduct, the Compliance Officer shall promptly initiate an investigation. The Compliance Officer may consult with or instruct legal counsel to conduct the investigation. Investigations may also be referred by the Compliance Officer to the Dean and investigation may be conducted jointly.
2. A complete and accurate record of each investigation, including recommendations for corrective action, shall be maintained by the Compliance Department for a period of six years.

## **REPORTING AND INVESTIGATION OF POTENTIAL VIOLATIONS OF THE COMPLIANCE PROGRAM cont...**

3. Upon the conclusion of an investigation, the Compliance Committee will recommend corrective action to the Board, if appropriate.
4. Audits are invaluable educational tools. Each time a physician is reviewed, either randomly or as a result of a reported incident, a letter shall be sent to the physician informing them of the preliminary audit results. After the meeting with the physician the results are finalized.

### **D. Corrective Action**

The goal of this Program is to detect and promptly correct activity which does not comply with the standards adopted pursuant to this Program. Attempts will be made to discuss and resolve issues in cooperation with the persons involved, when applicable. Illegal conduct shall be dealt with promptly, and shall be reported to the applicable authorities.

Appropriate corrective action should be consistent with the nature of the conduct and the surrounding circumstances including, but not limited to, the requirement that future billing be handled in a designated way, that additional training and education take place, that restrictions be placed on billing by certain providers, or that repayment be made (see Corrective Action).

### **E. Limited Disclosure**

The identity of any person who reports any possible illegal conduct to the Compliance Officer shall be disclosed, to the extent practical, only on a need to know basis or as required by law. Unauthorized disclosure of information may be grounds for appropriate disciplinary action.

## **CORRECTIVE ACTION**

### **Educational**

Correctional educational action is developed and implemented based on audit outcomes, or is the result of an investigation conducted under the direction of the Compliance Committee in response to reported incidents.

It is intended to provide correct knowledge, increase performance, and to reduce system deficiencies that cause the identified problems. Corrective educational action is generally appropriate for physicians that have been audited for the first time. However, the Compliance Committee determines if educational corrective action is the appropriate action on a case by case basis. If further corrective action is deemed appropriate, the decision may be made with the Compliance Committee, Dean, Department Chairman, Board of Directors, possible legal counsel and others deemed appropriate.

Corrective educational action is developed and implemented after the identified problem has been audited. The appropriate corrective educational action is developed to correct and increase the defined knowledge of the physician regarding documentation and coding of E/M services, improve individual physician performance, and identify causes of system problems. The Compliance Officer is responsible for the development, implementation and degree of corrective educational action assigned to each provider.

Developed corrective educational action describes:

- All corrective actions required to resolve knowledge deficits, performance issues and system causes.
- Measurable objectives for each corrective educational action, including degree of expected change in the physician's documentation and coding skills.
- Person(s) responsible for implementing/monitoring/evaluating/reassessing corrective educational action.
- Date corrective educational action is to be implemented.
- Date corrective educational action is to be evaluated for effectiveness in problem resolution.

Corrective educational action will be forwarded to the Compliance Committee, Dean, and the Department Chair.

## **CORRECTIVE ACTION - cont....**

### **Billing Restrictions**

The Compliance Committee may recommend that future billing of a physician be handled in a certain way to better monitor documentation and billing practices. The method and timeline will be outlined by the Compliance Committee and given to the Department Chairman and the Physician.

The Compliance Committee may recommend that restrictions be placed on the services a physician may provide due to compliance violations. The recommendation will be forwarded to the Department Chairman and Dean for approval.

### **Dismissal**

Repeated compliance violations, intentional violations or fraudulent or illegal activity are grounds for dismissal from the practice plan or corporation. The Compliance Officer can recommend dismissal after consulting with legal counsel, the University, the Department Chairman and the Dean.

## **AUDITING PROCESS**

### **BILLING - RANDOM**

Because payers have a contractual obligation to enrollees, they require reasonable documentation that services are consistent with the insurance coverage provided. Many insurance companies, including Medicare, track billing histories on practitioners. The purpose is to look for either an unusually high number of procedures or an unusually high number of high-level CPT codes for the practitioner's area of expertise. The Corporation uses the National E&M Bell Curve reports physician specialty to compare and pick up any aberrancies related to billing and coding of per physicians. This tool allows the Compliance Department to then focus audit activities on these specific CPT codes.

Monthly, the compliance committee will be given a practice report segregated by physician. The report will show the breadth and frequency of CPT evaluation and management (EM) codes used during the previous time period. From this report the committee will select which physicians will be audited. The OIG Random Number Generator will randomly choose ten outpatient charts for the physicians chosen to be audited. After obtaining the corresponding encounter form, the identifying information is entered and the criteria that have been met will be checked off using the review form (located in Part II of this manual) for each audited encounter. The physician documentation meets the criteria; the progress note will still copied. The progress note is copied and attached to the review form. All Review Forms will be turned into the Compliance Department for review by the Compliance Officer. A copy of the review form and progress note will be given at the request of the audited physician. If it is determined after a random audit that an investigation is necessary the steps outlined in the "Reporting and Investigating Violations" section of this manual will be followed beginning with a Focused Review.

#### **Focused Review**

Any practitioner that fails the random audit (error rate above 5%) will be subject to a Focused Review which will encompass an audit sample of charts for the previous quarter. Results will be forwarded to the Compliance Officer for review by the Compliance Committee. Corrective Action shall be determined following the guidelines outlined in the "Reporting and Investigating Violations" section of this manual.

#### **Billing –Reported**

Once the Compliance Officer receives a "Report of Violation" a Focused Review (as outlined in the "Audit Process Billing-Random" section of this manual) will be conducted on the practitioners' charts for the area cited as a possible violation.

Corrective Action will be undertaken as outlined in the "Reporting and Investigating Violations" section of this manual.

# Appendix

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# **1995 DOCUMENTATION GUIDELINES FOR EVALUATION & MANAGEMENT SERVICES**

## **I. INTRODUCTION**

### **WHAT IS DOCUMENTATION AND WHY IS IT IMPORTANT?**

Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient and is an important element contributing to high quality care. The medical record facilitates:

- the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time;
- communication and continuity of care among physicians and other health care professionals involved in the patient's care;
- accurate and timely claims review and payment;
- appropriate utilization review and quality of care evaluations; and
- collection of data that may be useful for research and education.

An appropriately documented medical record can reduce many of the "hassles" associated with claims processing and may serve as a legal document to verify the care provided, if necessary.

### **WHAT DO PAYERS WANT AND WHY?**

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

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.

## **II. GENERAL PRINCIPLES OF MEDICAL RECORD DOCUMENTATION**

The principles of documentation listed below are applicable to all types of medical and surgical services in all settings. For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient's status. The general principles listed below may be modified to account for these variable circumstances in providing E/M services.

1. The medical record should be complete and legible.

2. The documentation of each patient encounter should include:
  - reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
  - assessment, clinical impression or diagnosis;
  - plan for care; and
  - date and legible identity of the observer.
3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient's progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

### III. DOCUMENTATION OF E/M SERVICES

This publication provides definitions and documentation guidelines for the three key components of E/M services and for visits which consist predominately of counseling or coordination of care. The three key components--history, examination, and medical decision making--appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services. While some of the text of CPT has been repeated in this publication, the reader should refer to CPT for the complete descriptors for E/M services and instructions for selecting a level of service. **Documentation guidelines are identified by the symbol •DG.**

The descriptors for the levels of E/M services recognize seven components which are used in defining the levels of E/M services. These components are:

- history;
- examination;
- medical decision making;
- counseling;
- coordination of care;
- nature of presenting problem; and
- time.

The first three of these components (i.e., history, examination and medical decision making) are the **key** components in selecting the level of E/M services. An exception to this rule is the case of visits which consist predominantly of counseling or coordination of care; for these services time is the key or controlling factor to qualify for a particular level of E/M service.

For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

As an example, newborn records may include under history of the present illness (HPI) the details of mother's pregnancy and the infant's status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family. In addition, information on growth and development and/or nutrition will be recorded. Although not specifically defined in these documentation guidelines, these patient group variations on history and examination are appropriate.

**A. DOCUMENTATION OF HISTORY**

The levels of E/M services are based on four types 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 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.)

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

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 or 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*
- *noting 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 which 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.

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

## **HISTORY OF PRESENT ILLNESS (HPI)**

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, and
- 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 four or more elements of the HPI.

DG: *The medical record should describe four or more elements of the present illness (HPI) or associated comorbidities.*

## **REVIEW OF SYSTEMS (ROS)**

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

For purposes of ROS, the following systems are recognized:

- Constitutional symptoms (e.g., fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

A ***problem pertinent*** ROS inquires 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 inquires 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 inquires 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 may be hereditary or place the patient at risk); and
- social history (an age appropriate review of past and current activities).

For the categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care, CPT requires only an "interval" history. It is not necessary to record information about the PFSH.

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 of 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; subsequent nursing facility care; 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; and home care, new patient.*

## B. DOCUMENTATION OF EXAMINATION

The levels of E/M services are based on four types of examination that are defined as follows:

- **Problem Focused** -- a limited examination of the affected body area or organ system.
- **Expanded Problem Focused** -- a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- **Detailed** -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- **Comprehensive** -- a general multi-system examination or complete examination of a single organ system.

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

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

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

- Constitutional (e.g., vital signs, general appearance)
- Eyes
- Ears, nose, mouth and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

The extent of examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s). They range from limited examinations of single body areas to general multi-system or complete single organ system examinations.

DG: Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of "abnormal" without elaboration is insufficient.

DG: Abnormal or unexpected findings of the examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.

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

DG: The medical record for a general multi-system examination should include findings about 8 or more of the 12 organ systems.

### **C. DOCUMENTATION OF THE COMPLEXITY OF MEDICAL DECISION MAKING**

The levels of E/M services recognize four types of medical decision making (straight-forward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered;
- the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- the risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The chart below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of decision making
Minimal	Minimal or None	Minimal	<i>Straightforward</i>
Limited	Limited	Low	<i>Low Complexity</i>
Multiple	Moderate	Moderate	<i>Moderate Complexity</i>
Extensive	Extensive	High	<i>High Complexity</i>

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

### **NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS**

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

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems which are improving or resolving are less complex than those which are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

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

- *For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.*
- *For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnoses or as "possible", "probable", or "rule out" (R/O) diagnoses.*

DG: *The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications.*

DG: *If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.*

### **AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED**

The amount and complexity of data to be reviewed is 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 to be reviewed.

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

DG: *If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, e.g., lab or x-ray, should be documented.*

DG: *The review of lab, radiology and/or other diagnostic tests should be documented. An entry in a progress note such as "WBC elevated" or "chest x-ray unremarkable" is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.*

DG: *A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.*

DG: *Relevant finding from the review of old records, and/or the receipt of additional history from the family, caretaker or other source should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "Old records reviewed" or "additional history obtained from family" without elaboration is insufficient.*

DG: *The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.*

DG: *The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.*

### **RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY**

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

DG: Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

DG: If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure, e.g., laparoscopy, should be documented.

DG: If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.

DG: The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

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

**TABLE OF RISK**

<b>Level of Risk</b>	<b>Presenting Problem(s)</b>	<b>Diagnostic Procedure(s) ordered</b>	<b>Management Options Selected</b>
<b>Minimal</b>	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
<b>Low</b>	Two or more self-limited or minor problems One stable chronic illness, e.g., well controlled hypertension or non-insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain	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	Over-the-counter drugs Minor surgery with no identified risk factors Physical therapy Occupational therapy IV fluids without additives
<b>Moderate</b>	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, eg lumbar puncture, thoracentesis, culdocentesis	Minor surgery with identified risk factors Elective major (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
<b>High</b>	One or more chronic illnesses with severe exacerbation, progression, or side effects of treatments 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, or sensory loss.	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests 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

**D. DOCUMENTATION OF AN ENCOUNTER DOMINATED BY COUNSELING OR COORDINATION OF CARE**

In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.

## **Medicare B News Issue 207 October 14 2003**

**Heading: Clarification**

**Title: Documentation Guidelines Amended Records**

**Effective Immediately**

### **Medical Review Payment Decisions**

Incomplete or illegible records can result in denial of payment for services billed to Medicare. Claim payment decisions that result from a medical review of your records are not a reflection on your competence as a health care professional or the quality of care you provide to your patients. Specifically, the results are based on review of the documentation that Medicare received.

In order for a claim for Medicare benefits to be valid, there must be sufficient documentation in the provider's or hospital's records to verify the services were performed, were "reasonable and necessary", and required the level of care that was delivered.

Please understand that Medicare is aware that some patients do require professional services at greater frequency and duration than others, including more extensive diagnostic procedures. When this is the case, documentation substantiating the medical necessity for such treatment must be in the medical record. The documentation of all services rendered is absolutely necessary in order for a claim to be properly evaluated.

If there is no documentation, then there is no justification for the services or level of care billed. Additionally, if there is insufficient documentation on the claims that have already been adjudicated by Medicare, reimbursement may be considered an overpayment and the funds can be partially or fully recovered.

### **Elements of a Complete Medical Record**

When records are requested, it is important that you send all associated documentation that supports the services billed within the timeframe designated in the written request. Elements of a complete medical record may include:

- Physician orders, and/or certifications of medical necessity
- Patient questionnaires associated with physician services
- Progress notes of another provider that are referenced in your own note
- Treatment logs
- Related professional consultation reports
- Procedure, lab, x-ray and diagnostic reports

### **Amended Medical Records**

Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum, or a correction to the medical record, bears the current date of that entry and is signed by the person making the addition or change.

A **late entry** supplies additional information that was omitted from the original entry. The late entry bears the current date, is added as soon as possible and written only if the person documenting has total recall of the omitted information.

Example: A late entry following treatment of multiple trauma might add: *"The left foot was noted to be abraded laterally."*

An **addendum** is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record.

Example: An addendum could note: *"The chest x-ray report was reviewed and showed an enlarged cardiac silhouette."*

When making a **correction** to the medical record, never write over, or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign and date the deletion, stating the reason for correction above or in the margin. Document the correct information on the next line or space with the current date and time, making reference back to the original entry.

Correction of electronic records should follow the same principles of tracking both the original entry and the correction with the current date, time and reason for the change. When a hard copy is generated from an electronic record, both records must be corrected. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.

## **Falsified Documentation**

Providers are reminded that deliberate falsification of medical records is a felony offense and is viewed seriously when encountered. Examples of falsifying records include:

- Creation of new records when records are requested
- Back-dating entries
- Post-dating entries
- Pre-dating entries
- Writing over, or
- Adding to existing documentation (except as described in late entries, addendums and corrections)

Corrections to the medical record legally amended prior to claims submission and/or medical review will be considered in determining the validity of services billed. If these changes appear in the record following payment determination based on medical review, only the original record will be reviewed in determining payment of services billed to Medicare.

Appeal of claims denied on the basis of an incomplete record may result in a reversal of the original denial if the information supplied includes pages or components that were part of the original medical record, but were not submitted on the initial review.

**Applies to the states of: AK, AZ, CO, HI, IA, NV, ND, OR, SD, WA and WY.**

**Sources:**

**Medicare B News, Issue 196, dated April 15 2002: "Documentation Guidelines for Medicare Services"**

**§1833(e) Title XVIII of the Social Security Act (No Documentation)**

**§1842(a) (1) (c) of the Social Security Act (Carrier Audits)**

**§1862(a) (1) (A) of Title XVIII of the Social Security Act (Medical Necessity)**

**Schott, Sharon. "How Poor Documentation Does Damage in the Court Room." Journal of AHIMA 74, no. 4 (April 2003): 20-24.**

**Dougherty, Michelle. "Maintaining a Legally Sound Health Record." Journal of AHIMA 73, no. 8 (April 2003): 64A-G.**

Posted on: 10/14/2003

# Medicare Carriers Manual Part 3 - Claims Process

Department of Health &  
Human Services (DHHS)  
Centers for Medicare &  
Medicaid Services (CMS)

Transmittal 1780

Date: NOVEMBER 22, 2002

CHANGE REQUEST 2290

**HEADER SECTION NUMBERS**

15016 - 15018

**PAGES TO INSERT**

15-9 - 15-12.6 (10 pp.)

**PAGES TO DELETE**

15-9 - 15-12.5 (9 pp.)

**NEW/REVISED MATERIAL--*EFFECTIVE DATE: November 22, 2002***

***IMPLEMENTATION DATE: November 22, 2002***

Section 15016, Supervising Physicians in Teaching Settings, is revised to clarify the documentation requirements for evaluation and management (E/M) services billed by teaching physicians. The revised language makes it clear that for E/M services, teaching physicians need not repeat documentation already provided by a resident. In addition, the revisions clarify policies for services involving students and other issues and update regulatory references.

**DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.**

**These instructions should be implemented within your current operating budget.**

- Make fee schedule payments only for physicians' services to individual patients as defined in §15014.C.1;
- The physician (or other entity) must make its books and records available to the provider and the intermediary, as necessary, to verify the nature and extent of the costs of the services furnished by the physician (or other entity); an
- The lessee's costs associated with producing these services, including overhead, supplies, equipment, and the costs of employing non-physician personnel are payable by the intermediary as provider services. However, in the case of certain leasing arrangements involving hospital radiology departments, see §15022.B.3.

## 15016. SUPERVISING PHYSICIANS IN TEACHING SETTINGS

### A. Definitions.--For purposes of this section, the following definitions apply:

1. Resident means 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. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary. Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of "resident". Additionally, this status remains unaffected regardless of whether a hospital includes the physician in its full time equivalency count of residents.
2. A student means an individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. A student is never considered to be an intern or a resident. Medicare does not pay for any service furnished by a student. See Section C. 2 for a discussion concerning E/M service documentation performed by students.
3. Teaching physician means a physician (other than another resident) who involves residents in the care of his or her patients.
4. Direct medical and surgical services mean services to individual patients that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital making the reasonable cost election for physician services furnished in teaching hospitals. All payments for such services are made by the fiscal intermediary for the hospital.
5. Teaching hospital means a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.
6. Teaching setting means any provider, hospital-based provider, or non-provider setting in which Medicare payment for the services of residents is made by the fiscal intermediary under the direct graduate medical education payment methodology or freestanding SNF or HHA in which such payments are made on a reasonable cost basis.
7. Critical or key portion means that part (or parts) of a service that the teaching physician determines is (are) a critical or key portion(s). For purposes of this section, these terms are interchangeable.
8. Documentation means notes recorded in the patient's medical records by a resident, and/or teaching physician or others as outlined in specific situations (section C) regarding the service furnished. Documentation may be dictated and typed, hand-written or computer-generated, and typed or handwritten.

Documentation must be dated and include a legible signature or identity. Pursuant to 42 CFR 415.172(b), documentation must identify, at a minimum, the service furnished, the participation of the teaching physician in providing the service, and whether the teaching physician was physically present.

9. Physically present means that the teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

B. Payment for Teaching Physicians.--Pursuant to 42 CFR 415.170, pay for physician services provided in teaching settings using the physician fee schedule only if:

1. Services are personally furnished by a physician who is not a resident;
2. A teaching physician was physically present during the critical or key portions of the service that a resident performs subject to the exceptions as provided below in Section C; or
3. A teaching physician provides care under the conditions contained in Section C.3. which follows.

In all situations, the services of the resident are payable through either the direct GME payment or reasonable cost payments made by the fiscal intermediary.

C. General Documentation Instructions and Common Scenarios.--

1. Evaluation and Management (E/M) Services.--For a given encounter, the selection of the appropriate level of E/M service should be determined according to the code definitions in the American Medical Association's Current Procedural Terminology (CPT) and any applicable documentation guidelines.

For purposes of payment, E/M services billed by teaching physicians require that they personally document at least the following:

- a. That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
- b. The participation of the teaching physician in the management of the patient.

When assigning codes to services billed by teaching physicians, reviewers will combine the documentation of both the resident and the teaching physician.

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

On medical review, the combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.

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 or she would document an E/M service in a non-teaching physician 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 or she performed the critical or key portion(s) of the service and that he or 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 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 or she was present during the performance of the critical or key portion(s) of the service and that he or 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 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 or 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.

Following are examples of minimally acceptable documentation for each of these scenarios:

Scenario 1.--

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.--

Initial or Follow-up Visit: "I was present with 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.--

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."

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 any involvement with the plan of care.

2. E/M Service Documentation Provided By Students.--Any contribution and participation of a student to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirements set forth in this section for teaching physician billing.

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

3. Exception for E/M Services Furnished in Certain Primary Care Centers.--Teaching physicians providing E/M services with a GME program granted a primary care exception may bill Medicare for lower and mid-level E/M services provided by residents.

For the E/M codes listed below, teaching physicians may submit claims for services furnished by residents in the absence of a teaching physician:

<u>New Patient</u>	<u>Established Patient</u>
99201	99211
99202	99212
99203	99213

If a service other than those listed above needs to be furnished, then the general teaching physician policy set forth in section B applies. For this exception to apply, a center must attest in writing that all the following conditions are met for a particular residency program. Prior approval is not necessary, but centers exercising the primary care exception must maintain records demonstrating that they qualify for the exception.

The services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's fiscal intermediary. This requirement is not met when the resident is assigned to a physician's office away from the center or makes home visits. In the case of a non-hospital entity, verify with the fiscal intermediary that the entity meets the requirements of a written agreement between the hospital and the entity set forth in 42 CFR 413.86(f)(4) (ii). Under this exception, residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least 6 months of a GME approved residency program. Centers must maintain information under the provisions at 42 CFR 413.86(i). Teaching physicians submitting claims under this exception may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must:

- Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the resident;
- Have the primary medical responsibility for patients cared for by the residents;
- Ensure that the care provided was reasonable and necessary;
- Review the care provided by the resident during or immediately after each visit. This must include a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies) and
- Document the extent of his/her own participation in the review and direction of the services furnished to each patient.

Patients under this exception should consider the center to be their primary location for health care services. The residents must be expected to generally provide care to the same group of established patients during their residency training. The types of services furnished by residents under this exception include:

- Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;
- Coordination of care furnished by other physicians and providers; and
- Comprehensive care not limited by organ system or diagnosis.

Residency programs most likely qualifying for this exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology.

Certain GME programs in psychiatry may qualify in special situations such as when the program furnishes comprehensive care for chronically mentally ill patients. These would be centers in which the range of services the residents are trained to furnish, and actually do furnish, include comprehensive medical care as well as psychiatric care. For example, antibiotics are being prescribed as well as psychotropic drugs.

4. Procedures.--In order to bill for surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

a. Surgery (Including Endoscopic Operations).--The teaching surgeon is responsible for the preoperative, operative, and post-operative care of the beneficiary. The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be critical or key portions of the procedure. The teaching surgeon determines which post-operative visits are considered key or critical and require his or her presence. If the post-operative period extends beyond the patient's discharge and the teaching surgeon is not providing the patient's follow-up care, then instructions on billing for less than the global package in §4824.B apply. During non-critical or non-key portions of the surgery, if the teaching surgeon is not physically present, he or she must be immediately available to return to the procedure, i.e., he or she cannot be performing another procedure. If circumstances prevent a teaching physician from being immediately available, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.

(1) Single Surgery.--When the teaching surgeon is present for the entire surgery, his or her presence may be demonstrated by notes in the medical records made by the physician, resident, or operating room nurse. For purposes of this teaching physician policy, there is no required information that the teaching surgeon must enter into the medical records.

(2) Two Overlapping Surgeries.--In order to bill Medicare for two overlapping surgeries, the teaching surgeon must be present during the critical or key portions of both operations. Therefore, the critical or key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure. The teaching surgeon must personally document in the medical record that he/she was physically present during the critical or key portion(s) of both procedures. When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he or she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise. In the case of three concurrent surgical procedures, the role of the teaching surgeon (but not anesthesiologist) in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual patient and is not payable under the physician fee schedule.

(3) Minor Procedures.--For procedures that take only a few minutes (5 minutes or less) to complete, e.g., simple suture, and involve relatively little decision making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.

b. Anesthesia.--Pay an unreduced fee schedule payment if a teaching anesthesiologist is involved in a single procedure with one resident. The teaching physician must document in the medical records that he or she was present during all critical (or key) portions of the procedure. The teaching physician's physical presence during only the preoperative or post-operative visits with the beneficiary is not sufficient to receive Medicare payment.

If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a non-physician anesthetist, pay for the anesthesiologist's services as medical direction.

c. Endoscopy Procedures.--To bill Medicare for endoscopic procedures (excluding endoscopic surgery that follows the surgery policy in subsection a), the teaching physician must be present during the entire viewing. The entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope. Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

5. Interpretation of Diagnostic Radiology and Other Diagnostic Tests. -- Medicare pays for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed by or reviewed with a teaching physician. If the teaching physician's signature is the only signature on the interpretation, Medicare assumes that he or she is indicating that he or she personally performed the interpretation. If a resident prepares and signs the interpretation, the teaching physician must indicate that he or she has personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings. Medicare does not pay for an interpretation if the teaching physician only countersigns the resident's interpretation.

6. Psychiatry.--The general teaching physician policy set forth in section B applies to psychiatric services. For certain psychiatric services, the requirement for the presence of the teaching physician during the 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 to the physical presence requirement. In the case of time-based services, such as individual medical psychotherapy, see subsection 8 below.

Further, the teaching physician supervising the resident must be a physician, i.e., the Medicare teaching physician policy does not apply to psychologists who supervise psychiatry residents in approved GME programs.

7. Time-Based Codes.--For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, pay for a code that specifically describes a service of from 20 to 30 minutes only if the teaching physician is present for 20 to 30 minutes. Do not add time spent by the resident in the absence of the teaching physician to time spent by the resident and teaching physician with the beneficiary or time spent by the teaching physician alone with the beneficiary. Examples of codes falling into this category include:

- Individual medical psychotherapy (CPT codes 90804- 90829);
- Critical care services (CPT codes 99291-99292);
- Hospital discharge day management (CPT codes 99238-99239);
- E/M codes in which counseling and/or coordination of care dominates (more than 50 percent) of the encounter, and time is considered the key or controlling factor to qualify for a particular level of E/M service;
- Prolonged services (CPT codes 99358-99359), and
- Care plan oversight (HCPCS codes G0181 - G0182).

8. Other Complex or High-Risk Procedures.--In the case of complex or high-risk procedures for which national Medicare policy, local policy, or the CPT description indicate that the procedure requires personal (in person) supervision of its performance by a physician, pay for the physician services associated with the procedure only when the teaching physician is present with the resident.

The presence of the resident alone would not establish a basis for fee schedule payment for such services. These procedures include interventional radiologic and cardiologic supervision and interpretation codes, cardiac catheterization, cardiovascular stress tests, and transesophageal echocardiography.

Miscellaneous.--In the case of maternity services furnished to Medicare eligible women, apply the physician presence requirement for both types of delivery as you would for surgery. In order to bill Medicare for the procedure, the teaching physician must be present for the delivery. These procedure codes are somewhat different from other surgery codes in that there are separate codes for global obstetrical care (prepartum, delivery, and postpartum) and for deliveries only.

In situations in which the teaching physician's only involvement was at the time of delivery, the teaching physician should bill the delivery only code. In order to bill for the global procedures, the teaching physician must be present for the minimum indicated number of visits when such a number is specified in the description of the code. This policy differs from the policy on general surgical procedures under which the teaching physician is not required to be present for a specified number of visits.

Do not apply the physician presence policy to renal dialysis services of physicians who are paid under the physician monthly capitation payment method.

D. Election of Costs for Services of Physicians in Teaching Hospital.--A teaching hospital may elect to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of fee schedule payments for such services. A teaching hospital may make this election to receive cost payment only when all physicians who render covered Medicare services in the hospital agree in writing not to bill charges for such services or when all the physicians are employees of the hospital and, as a condition of employment, they are precluded from billing for such services. When this election is made, Medicare payments are made exclusively by the hospital's intermediary, and fee schedule payment is precluded.

When the cost election is made for a current or future period, each physician who provides services to Medicare beneficiaries must agree in writing (except when the employment restriction discussed above exists) not to bill charges for services provided to Medicare beneficiaries. However, when each physician agrees in writing to abide by all the rules and regulations of the medical staff of the hospital (or of the fund that is qualified to receive payment for the imputed cost of donated physician's services), such an agreement suffices if required as a condition of staff privileges and the rules and regulations of the hospital, medical staff, or fund clearly preclude physician billing for the services for which costs benefits are payable. The intermediary must advise the carrier when a hospital elects cost payment for physicians' direct medical and surgical services and supply the carrier with a list of all physicians who provide services in the facility. You must ensure that billings received from these physicians or hospitals are denied.

Ask the intermediaries in your service area for listings of teaching hospitals that have elected cost payment and for listings of physicians whose services are payable to hospitals on a cost basis. Flag your system to deny claims for physicians' services furnished in listed hospitals and to reject claims for the services of listed physicians when hospitals are not identified on the claim form. For rejected claims, determine the hospitals where the physicians provided the services, denying those performed in listed hospitals, and paying those performed in hospitals that have not elected to receive cost payment. (For more information about the teaching hospital cost election, see §2148 of the Provider Reimbursement Manual, Part 1.)

E. Services of Assistants at Surgery Furnished in Teaching Hospitals.--

General.--Do not pay for the services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service unless the requirements of subsections 3, 4, or 5 are met.

Each teaching hospital has a different situation concerning numbers of residents, qualifications of residents, duties of residents, and types of surgeries performed. Contact those affected by these instructions to learn the circumstances in individual teaching hospitals. There may be some teaching hospitals in which you can apply a presumption about the availability of a qualified resident in a training program related to the medical specialty required for the surgical procedures, but there are other teaching hospitals in which there are often no qualified residents available. This may be due to their involvement in other activities, complexity of the surgery, numbers of residents in the program, or other valid reasons. Process assistant at surgery claims for services furnished in teaching hospitals on the basis of the following certification by the assistant, or through the use of modifier -82 which indicates that a qualified resident surgeon was not available. This certification is for use only when the basis for payment is the unavailability of qualified residents.

"I understand that section 1842(b)(7)(D) of the Social Security Act generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the Medicare carrier."

Retain the claim and certification for four years and conduct post-payment reviews as necessary. For example, investigate situations in which it is certified that there are never any qualified residents available, and undertake recovery if warranted.

Assistant at surgery claims denied on the basis of these instructions do not qualify for payment under the waiver of liability provision.

2. Definition.--An assistant at surgery is a physician who actively assists the physician in charge of a case in performing a surgical procedure. (Note that a nurse practitioner, physician assistant or clinical nurse specialist who is authorized to provide such services under State law can also serve as an assistant at surgery.) The conditions for coverage of such services in teaching hospitals are more restrictive than those in other settings because of the availability of residents who are qualified to perform this type of service.

3. Exceptional Circumstances.--Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the special limitation in §15044, notwithstanding the availability of a qualified resident to furnish the services. There may be exceptional medical circumstances, e.g., emergency, life-threatening situations such as multiple traumatic injuries which require immediate treatment. There may be other situations in which your medical staff may find that exceptional medical circumstances justify the services of a physician assistant at surgery even though a qualified resident is available.

4. Physicians Who Do Not Involve Residents in Patient Care.--Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the special limitation in §15044, if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients. Generally, this exception is applied to community physicians who have no involvement in the hospital's GME program. In such situations, payment may be made for reasonable and necessary services on the same basis as would be the case in a non-teaching hospital. However, if the assistant is not a physician primarily engaged in the field of surgery, no payment be made unless either of the criteria of subsection 5 is met.

5. Multiple Physician Specialties Involved in Surgery.--Complex medical procedures, including multistage transplant surgery and coronary bypass, may require a team of physicians. In these situations, each of the physicians performs a unique, discrete function requiring special skills integral to the total procedure. Each physician is engaged in a level of activity different from assisting the surgeon in charge of the case.

The special payment limitation in §15044 is not applied. If payment is made on the basis of a single team fee, deny additional claims. Determine which procedures performed in your service area require a team approach to surgery. Team surgery is paid for on a "By Report" basis.

The services of physicians of different specialties may be necessary during surgery when each specialist is required to play an active role in the patient's treatment because of the existence of more than one medical condition requiring diverse, specialized medical services. For example, a patient's cardiac condition may require that a cardiologist be present to monitor the patient's condition during abdominal surgery. In this type of situation, the physician furnishing the concurrent care is functioning at a different level than that of an assistant at surgery, and payment is made on a regular fee schedule basis.

#### 15018. PAYMENT CONDITIONS FOR ANESTHESIOLOGY SERVICES.

General Payment Rule.--The fee schedule amount for physician anesthesia services furnished on or after January 1, 1992 is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality. The base unit for each anesthesia procedure is listed in subsection K, Exhibit 1. The way in which time units are calculated is described in subsection G. Do not allow separate payment for the anesthesia service performed by the physician who also furnishes the medical or surgical service. In that case, payment for the anesthesia service is made through the payment for the medical or surgical service. For example, do not allow separate payment for the surgeon's performance of a local or surgical.

## CMS's Final Rule for Teaching Physicians

**Definition.**--An assistant at surgery is a physician who actively assists the physician in charge of a case in performing a surgical procedure. **(Note that a nurse practitioner, physician assistant or clinical nurse specialist who is authorized to provide such services under State law can also serve as an assistant at surgery.)** The conditions for coverage of such services in teaching hospitals are more restrictive than those in other settings because of the availability of residents who are qualified to perform this type of service.

**Exceptional Circumstances.**--Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the special limitation in §15044, notwithstanding the availability of a qualified resident to furnish the services. There may be exceptional medical circumstances, e.g., emergency, life-threatening situations such as multiple traumatic injuries which require immediate treatment. There may be other situations in which your medical staff may find that exceptional medical circumstances justify the services of a physician assistant at surgery even though a qualified resident is available.

**Physicians Who Do Not Involve Residents in Patient Care.**--Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the special limitation in §15044, if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients. Generally, this exception is applied to community physicians who have no involvement in the hospital's GME program. In such situations, payment may be made for reasonable and necessary services on the same basis as would be the case in a non-teaching hospital. However, if the assistant is not a physician primarily engaged in the field of surgery, no payment be made unless either of the criteria of subsection 5 is met.

**Multiple Physician Specialties Involved in Surgery.**--Complex medical procedures, including multistage transplant surgery and coronary bypass, may require a team of physicians. In these situations, each of the physicians performs a unique, discrete function requiring special skills integral to the total procedure. Each physician is engaged in a level of activity different from assisting the surgeon in charge of the case. The special payment limitation in §15044 is not applied. If payment is made on the basis of a single team fee, deny additional claims. Determine which procedures performed in your service area require a team approach to surgery. Team surgery is paid for on a "By Report" basis.

The services of physicians of different specialties may be necessary during surgery when each specialist is required to play an active role in the patient's treatment because of the existence of more than one medical condition requiring diverse, specialized medical services. For example, a patient's cardiac condition may require that a cardiologist be present to monitor the patient's condition during abdominal surgery. In this type of situation, the physician furnishing the concurrent care is functioning at a different level than that of an assistant at surgery, and payment is made on a regular fee schedule basis.

## **TEACHING DEFINITIONS/GUIDELINES**

Please refer to HCFA's "Medicare Final Rule for Teaching Physicians" located in this manual for more in depth definitions.

### **Anesthesiology**

Because this is a time based code, the teaching physician must be physically present during the time for which claim is made. The teaching physician must also be present during induction and emergence. Time and the teaching physician's presence must be documented in the medical record.

### **Assistant at Surgery**

An assistant at surgery is a physician who actively assists the physician must be physically present during the time for which claim is made. Time and the teaching physician's presence must be documented in the medical record.

### **Critical Care**

Because this is a time-based code, the teaching physician must be physically present during the time for which the claim is made. Time and the teaching physician's presence must be documented in the medical record.

### **Direct Services**

Services to a patient that are either personally furnished by a physician or furnished by a resident under the supervision of a physician who has the privilege of billing and receiving payments under Medicare's Physician Payment Schedule (RBRVS).

### **E/M Services**

For each patient encounter, selection of the appropriate level of E/M service should be based on "Documentation Guidelines for Evaluation and Management Services" developed by the American Medical Association and featured in the manual. When teaching physicians document their presence and participation in the E/M service, the level of service must be selected based on the extent of history, examination, and complexity of medical decision-making required.

The teaching physician must be physically present during the portion of the service that determines the level of service billed. Their documentation should include references to notes entered by the resident. In all cases, teaching physicians must personally document their presence and participation in the service in the medical record. The documentation by the teaching physician may be either in writing or via a dictated note, and expressed in the following ways.

### Example 1

A personal notation must be entered by the teaching physician documenting their participation in the three (3) key components of the service. Teaching physicians need not repeat the documentation of these components in detail; they may give a brief summary that ties into the resident's entry confirming or revising the key elements as defined in each code level by CPT (i.e., history, examination, medical decision making).

### Example 2

All key components are obtained personally by teaching physicians without a resident present or input from a resident. In this case, teaching physicians should document on the same basis that they would for an E/M service in a non-teaching setting.

### **Medical Student**

A medical student is never considered to be a resident. Any contribution from a medical student in the performance of a billable service or procedure must be performed in the physical presence of the physician who will receive payment.

### **Minor Surgery**

The teaching physician must be physically present during the entire procedure. The teaching physician's presence must be documented in the medical record.

### **Pathology**

Teaching physicians must indicate that they have personally reviewed the specimen slides and the resident's interpretation, and either agree with the interpretation or edit the resident's findings. The teaching physician must document findings and changes in the medical record.

### **Psychiatry**

The teaching physician's presence requirement may be concurrent observation of the service by use of a two-way mirror or by video equipment. Audio-only equipment does not meet the physical presence requirement. The teaching physician's presence must be documented in the medical record.

### **Radiology**

Teaching physicians must indicate that they have personally reviewed the images and the resident's interpretation, and either agree with the interpretation or edit the resident's findings. The teaching physician must document findings and changes in the medical record.

**Resident**

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. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary.

**Scopies**

The teaching physicians must be physically present during the entire viewing portion of the procedure. The entire viewing portion includes insertion and removal of the device. Viewing of the entire procedure through a monitor in another room does not meet the requirement that the teaching physician be present. The teaching physician's presence must be documented in the medical record.

**Surgery**

The teaching physician must be physically present during all critical portions of surgical, high-risk or other complex procedures and be immediately available during the entire service. Critical portion is defined as the period between the opening and closing of the surgical field. The teaching physician's presence must be documented in the medical record.

**Teaching Physician**

Teaching physicians are physicians (other than another resident) who involve residents in the care of their patients. The teaching physician has billing privileges with Medicare and an established UPIN number.

**Teaching Setting**

Applies to any provider, hospital-based provider, or non-provider setting in which Medicare payment for services of residents is made by fiscal intermediary under the GME payment methodology. This includes freestanding SNF's or HHA's in which such payments are made on a reasonable cost basis.

## **CPT DEFINITIONS**

### **Confirmatory Consultation**

When a consultation is initiated by a patient and/or family and is not requested by another physician, it should be coded as a confirmatory consultation. Second and third options should also be coded as confirmatory consultations. Their purpose is to provide an option or advice only.

### **Consultation (Inpatient or Outpatient)**

The patient is referred by an attending (primary care) physician to a specialty physician for expert advice and possible treatment. The patient is being seen for the first time by the specialty physician. The patient may receive diagnostic testing, medication, and/or surgery at the time of the first visit. The specialty physician recommends, prescribes, performs diagnostic testing or initiates surgical intervention and maintains contact with the primary care physician regarding the patient's plan of care (written letter to PCP, cc's of specialist's progress note, documented phone conversation) code this as a consult. Subsequent visits to the specialist should be coded as established patient visits.

### **CPT (Current Procedural Terminology)**

A CPT code is a group of five numbers assigned to a specific procedure or physician service. The five-digit codes, together with their descriptions, are the means by which physician's bill and report services to insurance carriers for reimbursement.

### **Critical Care Services**

These services are provided in, but not limited to, critical care areas such as intensive care units, and coronary care units. Patients are critically ill and require the constant attendance of the physician.

### **Direct Services**

Services to a patient that are either personally furnished by a physician or furnished by a resident under the supervision of a physician who has privilege of billing and receiving payments under Medicare's Physician Payment Schedule (RBRVS)

### **Discharge (Hospital)**

This service is used by the physician to report all services provided to a patient on the date of discharge. It is used only once during a hospital inpatient stay that is greater than 24 hours.

## **Emergency Department Service**

These services are provided in the emergency department which is an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be open with a physician available 24 hours a day.

## **Established patient**

An established patient is one who has received professional services from the physician, or another physician of the same specialty who belongs to the group practice, within the past three (3) years.

## **Hospital or Inpatient Service**

This service is provided to hospital inpatients and patients in a partial hospital setting. Services consist of initial hospital care, subsequent hospital care, and hospital discharge service.

## **Initial Hospital Care**

This service is used only once during an admission to report the first hospital inpatient encounter with the patient by the admitting physician.

## **Medical Necessity**

HCFA's definition for medical necessity is "a service that is reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. The following must apply:

- Consistent with the symptoms or diagnosis of the illness or injury under treatment.
- Necessary and consistent with generally accepted professional medical standards (i.e., not experimental or investigational).
- Not furnished primarily for the convenience of the patient, the attending physician, or any other physician or supplier.
- The service must be furnished at the most appropriate level which can be provided safely and effectively to the patient.

## **Newborn Care Service**

This service is provided to the normal or high-risk newborn in several different settings which include birthing rooms and home deliveries.

### **New Patient**

A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three (3) years.

### **Neonatal Intensive Care Service**

This service is provided to the neonate or infant who is considered to be critically ill and is in the neonatal intensive care unit (NICU).

### **Observation Care Service**

This service is provided to a patient who is designated/admitted as “observation status” in the hospital. It is not to be used on the post-operative patient who is recovering from a procedure. Service is limited to 24 hours or less.

### **Office or Outpatient Service**

This service is provided in the physician’s office, in an outpatient or other ambulatory facility, or in the observation area of a hospital. A patient is considered an outpatient until hospital inpatient status occurs.

### **Preventative Medicine Service**

This service is provided to adults and children who are in good health and absent of medical complaints. The extent and focus of this service will largely depend on the age of the patient and circumstance of the examination.

### **Prolonged Care Service**

This service is provided when a physician had direct (face-to-face) patient contact that is beyond the usual service in either the inpatient or outpatient setting. It is reported in addition to other E/M services at any level.

### **Referral for Treatment**

The patient is referred by an attending (primary care) physician and is being seen for the first time by the specialty physicians, who will continue the patient’s care. The specialty physician makes follow-up appointments for the patient. When the specialty physician clearly assumes care of the patient this is a referral and should be coded with the appropriate E/M visit code.

### **Subsequent Hospital Care**

This service is used to report the physician’s service each day the patient maintains the inpatient hospital status.

## MODIFIERS

Modifiers are used with evaluation and management services to describe events or circumstances that have altered the original intended service. Often modifiers describe unplanned procedures or events during the physician/patient encounter.

- **Modifier – 21 Prolonged E/M Service**
  - (Requires documentation be sent with billing information)  
When the face-to-face service provided is greater in time than the specific time for the selected code in the evaluation and management category, modifier 21 would be used. The total amount of time spent face-to-face with the patient must be documented in your note. The modifier is “attached” to the evaluation and management code (example 99202-21).
- **Modifier – 22 Unusual Procedural Services**  
When the service provided is greater than that usually required for the listed procedure, it may be identified by adding modifier – 22 to the usual procedure number.
- **Modifier – 23 Unusual Anesthesia**  
Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. The circumstance may be reported by adding the modifier 23.
- **Modifier – 24 Unrelated E/M during Post-op Period**
  - (Requires documentation be sent with billing information)  
Modifier 24 is used for an unrelated evaluation and management service by the same physician during a post-operative period. To avoid automatic denial during a surgical post-operative period, modifier 24 must be used. It tells the payer that the service being rendered is unrelated to the original surgical procedure. The modifier is “attached” to the E/M code (example: 99202-24).
- **Modifier – 25 Separate E/M on Day of Procedure.**  
Modifier 25 is used for a significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service. The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual pre-operative and post-operative care associated with the procedure that was performed.
- **Modifier – 26 Professional Component**  
Certain procedures are a combination of a physician component and technical component. Modifier 26 is used to indicate that the physician is billing for the professional component only. A physician providing diagnostic or therapeutic

## MODIFIERS cont...

radiology services, ultrasound or nuclear medicine services in a hospital would use modifier 26.

- **Modifier – 32 Mandated Service**  
Services related to mandated consultation and/or related services (e.g. PRO, third party payer, governmental, legislative or regulatory requirement) may be identified by adding the modifier 32 to the basic procedure or service.
- **Modifier – 47 Anesthesia by Surgeon**  
Regional or general anesthesia provided by the surgeon may be reported by adding modifier 27 to the basic service.
- **Modifier – 50 Bilateral Procedure**  
Unless otherwise identified in the listings, bilateral procedures that are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure or service may be identified by appending the modifier 51 to the additional procedure or service code.
- **Modifier – 51 Multiple Procedures**  
When multiple procedures/services are performed (other than E/M) at the same session, a modifier 51 is used. The most significant procedure is listed as usual with all subsequent procedures appended with a 51 modifier.
- **Modifier – 52 Reduced Services**  
Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced.
- **Modifier - 53 Discontinued Procedure**  
Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started, but discontinued. This circumstance may be reported by adding the modifier 53 to the code reported.
- **Modifier - 54 Surgical Care Only**  
When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding the modifier 54 to the procedure number.
- **Modifier – 57 Decision for Surgery**  
(Does not require documentation to be sent with the billing information)  
Modifier 57 is used to identify an E/M service provided by the physician on the day before or on the day that the physician had decided to perform the surgery. This

## MODIFIERS cont...

modifier can be used with all E/M code levels for visits or consultations. The modifier is “attached” to the E/M code.

- **Modifier – 58 Service During Post-op Period**  
When a procedure is prospectively planned as a staged procedure, or when the secondary and subsequent procedure is more extensive, or to indicate therapy following a diagnostic surgical procedure, Modifier 58 is “attached” to the staged procedure.
- **Modifier – 59 Distinct Procedural Service**  
For procedures/service not ordinarily performed or encountered on the same day by the same physician, but appropriate under certain circumstances (e.g. different site or organ system, separate excision or lesion) modifier 59 is used.
- **Modifier – 62 Two Surgeons**  
Two surgeons may be required to manage a specific surgical problem. When two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the single definitive procedure code.
- **Modifier – 76 Repeat Procedures by Same Physician**  
The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service.
- **Modifier – 77 Repeat Procedures by Another Physician**  
The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated.
- **Modifier – 79 Unrelated Procedure During Post-op Period**  
The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure.
- **Modifier – 91 Repeat Clinical Diagnostic Lab Test**  
In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent treatment results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of the modifier 91.
- **Modifier – 99 Multiple Modifiers**  
Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and the other applicable modifiers may be listed as part of the description of the service.

- **Modifier GE**  
(Used only by Medicare)  
Indicates the service has been performed by a resident without the presence of a teaching physician under Medicare's primary care exception rule. Your organization's GME program must be granted the primary care exception from Medicare to use this modifier. This modifier is used in the Internal Medicine, Geriatric Medicine, Pediatrics and Obstetrics and Gynecology divisions only. The resident must have completed six (6) months of an approved residency program to justify using this modifier. Services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care facility. Codes 99201 – 99203 and 00211 – 99213 are the only codes used with this modifier.
- **Modifier GC**  
(Used only with Medicare)  
Indicates the service has been performed in part by a resident under the direction and supervision of a teaching physician following Medicare's Teaching Physician Guidelines.

## **Sample Documentation – 99201**

### **Level I Initial Office Visit**

The patient is a 23-year-old male who needs a refill of prescription for Ventolin tabs and Proventil inhaler. Patient moved here two months ago from Florida. Diagnosed with asthma at age eight. He says his asthma is well controlled on current regimen of meds. He says he used the inhaler two to four times a week, generally after performing activities like tennis or skating.

PX: WDNW male in no acute distress; temp 98.6, pulse 65, BP 110/70; respiration 18; HEENT within normal limits; lungs clear to auscultation, no rales or wheezing.

Impression: Asthma, stable on present medications.

Plan: Rx written for three months for current medications; recheck in three months, sooner if any problems. Patient was advised to schedule baseline physical upon next visit.

### **(General Multisystem)**

#### **How This Level of E/M Service Was Assigned**

- History: CC: A 23-year-old male needs a refill of Ventolin tabs and Proventil inhaler. HPI: Brief to extended problem pertinent information. ROS: None. PFSH: one. History documentation equates to “problem focused.”
- Physical examination (general multisystem): There are two constitutional bullet elements documented: (1) vital signs and (2) general appearance of patient. HEENT: One bullet element. Respiratory: One bullet element is noted. Total number of elements noted in documentation equals four; therefore, physical examination documentation equates to “problem focused” by 1997 guidelines. By 1995 guidelines, three systems are covered which equates to expanded problem focused.
- Medical decision making: Diagnosis made by the physician is “asthma, stable.” The patient did not bring any medical records to be reviewed, and no diagnostic tests or studies were ordered and/or reviewed. The patient’s problem is a stable but chronic illness treated at this time by prescription drug management. This equates the risk to a moderate level; however, the remainder of the medical decision making process qualifies only as straightforward. The overall medical decision making is “straightforward.”
- Final E/M level of service: CPT code 99201 is assigned. The requirements of problem focused history, problem focused exam, and straightforward medical decision making are met. One of the key components – the physical exam – has exceeded the requirements by one level, but this does not elevate the overall level of service. This is an example of a case where the decision making was well above the level of history. The lack of ROS was all that prevented this encounter from being rated a 99202. Under proposed 2000 guidelines, even the decision making would be rated low.

## **Sample Documentation – 99202**

### **Level II Initial Office Visit**

S: This 20-year-old male patient, new to my practice, who presents with painful right middle finger nailbed and surrounding area of a three-day duration. Pt. denies trauma to the area. The fingernail discomfort has rapidly progressed to its present state. Pt. denies noticing suppuration/drainage. No self-treatment.

ROS: No arthralgias. All other joints without complaint.

O: Right hand – middle distal phalange with periungual induration. Skin with increased warmth and sensitivity. Joints WNL. Full ROM. Other right hand nailbeds WNL. Remainder of upper extremity WNL. Neuro intact; sensory as stated.

A: Paronychia, right third digit.

P: Warm soaks q.4 to 6 h. Begin E-mycin 333 mg one every eight hours, #21. Protect digit. ASA/Tylenol PRN pain. Return as needed.

**(General multisystem)**

## **Sample Documentation – 99203**

### **Level III Initial Office Visit**

History: 41-year-old male complaining of pain, stiffness, “clicking” and swelling of both knees that is of gradual onset but seems to be getting worse. He cannot pinpoint when he first noticed a problem, but it was several months before his move here six months ago. He first noted pain in his knees after exercise but notes that exercise also makes the stiffness better. He occasionally gets nonradiating backache, especially after lifting and doing yard work, but sometimes it happens for no apparent reason. Over-the-counter preparations such as Advil with rest and heat help his back and used to make his knees feel better, but lately they seem worse. He notes no paresthesias from his back. Past history is otherwise noncontributory. He notes no problems with gait or stability.

Physical Exam: Well-developed, somewhat obese white male. Height 5’10”, weight 205 pounds. BP 130/92. Gait and station are normal. Back appears normal; no kyphosis or scoliosis; no tenderness upon palpation or the lumbar area. Flexes to 90 degrees. Leg lengths even and joints symmetrical. Knees are nontender and are not erythemic or warm. Full range of motion. No back pain on straight leg raising. McMurray’s negative. There is moderate crepitation noted on movement of the knees. Hip movement is normal and the patient reports no pain. Muscle strength, pulses and reflexes are all within normal limits. Babinski is negative. Normal response to touch and pinprick.

Impression: 1. Osteoarthritis, bilateral knees.  
2. History of lumbago without evidence of sciatic nerve involvement.

Plan: Discussion with the patient regarding osteoarthritis, treatment options and nature of the condition. Patient instructed in the importance of daily exercise including stretching exercises to avoid further damage to the joints. Importance of weight reduction in management of DJD was also strongly stressed. Patient was instructed to use aspirin to relieve knee and back pain, and was given a referral for physical therapy evaluation and instructions on exercises and activities to help manage his condition. The patient was instructed to return in four months for follow-up and to call sooner if there were any problems. The patient was advised to contact his PCP for hypertension follow up.

**(Single organ system – musculoskeletal)**

## Sample Documentation – 99204

### Level IV Initial Office Visit

This is a 44-year-old female new pt. who presents with fever/chills, headache, facial tenderness and swelling, and general malaise of a two-day duration. Pt. reports feeling “like a mack truck has run over me.” Current symptoms began with a slight sore throat two days ago. The sore throat has diminished. Pt. does admit to rhinitis and nasal congestion. No cough. Appetite is diminished. Pt. does not want to report to work today and would like a sick certificate for same. Pt. does provide a history of sinusitis, treated in the past with antibiotics. Has never been to an ENT specialist. No sinus films taken in the past.

ROS: HEENT: As above. No other significant factors. Headaches only with current symptomatology. No respiratory complaints. No GYN complaints; last menses three weeks ago. Otherwise negative.

PMH: T&A age 12. Sinusitis, as above.

FH: Unremarkable.

SH: Smokes cigarettes one pack/day; no ETOH. Works as a financial advisor.

O: T: 99.6. Bp: 130/82; P: 88; R: 22. General: well-developed, well-nourished female appearing mild to moderately ill. HEENT: normocephalic. Eyes: sclerae sl. Injected. PERRLA. Throat: sl. Erythematous pharynx. No exudates. Tonsils absent. Tongue WNL. Dentition: good condition. Nose: mucosa pale. Yellowish exudates noted. Ears: TM's WNL, bilaterally. No sign middle ear fluid. Some cerumen debris noted in canals. Facial tenderness on palpation over ethmoid and maxillary sinuses. Chest: all fields clear; no rales/rhonchi. Heart: NSR; no murmur. Abdomen: benign. No mass; tenderness. No organomegaly. Neuro non-focal. Skin warm and dry.

A: Probable pansinusitis. Rule out sinus anomalies.

- P:
1. Obtain sinus series from Community Radiology; order given.
  2. Augmentin 500 mg one t.i.d. for 10 days with meals.
  3. Encourage fluids; bedrest x 48 hours. Sick certificate given.
  4. Can take OTC Sudafed PRN.
  5. Acetaminophen for pain PRN.
  6. Call for follow-up appt. if no improvement in a few days.

**(General multisystem)**

## Sample Documentation – 99205

### Level V Initial Office Visit

Reason for visit: “Need a new doctor.”

History: This 47-year-old male states he “needs a new doctor” because he was discharged by his former physician about three months ago for noncompliance with hypertensive regimen. He has not seen anyone in the interim, and he takes his medications only sporadically when “it gets really bad.” He uses a home BP monitor to check his blood pressure weekly. The patient sought treatment today following an episode of apparent amaurosis fugax last night, with vision returning to normal after about one hour. This was the first such episode for this patient who recognized the episode from his reading material. The patient also reports at least two episodes of probable TIA.

He was diagnosed with hypertension at age 38, and has been on a variety of hypertensive medications since then, with reportedly continual problems with various side effects of treatment. He has investigated a variety of alternative treatments for hypertension including various diets, herbs, and vitamins, acupuncture, various devices such as metal bracelets, prayer meetings, meditation, etc., in an attempt to control his disease without medications, with admitted limited success. He has not tried biofeedback training. He admits his blood pressure has not been well controlled.

Patient history is otherwise unremarkable. No surgery. Fractured ankle at age 24. No meds except antihypertensive and a variety of over-the-counter vitamins and herbal preparations.

His mother is alive and well at age 74, no known health problems except “her age”. His father died of MI at the age of 57 and was hypertensive. He has one sister, age 50, who is overweight and hypertensive; he is divorced with two children ages 15 and 12 and apparently has little contact with the children but believes they are healthy. Grandparents apparently all died of “old age” at age 75 and older; his paternal grandfather died in an accident. Family history is otherwise unknown. He quit smoking about five years ago; was a one-pack a day smoker since age 16; drinks “four to five” beers three to four times a week; hard liquor rarely. Reports no illicit drug use; has lived with his girlfriend for the past four years; works as an executive for a manufacturing firm. Exercise includes walking “an hour or so” three to four times a week apparently depending on the weather. Otherwise the patient reports no other problems. Review of systems otherwise negative. See self-history form completed by patient.

#### Physical Examination:

BP supine 240/110 (left arm), P 80, BP (left leg) 254/118

BP standing 226/112 (left), P 84, BP 222/110 (Right standing); R: 18, not labored, T: 98.8, weight 198 lbs., Ht. 5’9”

Well-developed overweight white male in no acute distress.

Eyes – PERRL, EOMI, Fundi flat. + venous pulsations, arteriolar narrowing, copper wiring and A-V nicking.

No hemorrhages or exudates.

ENT – good dentition, normal mucosa.

Neck supple, no masses or thyromegaly, no JVD

Respiratory – normal excursion, clear to percussion and auscultation.

Heart – regular rate and rhythm, S4 gallop and grade II non-radiating murmur at left sternal border. Normal carotid upstrokes with bruit on left.

Abdomen – rounded, soft, non tender, no masses or organomegaly. No aortic bruit or pulsation.

Rectal – normal tone, no masses, BPH Gr. I, heme neg.

Musculoskeletal back non tender, straight, motor + 4/4 – all extremities, no joint deformities.

Extremities – no clubbing, cyanosis, edema. Pulses +2 arms, +1 legs (no dorsalis pedis either foot).

Skin dry, normal turgor.

Neuro/Psychiatric – alert and oriented X3, normal gait and station, no focal defects.

DTR's +2; affect defensive and anxious.

Impression and plan:

1. Longstanding hypertension, uncontrolled, with probable end organ changes. Exam indicates no real emergency; therefore, will treat as outpatient. The patient indicates that lightheadedness and impotence are the most bothersome residuals.
2. Begin Moexipril 15 mgm qd.
3. UA, full chemistry panel, EKG, cholesterol today.
4. Return in three weeks, recheck orthostatics, K, and creatinine.
5. I had a discussion with this patient about his hypertension. The patient has a good understanding about the potential side effects of the various drugs used to treat his disease. I apprised the patient in detail of the potential side effects of not treating his condition. The patient expressed an understanding of the high risks of non-compliance, stating no one had “spelled it out before.” I firmly explained to the patient that I would be willing to help him explore alternative therapy for hypertension, but only if he were to strictly adhere to a conventional regimen of therapy until his hypertension was well controlled and stable, and to explore the alternatives in addition to conventional therapy and not instead of it.

**(Single organ system – cardiovascular)**

## **Sample Documentation – 99212**

### **Level II Established Patient Office Visit**

Patient comes in for suture removal; three sutures were placed in left index finger 10 days ago in the ED, following an accidental laceration from a broken glass. Tetanus booster given in ER.

Exam: Digit healing well. No erythema, exudates or tenderness.

Plan: All sutures removed without difficulty. Wound dressed. Patient given instructions on wound care; instructed to call with any problems.

**(General multisystem)**

## Sample Documentation – 99214

### Level IV Established Patient Office Visit

Chief complaint: One day history of left ear pain and discharge.

This five-year-old female presents with left ear pain and discharge from the left ear canal. The mother reports the child awakened during the night complaining of pain in the left ear. The mother noted purulent discharge coming from the left ear canal which she states was increased this morning. The mother reports that the child was swimming in a lake at a family picnic two days prior to this visit. The child says she cannot hear well and appears to have difficulty in hearing questions. The mother says the child had a fever of 100 degrees this morning. The child indicates that her throat is sore; no G.I. complaints or other symptoms. She slept poorly last evening and refused to eat or drink. Immunizations are up to date. The child has had four prior episodes of serious otitis media associated with tonsillitis and pharyngitis; no prior episodes of otitis externa. She had chickenpox at age 16 months. No other pertinent history; no medications, no known allergies. Developmental milestones are within normal limits. No other family members are ill or have been within the past few weeks.

PE: Pulse 94 and regular, respirations 20 and unlabored, temperature 101.7; wt. 42. Well-developed, well-nourished child, appearing somewhat flushed, cranky and tired. HEENT normocephalic, no tenderness over the sinuses. Eyes clear, conjunctivae pink; nose, clear. Pharynx shows red, infected tonsils, +2 enlarged, no Koplik's spots on palate. Mouth otherwise normal. Left ear canal red, swollen with purulent material filling the canal and tenderness of the external ear. Right canal is clear – the TM is erythematous and slightly bulging. Fluid level noted retro-tympanically. The left TM was not visualized. Neck supple, minimal cervical lymphadenopathy present. Exam of the nose revealed yellow discharge. Chest is clear to P&A with no wheezes, rales or rhonchi. Heart regular rate and rhythm, no murmurs. Abdomen soft non-tender. No organomegaly. Skin: no rash, turgor good.

Impression:   1. Left otitis externa with possible tympanitis  
                  2. Right otitis media  
                  3. Acute tonsillopharyngitis

Plan:           1. 4 drops of Pedi-Otic were placed in the left canal, and the mother was given a prescription for same three drops, TID x one week, both ears.  
                  2. Amoxicillin Suspension 250 mgm TID x 10 days.  
                  3. Recheck 10-14 days.  
                  4. Consider ENT referral if no improvement.

Note: the exam here was detailed by 1997 guidelines but comprehensive by 1995/2000. The history is detailed due to the extent of ROS. Decision making is moderate by the table of risk, with an established problem worsening and a new problem.

**(Single organ system – ENT)**

## Sample Documentation-99215

### Level V Established Patient Office Visit

Chief Complaint: 61 y.o. white female with fever, weakness, weight loss and headaches x 3 weeks.

HPI: This patient reports fevers up to 102 degrees, no chills or sweats. Complaints of bilateral headaches, worse in the morning. Denies having any of the symptoms prior to this illness. Has lost seven days of work in the past three weeks due to "just feeling bad," Notes anorexia, no dysphasia. Denies cough, rhinitis, ear pain or photophobia. Denies shortness of breath, sputum production, pleuretric or chest pain. Denies nausea, vomiting, diarrhea or abdominal pain. Denies flank pain, dysuria or urgency. Denies skin rashes.

Notes recent pain and stiffness in neck, shoulders and hips, not relieved by aspirin. Has had one episode of jaw pain while chewing. Admits to left-sided scalp tenderness.

Meds: Estrogen/Progesterone replacement, OTC multivitamins.

PMH: G4, P3, AB1, three children alive and well. Lives with husband. No tobacco, uses alcohol socially, denies illicit drugs. Appendectomy age 15; fracture of right femur 20 years ago, no sequelae. No allergies. Prior to this illness, walked 5-7 miles a week and played tennis twice a week.

ROS: HEENT: Recent blurred vision such that she is afraid to drive. No dental problems.

Pulmonary See HPI

Cardiovascular: No pressure, pain, palpitations, syncope. No orthopnea, paroxysmal nocturnal dyspnea or dyspnea or exertion. O/W neg.

G.I.: See HPI.

GU: Menopause 10 years ago. See HPI.

Musculoskeletal: No history of arthritis or joint problems. Now stiff and painful neck, shoulders, hips.

Neurologic: See HPI. No focal weakness, numbness, parentheses. No seizure history.

Difficulty walking due to painful joints and weakness.

Physical Exam: Height 5' 4". Weight 118 lbs. (-6 lbs. in 6 months). Bp: 110/70T; 100.5 P: 65R: 18. General Appearance: Well developed, obviously fatigued white female in no acute distress.

HEENT: PERRLA, EOMI, conjunctivae and sclerae clear. TM's intact, nasal passages clear.

Teeth in good condition without signs of infection. Swelling and tenderness over both

temporal arteries. Artery on left no pulse is palpable. Bilateral temporal bruits ¼.

Neck: Muscular stiffness noted. No bony tenderness, bilateral carotid bruits. No masses.

Lungs: Normal PMI, regular respiratory excursion, clear to percussion and auscultation.

Heart: Normal PMI, regular rate and rhythm; no gallops, murmurs or rubs. No neck vein distention.

Abdomen flat, healed appendectomy scar RLQ, soft, mo masses, organomegaly or tenderness.

Spine/Back: Non-tender, flexes to 90 degrees with effort, no CVA tenderness.

GU: Deferred to her gynecologist. Last exam 3 months ago reported normal.

Musculoskeletal: Diffuse rigidity of hips and shoulders bilaterally. No redness, heat, effusions or focal deformities. Neck and deltoid areas markedly tender. No edema.

Skin: Warm, dry, no rashes, normal turgor.

Neurological: Alert, oriented to person, place and time. No focal defects, DTR's + 2 upper, +1 lower.

Rectal: normal tone, no masses, stool heme negative.

Impression: 1. Temporal Arteritis with Polymyalgia Rheumatica.

2. R/O occult infection, specifically UTI, abscess.

Plan: 1. CBC with Diff, ESR, UA.

2. If ESR is elevated and CBC and UA do not show infection, start prednisone 60 mg daily x 2 weeks and re-check. Clinical presentation precludes temporal biopsy at this time.

**(General multisystem)**

## **Sample Documentation – 99221**

### **Level I Initial Hospital Care**

Nine-year-old female admitted from office after presenting with three day history of fever, cough and malaise. Fevers to 102, cough worse at night described as ‘wet and loose sounding’. OTC meds for cough and sinus ineffectual. Some night sweats, no chills, N/V, or GU problems. No Hx of respiratory problems, no prior surgeries. NKDA. Child attends public school.

**PHYSICAL EXAM:** Vitals per written chart WNL T: 103. Well-developed, well-nourished female child resting quietly, alert and oriented but somewhat lethargic. Head normocephalic. PERRLA-Fundi disc edges sharp. Both TMs red and injected. ENT: nose slight erythema, OP w/o exudates, neck supple, no nodes. No meningeal signs. Chest: ronchi audible in lower lobes, breathing unlabored. CV RRR. ABD soft non-tender, no CVAT, no HSM. Neuro WNL. Skin warm to touch. Post tibial pulses +1 bilaterally. Muscle strength +2, and DTR’s +1.

X-ray reveals bilateral lower lobe infiltrates.

**IMPRESSION:** Bilateral lower lobe pneumonia.

**PLAN:**

1. Admit for IV hydration, pulse oximetry monitoring.
2. Begin Rocephin – see orders.
3. Sputum for gram stain

**(General multisystem)**

## **Sample Documentation – 99222**

### **Level II Initial Hospital Care**

History: 72-year-old white male admitted after falling down the stairs at home earlier today. He was in obvious pain in ED and was given sedating analgesics. Some of the history was obtained from his wife. He noted immediate severe pain in his left hip area and pain in his left shoulder. Denies head trauma, no LOC, no visual disturbances, no bleeding, neck or back pain. Past history is generally otherwise noncontributory. Family history non-contributory. He had an MI seven years ago followed by two-vessel CABG; he had gallbladder surgery at age 38 and a fractured ankle at age 19. He reports occasional problems with arthritis in his knees and shoulders. No medications and no allergies. Review of symptoms otherwise within normal limits. No dizziness, palpitations, tremor or muscle weakness; no GI or GU complaints.

Physical Exam: BP 140/85, temperature 98.7, pulse 80, respirations 22. Well-developed, well-nourished male, resting quietly in bed, alert, oriented and appropriate but drowsy secondary to administered med. HEENT: Head atraumatic. Negative Battles Sign. PERRLA-Fundi flat. ENT – no hemotympanum. Lungs clear with unlabored breathing. Neck/spine nontender. There is bruising over the left shoulder but no obvious deformity. Range of motion and muscle strength normal as far as can be assessed. Right shoulder and right and left upper extremities otherwise normal. There is obvious deformity of the left lower extremity in the upper femoral area with eversion and foreshortening of the limb with marked tenderness and bruising over the area; knee and lower leg are normal; right lower extremity is normal. Both feet are warm to touch. Post tibial pulses +1 bilaterally. Normal finger to nose. No nystagmus. Muscle strength +2, and DTR's +1, with stocking response to touch and pinprick.

X-ray of both shoulders and upper extremities shows no bony or soft tissue abnormality. There are mild degenerative changes in the shoulder and elbow and generalized demineralization. X-ray of the left hip shows a comminuted fracture with dislocation of the fragments and subluxation of the shaft of the femur. The right hip is normal. There are mild degenerative changes in the hip joints, with some bony demineralization.

Impression:    Comminuted fracture, left femur, as described on x-ray  
                  Contusion, left shoulder

Plan:           1. Admit for open reduction, internal fixation of the left femur fracture  
                  after cardiology evaluation for cardiac risk.  
                  2. UA for blood.  
                  3. See admitting orders.

**(General Multisystem)**

## Sample Documentation – 99223

### Level III Initial Hospital Care

History: This is a 49-year-old male presented to the ER with a 15-year history of alcohol abuse with known liver decompensation and cirrhosis. He came to the emergency room because of hematemesis which began about six hours before admission when he vomited three times. The first time he brought up bright red blood, the second and third times he brought up coffee-ground emesis. In the ED he was noted to be confused as to time and place and was febrile.

Past history reveals that his general health has otherwise been good with no hypertension, heart disease, renal disease, diabetes or other significant medical problems. He has two prior hospitalizations, one for nonspecific gastroenteritis with diarrhea and dehydration, and another episode about three years ago for mild liver decompensation with jaundice, ascites and peripheral ankle edema which responded to bed rest, diet and salt restriction. Review of systems at this time is otherwise within normal limits.

Family history: father died at age 57 with acute varicocele hemorrhage with advanced Laennec's cirrhosis. His mother is age 69, in good health. One brother died at age 11 from complications of acute glomerulonephritis. No family history of hypertension, diabetes, coronary disease, or other hereditary or familial disorders. History was obtained primarily from his mother who accompanied him to the emergency room.

He is single, lives alone, has a ninth-grade education; he is a construction worker but has been unemployed for seven months. He smokes a pack and one-half of cigarettes daily and uses alcohol on a daily basis, usually vodka. No regular medications; he drinks five or six cups of coffee daily.

Physical Exam: Well-developed/well-nourished male appearing older than his stated age. Temperature 100.1, blood pressure 112/84, pulse 68 and regular, respiration 28. He is lying in bed with purposeless movements of extremities, responds to questions but answers inappropriately. Conjunctivae pale, scleral icterus, PERRLA, EOMI. TM's intact; oral mucosa pale, teeth in poor repair, oropharynx not injected. Neck veins flat, no thyromegaly. Trachea midline. Lungs clear to percussion and auscultation. Heart regular rate and rhythm; no murmurs or thrills. Abdomen protuberant with a fluid wave; liver edge is 3 fingers below the right costal margin; spleen tip felt on the left; no tenderness. No abnormal venous pattern on the abdominal wall. No submandibular, cervical or inguinal adenopathy. 2+ pitting edema of the lower extremities; pulses normal. Cranial nerves intact; deep tendon reflexes diminished; Babinski negative, + Asterixis.

Labs: Lab results in the ED showed H&H of 6 and 19, WBC 21,000, with a shift to the left; bilirubin 6.2, 4.2 direct and 2 indirect; alkaline phosphatase 165; SGOT 310, SGPT 140; serum ammonia 174 (11-55); BUN 46; creat. 1.2; albumin 2.4; K 3-6; PT/PTT-prolonged.

Impression:    Hepatic encephalopathy            Rule out peptic ulcer disease  
                  Laennec's cirrhosis                    Rule out alcoholic gastritis  
                  Hepatic decompensation            Rule out esophageal varices  
                  Portal hypertension                    Rule out spontaneous bacterial peritonitis  
                  Esophageal varices with hematemesis

Plan: He will be admitted and subsequently scheduled for immediate upper GI endoscopy. He will have blood cultures, urine cultures, peritoneal fluid culture, chest x-ray to rule out infectious process. He will be transfused with packed RBCs to a hematocrit of at least 30. Lactulose enemas. NPO, careful diuresis. Follow electrolytes.

**(General multisystem)**

## **Sample Documentation – 99231**

### **Level I Subsequent Hospital Visit**

Gastric ulcer, now stable. Since admission, she has received three units of packed RBCs; hematocrit 29.9, hemoglobin 9.2. Tolerating clear liquids well. No GI complaints at this time. NG tube was removed. Stools remain somewhat melanotic and heme +.

Blood pressure, pulse, respirations are stable; temperature normal. Abdominal exam is basically unchanged from yesterday.

Endoscopy yesterday showed a large gastric ulcer at the lesser curvature of the angulus covered with a large clot; ulcer was benign in appearance, pathology report pending.

She is now hungry and can be fed. I think that her acute bleed has stabilized, and she will be discharged in the next two to three days; there are no apparent cardiovascular or pulmonary complications.

**(General multisystem)**

## **Sample Documentation-99232**

### **Level II Subsequent Hospital Visit**

**S:** Both the patient and the nursing staff note increasing redness around venous stasis ulcers. The patient is complaining of more pain in the area of the pretibial ulcer on the right lower extremity.

**O:** The patient is resting quietly in bed, but he is increasingly anxious about his condition. Blood pressure, respiration and pulse stable; temperature now elevated to 100.6. Lungs clear, CV RRR, +4, No S3, no murmur. Large stasis ulcer in the pretibial area of the right lower extremity measuring 1x2.5 cm, unchanged from the last exam 24 hours ago. There is obvious erythema covering the ulcerated area about 3 cm. with a definite red streak extending proximally to just below the level of the knee. Skin is warm to touch, exquisitely tender adjacent to the ulcer and moderately tender over the red streak. The left leg shows two 2-cm ulcers, unchanged from the last exam with no surrounding erythema. The ulcer craters are filled with dry, intact eschar and there is a 1+ edema of the left lower extremity.

**A:** Hospital-acquired secondary infection of the stasis ulcer with surrounding cellulitis and early ascending lymphangitis.  
Edema due to local stasis.

**P:**

1. Debride eschar.
2. Swab ulcer for C&S of the purulent drainage, and stat gram stain.
3. Unasyn IV Q 6 hrs, pending results of gram stain and culture.
4. Elevate lower extremities on pillows to four inches above the level of the right atrium.
5. Start wet-to-dry dressings for large ulcer on the right lower extremity.

**(Single organ system-skin)**

## **Sample Documentation – 99233**

### **Level III Subsequent Hospital Visit**

History: The patient reports 20 minutes of squeezing, substernal chest pain associated with shortness of breath, diaphoresis, and nausea. Pain was not relieved by two sublingual nitroglycerine, does not change with position. There has been no sharp chest pain. The pain began when she went to the bathroom. This was her first BM since admission and she had to “strain” a fair amount. Otherwise, review is negative and unchanged since admission.

Exam: She appears to be in moderate discomfort. Temperature 98.6, pulse 80, respirations 22 and blood pressure 122/84. HEENT: EOMI, PERRLA, TM's normal, oropharynx clear. Neck: no jugular venous distention or abdominal jugular reflux. Chest clear to auscultation and percussion; Heart: PMI midline. Regular rate and rhythm, no gallop or murmur or rubs. Pulses are full and equal in all extremities. Abdomen flat and soft, bowel sounds normoactive; no hepatosplenomegaly. Extremities: no edema, full range of motion without cyanosis, clubbing or edema. Skin is cool and clammy.

EKG inverted T-waves laterally with acute 1 mm ST elevation and new reciprocal changes inferiorly.

Assessment: Four days status post subendocardial myocardial infraction with new onset of chest pain and EKG changes. Unstable angina, possibly extension of MI. Discussion with the patient and her family included discussion of diagnostic results, management options, potential medication side effects, and the need for consultation to evaluate patient for cardiovascular intervention.

Plan:

1. Nitroglycerine IV per protocol
2. Morphine IV per protocol
3. Stat cardiovascular surgery consultation
4. Begin heparin drip
5. Beta blocker, follow heart rate
6. Hold ace inhibitor

Note: This encounter could well require prolonged services or critical care by the time this day is over.

**(Single organ system-cardiovascular)**

## Sample Documentation – 99238

### Hospital Discharge Day Management

S: This is the fourth hospital day for this 68-year-old white female admitted with congestive heart failure. She is totally symptom-free at this time. She has neither positional nor exertional dyspnea. She denies chest pain, she denies nausea. Her appetite has improved and is essentially back to normal.

O: This pleasant lady appears comfortable, she is neither dyspneic or cyanotic. Inspection of the neck reveals no jugular venous distension. Auscultation of the heart is normal, sinus rhythm at 80 per minute without intermittenencies or murmurs. Auscultation of the lungs: completely clear, no wheezes, rales or rhonchi. Examination of her lower extremities reveals no edema.

A: Congestive heart failure secondary to mild coronary artery disease, now compensated and stable.

P: Patient will be discharged home with the following discharge instructions:

1. RX furosemide 20 mg p.o. q. a.m.
2. RX Lanoxin 0.125 mg each a.m.
3. RX isosorbide 10 mg p.o. TID
4. Potassium chloride 6 meq p.o. TID
5. Arrangements for Meals on Wheels with no-salt-added diet
6. Instruction sheet for no-salt-added diet given
7. Arrange for visiting nurse home evaluation within 24 hours of discharge
8. Arrange a follow-up visit at the office in one week, serum Lanoxin and potassium levels to be drawn at that time
9. Family conference completed. Family members agreed to arrange for assistance for the patient with laundry services and housecleaning.

**(Final hospital discharge, 30 minutes or less)**

## **Sample Documentation – 99241**

### **Level I Office/Outpatient Consultation**

TO: Dr. Attending Physician

FROM: Dr. Consultant

This 26-year-old female is seen at the request of Dr. Attending Physician to evaluate a lump the patient found in her right breast. She states that she found the mass three days ago during a regular, monthly self examination. She states that the mass is “a little sore”. She has had no such masses before; no history of injury to the area. No other significant past history. No family history of breast cancer.

Menses are regular, and the patient is “within a couple of days” of beginning her menses. The patient is not on oral contraceptives or other medications.

Px: BP 120/80, respirations 18, temperature 98.7, pulse 65. Neck shows no masses or palpable nodes. Breasts are small, symmetrical and generally nontender. There is a small, 5-cm nodule palpable in the right inner quadrant; it is easily movable, well circumscribed and feels cystic. There are no other masses. No nipple discharge or other abnormalities. No axillae lymphadenopathy.

Assessment: Cyst of breast, right

Recommendation: Patient was reassured that this mass is probably a cyst and not likely to be malignant, and this seemed to relieve her anxiety. We discussed the possibility of fine-needle aspiration of the cyst. The patient, however, indicates that she is “very afraid” of needles and prefers not to have this procedure done today. Because of the patient’s concern over aspiration, I recommend ultrasound to distinguish simple vs. complex cyst. She agrees to the ultrasound, which our office will schedule.

Thank you for asking me to see your patient. I recommend that we proceed with the needle aspiration in the near future if the ultrasound shows the cyst to be suspicious.

**(Single organ system – GYN)**

## **Sample Documentation – 99242**

### **Level II Office/Outpatient Consultation**

TO: Dr. Attending Psychiatrist  
FROM: Dr. Consultant  
RE: Admitting Evaluation

Chief complaint: “They brought me for a checkup.”

History: This 24-year-old white male is seen for the first time for medical evaluation at the request of Dr. Attending Psychiatrist at the County Mental Health Facility where he was sent from County Correctional Facility after being charged with assault. He was admitted to CMHF for treatment. He is seen today for an admitting H&P.

Past History: He states that he has no serious medical problems. His only past illness was chickenpox and occasional upper respiratory infections. He smokes about a pack of cigarettes a day and drinks “some,” but would not elaborate further.

Allergies: He states that he was given Haldol while in a reformatory eight years ago which caused him to choke and stutter. No other allergies.

Illicit drug use: He reports using cocaine and smoking marijuana in the past but “none in the past few months.” Admitting drug screens at CCF were normal.

Family History: Father is 43, mother 41, both living and well. He has an older sister age 25, and a brother age 21, both living and well. He has an aunt who is alcoholic and an uncle who died at age 28 of testicular cancer. His maternal grandmother died of myocardial infraction. Other grandparents are living and well.

Review of systems: No specific complaints on general review but admits to feeling anxious and depressed. Cardio respiratory: No chest pain, shortness of breath, palpitations or hemoptysis. GI: No nausea, vomiting, diarrhea, constipation. GU: No dysuria, urgency, frequency. Neuromuscular: no myalgia, arthralgia.

Physical exam: This is a well-developed, well nourished, moderately obese white male in no acute distress.

Height 5’6”, weight 185, temperature 98.3, pulse 72, respirations 20, blood pressure 135/88.

HEENT: Some male pattern alopecia starting; he has a large sebaceous cyst on the scalp, midline, measuring about 2cm in diameter. He states that this is getting larger and would like it removed because it is sometimes tender. Eyes: EOM intact. PERRLS, Snellen chart tests reveal vision 20/25 on right and 20/20 on the left, uncorrected. Ears: TM’s intact; hearing is grossly normal. Nose, mouth and throat: nose patent, tongue midline; pharynx not injected.

Neck: Supple; no bruits; no lymphadenopathy; thyroid normal.

Chest: Symmetrical expansion; lungs clear to auscultation and percussion.

Heart: regular sinus rhythm; no murmurs or gallops. S1, S2 normal.

Abdomen: Moderately obese; no organomegaly, masses, tenderness or hernia. A bowel sounds normal and active in all quadrants.

Rectal/genital: Circumcised, no lesions of penis, both test descended; no inguinal hernia; rectal negative to inspection, sphincter tone normal; prostate normal; stool guaiac negative.

Neurological: Sensation to touch and pain normal. Cranial nerves II-XII intact; No pathological reflexes.

Babinski negative. Deep tendon reflexes +2 and symmetrical.

Extremities: No varicosities or edema. Full range of motion in all extremities. Muscle strength normal.

Skin: Normal except for sebaceous cyst of scalp

- Impression:
1. Sebaceous cyst of scalp.
  2. Probable non-allergic intolerance to Haldol
  3. R/O situational depression

Medical Management Recommendation:

1. Avoid Haldol
2. Consider excision of scalp cyst in near future
3. No other medical problems at this time
4. Psychiatric consultation to follow.

Thank you for allowing me to see your patient.

**(General multisystem)**

## **Sample Documentation – 99243**

### **Level III Office/Outpatient Consultation**

TO: Dr. Attending Physician  
FROM: Dr. Consultant  
RE: Evaluation of retinopathy

This is a 32-year-old insulin-dependent diabetic being seen at the request of her family physician for evaluation of diabetic retinopathy. Her diabetes was diagnosed at age 12, and she has been controlled with insulin since that time. Her diabetes is basically stable and controlled by diet and medication. She is periodically evaluated for retinopathy. With the last examination about one year ago, reportedly she had very minimal nonproliferative retinopathy. The patient is not hypertensive. She has had no visual changes or problems, no blurring of vision, vision loss, scotoma, floaters, pain or photophobia. No dizziness, unsteadiness, lightheadedness or impairment of night vision. Review of systems otherwise within normal limits; she has no other health problems. She checks her blood sugar daily and adheres to her diabetic regimen. She takes no medications except her sliding scale insulin.

Exam: Visual acuity good with current corrective lenses; conjunctive are clear. No icterus. Gross visual fields intact. Extraocular movements intact; no nystagmus. Pupils equal, round react normally to light and accommodation. Pupils were dilated. Slit lamp examination showed no corneal abnormalities. Anterior chambers normal. Lenses clear. Intraocular pressures normal. Minimal nonproliferative retinopathy with a few very small areas of pinpoint exudates. Optic discs are flat and normal; posterior segments otherwise normal.

ASSESSMENT: Minimal nonproliferative retinopathy  
Insulin dependent diabetes mellitus

DISCUSSION & RECOMMENDATIONS: In comparing her current findings to my charts and mapping from her examination a year ago, I believe there has been no progression of her retinopathy in the past year. No intervention needs to be undertaken at this time. The patient should be cautioned to be particularly watchful for any change in visual symptomatology, to report any changes promptly, and to continue her efforts to follow her diabetic treatment plan faithfully. She should, of course, continue to receive yearly ophthalmologic evaluations.

Thank you for allowing me to participate in the care of your patient. I will be happy to see her again if any problems should arise.

**(Single organ system – eye)**

## Sample Documentation – 99244

### Level III Office/Outpatient Consultation

Dr. Internal Medicare Consult

1234 Anyway Place

Scottsville, Ohio 45111

January 7, 1999

Dear Dr. Orthopaedic Surgeon:

Thank you for your request for an Internal Medicine consultation on this 49-year-old male, who presents for pre-operative physical examination and clearance, scheduled for a right hip replacement in two weeks. The patient is hypertensive, has multifocal osteoarthritis with femoral head and acetabular degeneration of the right hip, and status-post polypectomy of the large intestine one year ago. The patient presents today with no new complaints though does need refills on antihypertensive med. Currently takes Ziac 5 mg/6.25 mg daily. Takes Motrin PRN, Voltaren 100 mg/day for arthritic exacerbation and pain. The OA of the right hip has grossly interfered with the patient's ADLs, and subjects him to constant pain and impaired gait.

PMH: Usual childhood diseases. T&A age 14; fracture right wrist age eight. Degenerative arthritis for "years". Fell and injured the right hip some years ago, without apparent sequelae until recently.

SH: Married; wife alive and well. Children: three, all well.

FH: As above. Siblings: two older brothers, both alive and well but history of DM and cataracts; one with history of colon CA. Mother and father died of "old age". History of HTN in brother and mother. No endocrine diseases, no thyroid problems, CA as noted.

ROS: HEENT: no complaints. Throat: T&A as noted. Ears: hears well without tinnitus. Cardio: HTN as noted, controlled on combination beta blocker/diuretic medication with good results. Denies other problems (angina, SOB). Resp/chest: no complaints. GI: occasional dyspepsia. Occasional diarrhea. Previous surgery as noted; no CA sequelae. Submits to annual colonoscopies by GI specialist. GU: urine dribbling; no other complaints. Skin: no complaints. No delayed lesion healing. Heme: no history excess bleeding. Musculoskeletal: Old fx as noted. OA as described, followed by orthopaedic surgeon. Takes meds as noted with some relief. Endo: no complaints. Neuro: no complaints. Psych: leads active life, OA-permitting. Occasional frustrations secondary to OA pain/debility.

O: Ht. 5'11"; Wt. 195 lbs. T: 98.6; P: 68; Bp: 136/88. General: well-developed, well-nourished adult male in no acute distress, who walks with guarded gait with slight limp, favoring to the left. Alert, oriented X 3. Head: WNL. No suspicious lesions. Ears, nose, throat: All WNL. Nasal mucosa pale; no exudates. Pharynx WNL. Ear canals hairy with minimal cerumen present. TM's clear. Eyes: PERRLA. EOMI. Sclerae and conjunctivae clear. Fundi: discs flat with narrowed arterioles. Neck: no cervical

lymphadenopathy. No tenderness. FROM. No JVD or bruits. CV: normal heart sounds; S1, S2. Has S4 gallop. No murmur or rub noted. Resp: good breath sounds, clear to P&A. Abd: no mass, tenderness, organomegaly (spleen/liver). BS sl. Hyperactive. Genitals: WNL. Testicles nontender and without mass. Some varicosities noted. Penis uncircumcised; several small papillomas in fold of prepuce noted but otherwise WNL. Rectal: no masses or hemorrhoids. Prostate nontender, +2 firm, not boggy. Skin: normal in color, turgor and without lesion.

Extremities/Joints: FROM though with obvious discomfort when performing SLR on the right. Hip ROM limited by pain. No arthritic changes noted over hands. There is minimal muscle atrophy noted at the right thigh, though not marked. Neuro: alert and oriented x 3. DTRs +2 in upper extremities and lower extremities.

The patient is accompanied by x-rays of the right and left hips with a full report by Radiology. On review of the films, there is severe degenerative joint disease of the right hip with mild changes on the left. Report states "severe osteoarthritis of the right hip involving the femoral head and acetabular rim."

EKG: NSR at 70; PR 0.12; QRS 0.08. Normal axis; no ischemic changes. UA: neg for glucosuria; WBCs neg; RBCs neg; ketones neg; protein neg; neg for bacteria; color: light yellow, clear; specific gravity: 1.018; pH 7.5.

A: Cleared for surgery pending labs. Bilateral OA, worse in right hip vs. left. Mild HTN, med-controlled. S/P polypectomy.

P: OK for surgery. Follow HTN. Refill Ziac. Anesthesia will manage HTN perioperatively. Handicapped parking sticker application completed and provided to patient.

This comprises the consultation note for this patient. I have suggested to the patient, who recently moved to this area and does not have a preferred Internist, that I can follow him for the above IM findings. The patient's blood was drawn and sent to the health plan's lab for CBC w/diff, platelets, SMA-20, clotting studies. A pre-op CXR has been ordered. Results of these tests will be provided to the pre-op center upon their arrival. Thank you for your kind request of this most pleasant patient. If I can be of further service to you, please let me know.

Internal Medicine Physician

**(General multisystem)**

## Sample Documentation-99245

### Level V Office/Outpatient Consultation

TO: Dr. Attending Psychiatrist

FROM: Dr. Consultant

RE: Evaluation of chest pain

History: This 63 year old female is seen at the request of Dr. Attending for evaluation of exertional chest pain. The patient reports upper chest pain radiating to the throat for the last 20 days; she reports one episode a day with each episode lasting 10 to 15 minutes occurring with normal physical activity such as housework. Another episode occurred at rest in the early AM hours, awakening the patient from sleep, associated with shortness of breath and fatigue. Also complains of an episode of syncope lasting about three minutes, 48 hours ago while standing at the sink. Her husband says the patient suddenly fell to the floor, bruising herself, but she exhibits no seizure - like activity

Past History: No allergies. Hysterectomy/oophorectomy age 56; usual childhood diseases; peptic ulcer age 52. She smokes a pack a day of cigarettes, and has borderline hypertension. No diabetes, hyperlipidemia or obesity. No other surgery or significant illnesses. She drinks three to four cups of coffee a day; ETOH socially. Three grown children, all healthy. No family history of MI. Mother dies of early renal failure at age 46; father died of liver cancer at age 73. Two sisters, both well. See self-history forms completed by patient.

Review of systems: She says a murmur was noted once on an insurance physical. She has aching in her legs below the calf, left more than right, on exertion such as walking up steps gradually increasing over the past three years, but the aching goes away with rest. No palpitations, shortness of breath, tremors, edema, dizziness, rheumatic fever, current GI or GU complaints, although she was treated for an ulcer in the past. She had migraines in the past. No problems with easy bruisability or unsteadiness or musculoskeletal problems. GYN: no problems since hysterectomy. Review of systems otherwise within normal limits.

Physical exam: General; BP 140/90, no orthostatic changes, pulse 72, respirations 14, afebrile. Well developed, slender white female in no acute distress, well oriented, communicative and verbalizing some apprehension about her health.

Neck: Jugular venous pressure normal. Carotid pulses full with bruit or transmitted murmur.

Lungs: Clear to percussion and auscultation. No intercostals retractions.

Cardiovascular: PMI normal, S1 and S2 and S4, present; no S3 or gallop or rub. Grade III/VI systolic murmur, radiates to carotids and a grade 1/6 diastolic blowing, murmur radiating to the carotids. No abdominal bruits. No carotid bruits..

Abdomen: Shows no masses, tenderness, organomegaly.

Extremities: bilateral soft femoral bruits. Pulses are diminished in DP/PT arteries bilaterally. No pedal edema or varicosities.

EKG: Sinus rhythm at 72. PR 0.16, Axis +30, no old MI or ischemic changes. QRS 0.08.

- Impression:
1. Crescendo Angina
    - A. R/O CAD
    - B. R/O Aortic Stenosis
  2. Syncope
    - A. due to cardiac arrhythmia secondary to ischemia
    - B. R/O aortic stenosis
  3. Aortic stenosis
    - A. no history of rheumatic fever
    - B. consider congenital bicuspid aortic valve type
  4. Claudication
    - A. consistent with peripheral atherosclerosis
    - B. level below knee L>R

Recommendations:

1. Stat admission to CUU
2. R/O MI protocol
3. Check lipids, thyroid function, CBC
4. Stat echocardiogram
5. Possible cardiac catheterization
6. Smoking cessation emphasized

I discussed the above recommendations and risks with the patient and her husband, who both understand and agree with the need for emergency admission. As you recall, I telephoned your office and as per our discussion arranged for the emergency admission.

We also discussed various medications that may be used for angina with aortic stenosis and claudication before it is begun.

Thank you for allowing me to participate in the care of your patient.

**(Single organ system-cardiovascular)**

## **Sample Documentation – 99251**

### **Level I Initial Inpatient Consultation**

TO: Dr. Attending Physician  
FROM: Dr. Consultant  
RE: Management of pernicious anemia

This 68-year-old was admitted to the hospital last night following a fall down an escalator with resultant exacerbation of his chronic back problems. The patient has known pernicious anemia, diagnosed about three years ago and receives monthly B12 shots which have controlled the anemia well. The patient had his last B12 shot one week ago. No other pertinent history or complaints.

EXAM: Vitals were reviewed and are stable. There is some bruising over the back area, including lower lumbar and buttocks, and upper thigh, and there are a few areas of ecchymosis over the left arm and shoulder. No other ecchymosis or bruising observed. HEENT within normal limits. No pallor or glossitis. Heart and lungs clear to auscultation and percussion; regular rate and rhythm. No abdominal tenderness or masses. No peripheral edema. Neuro – alert and oriented x 3. No ataxia.

Admitting laboratory blood work all within acceptable limits. HGB 12g, HCT 35%, MCV 95.

IMPRESSION: Known pernicious anemia currently well controlled in a trauma patient.

RECOMMENDATIONS: Observe, but anticipate no problems with anemia at this time. Continue current B12 regimen.

Thank you for asking me to see this patient; I will be happy to see him again if any problems arise.

**(Single organ system – hematology/immunology/lymphatics)**

## **Sample Documentation – 99252**

### **Level II Initial Inpatient Consultation**

TO: Dr. Attending Physician  
FROM: Dr. Consultant  
RE: Evaluation of hearing loss

I was called in consultation to evaluate this 45-year-old male for progressive hearing loss. The patient was admitted four days ago for bleeding ulcers, and upon history and physical examination was noted to have decreased hearing. The patient denies any history of chronic middle ear disease as a child. He does report minimal tinnitus when he is sitting in a quiet room, but denies any dizziness. His wife has complained that she has to repeat things and wondered if he needed a hearing aid. He has a past history of noise exposure while hunting and while working in a manufacturing plant in his early 20s. He has worn ear protection while using firearms or around machinery for the past 12 years.

Physical exam: External auditory canals are clear; TM's are intact with no scarring or bulging, normal mobility. Rinne and Weber tests are normal. Exam of the nose and sinuses shows no obstructions, discharge, tenderness or other abnormalities. Oral cavity is clear; teeth are in good repair. Oropharynx and posterior pharynx all within normal limits.

Audiometry shows bilateral sloping, moderate high frequency sensorineural hearing loss from 2 kHz without an air-bone gap. Impedance studies were normal.

IMPRESSION: Bilateral moderate high frequency sensorineural hearing loss

#### **RECOMMENDATIONS:**

Hearing aid evaluation and fitting  
Hearing conservation program to reduce and protect him from noise trauma

Thank you for allowing me to see your patient.

**(Single organ system – ENT)**

## **Sample Documentation – 99253**

### **Level III Initial Inpatient Consultation**

TO: Dr. Attending Physician  
FROM: Dr. Consultant  
RE: Evaluation of cataracts

History: This 79-year-old white female with multiple problems was transferred from her nursing home two days ago for chest pain, nausea and vomiting which are being treated by her attending physician. He has requested that I evaluate the patient for possible cataract surgery. The patient is somewhat difficult to communicate with, and history was taken from the hospital record and from her daughter. The daughter states that her mother was diagnosed with cataracts some time ago and had declined surgery although she was warned about the possibility of losing her sight if the cataracts progressed. The daughter states that her mother's vision has gradually gotten worse over the past few years, and her mother has recently indicated that she can no longer read, see the television, or distinguish among utensils at the table. The patient has stated that she would be willing to have the procedure done.

The patient has a past history of arthritis, mild hypertension, diverticulosis with occasional diverticulitis, status post hysterectomy; has one child, age 55, living and well; and was widowed in her 50s when her husband died in an accident. Review of systems is generally as recorded in the admitting note except that her gastrointestinal symptoms and mentation are markedly improved with treatment and hydration. No known allergies; no other significant history or complaints.

Physical examination: Elderly, thin, well-developed white female, oriented to time and place, BP 148/86. The patient is pleasant but clearly prefers that her daughter speak for her. She responds appropriately to direct questions. The patient hears well.

Examination of the eyes shows limited visual acuity due to mature cataracts in both eyes. Extraocular movements intact. Conjunctivae pink. Pupils equal, reactive to light and accommodation. Slit lamp exam shows normal anterior chambers, mature posterior subcapsular cataracts. Discs and posterior segments normal as far as can be determined at this time but examination is obscured by the cataract. Intraocular pressures normal.

Impression: Bilateral mature posterior subcapsular cataracts

Recommendations: The patient will clearly benefit from removal of the cataracts and replacement with intraocular lens. After discussion with the patient and her daughter, we decided to schedule the first cataract procedure as soon as possible, with the second to follow at a suitable interval. Intraocular lens will be placed at the time of surgery with anticipated visual correction to 20/25. The daughter asked whether or not the first procedure could be done before her mother was discharged. I advised her that surgery would not be done until her GI symptoms are completely resolved, and therefore she would be discharged prior to the procedure.

Thank you for allowing me to see this patient.

**(Single organ system – eye)**

## **Sample Documentation – 99254**

### **Level IV Initial Inpatient Consultation**

TO: Dr. Attending Physician  
FROM: Dr. Consultant  
RE: New onset – seizure activity

History: This seven-year-old male was admitted because he experienced three episodes of seizure activity in the week prior to admission. All three episodes occurred early in the morning, shortly after awakening, and all were observed by family members. The episodes reportedly lasted from two to three minutes on each occasion and involved generalized tonic-clonic movements and loss of consciousness; with loss of bladder control. The patient experienced a definite postictal state, sleeping for three hours and complaining of muscle aches and pains upon awakening with no memory of the seizure activity. The family states that they believe that each episode seems progressively longer. The patient has had no seizures observed in the hospital. The only aura-type prodrome that may be present is tingling in the left leg the night before each event. No fevers in association with the seizures.

Past History: Product of a normal pregnancy, labor and delivery. Normal developmental milestones. Detailed history from both parents elicited to etiology for seizure onset. The patient's immunizations are up to date. He has no past history of chronic conditions including infections, asthma or any other conditions. He sprained his ankle last fall. He is active, participating in sports activities, has a normal diet, and has no past or recent history of other trauma, especially head trauma. He has had no illnesses within the past several weeks, no colds, fevers, flu, GI or GU disturbances and no neurological symptoms.

He lives with his family, is a second grader and does well in school, and has no learning difficulties. No one in the family has been ill within the past several weeks. No alcohol, tobacco or drug use. Past, family, social history and review of systems is otherwise within normal limits. No known exposure to toxic substances.

Physical examination: Vitals including blood pressure, pulse, temperature, respirations, height and weight all within normal limits for age. Well developed, well nourished child. Alert and oriented, lying quietly in bed, somewhat mischievous, but cooperative and relaxed.

HEENT: Eyes show flat discs, EOMI, PERRLA, no abnormalities. ENT clear. Neck supple, no masses or tenderness. Lungs clear. Heart regular rhythm, no murmur.

NEUROLOGICAL: Gait and station are normal. Muscle strength and tone equal and age-appropriate in all extremities. Recent and distant memory appropriate. Attention span excellent for his age. Language and fund of knowledge appropriate for his age group. Cranial nerves II through XII all completely normal. Sensation normal to touch and pinprick. Deep tendon reflexes +2 in all four extremities. Cerebellar finger to nose, upper and lower rapid alternating movements, heel to shin all normal for age. Fine motor coordination appropriate for his age.

Lab: EEG done as an outpatient prior to last seizure showed spike discharges from left temporal lobe.

IMPRESSION: Tonic-clonic seizure. Possibly following a partial seizure with secondary generalization.

DISCUSSION: Workup will include fasting glucose, calcium, magnesium and electrolyte. Further investigation with neuro-imaging in a child with a normal history and neuro exam is not indicated at this time. Will begin Phenobarbital 4 mgm/KG/Day.

I have discussed these recommendations with his parents, and they agree to proceed with the workup and treatment plan if you agree. Thank you for allowing me to participate in the care of your patient.

**(Single organ system – neurology)**

## **Sample Documentation-99255**

### **Level V Initial Inpatient Consultation**

TO: Dr. Attending Psychiatrist  
FROM: Dr. Consultant  
RE: Evaluation for GI bleed

History: This is the first Community Hospital admission for this 76 year old female who noted the onset of black tarry stools and lightheadedness some three days prior to admission. She has a known history of recurrent peptic ulcer disease over the past 10 years for which she has been treated with the usual dietary restrictions, H2 blockers and antacids. She also is a long-standing hypertensive, without complications, for which she is presently on Vasotec 10 mg a day and HCTZ 25 mg a day. There is no past history of renal involvement of cardiac involvement. The day prior to admission, her lightheadedness increased with dizziness on mild exertion. Her black stools become more frequent. She had the onset of the sensation of substernal chest pressure, which on the morning of admission progressed to anterior chest pain with some radiation into the neck toward the left shoulder.

On admission to the hospital in the ER, she was noted to have hematocrit and hemoglobin of 22 and 7. Her EKG revealed ST depression and T-wave inversion in the lateral precordial leads, consistent with subendocardial ischemia. Her blood pressure was 98/64. She responded to the use of sublingual nitrates and the addition of parenteral calcium channel blocker to her regime. She also received three units of packed RBC's with her hematocrit now 30 and hemoglobin of 10, with normal limits.

Past History: Previous hospitalization was for a hysterectomy at age 42, for menometrorrhagia. No other surgery. Only other hospitalization was for childbirth, gravida 2, para 1, AB 1. No other significant medical problems or chronic illness. Review of systems otherwise within normal limits.

Family History: Father died at age 81, acute myocardial infraction; he was hypertensive with NIDDM controlled by diet. Mother died at age 59 of ovarian cancer. Three brothers, all deceased, one of complications of alcohol abuse, one of coronary heart disease and one of complications of diabetes. Her sister, age 69, is living with mild hypertension, controlled medications. No other relevant family history. She is married; her husband is 77 abd in good health except for diffuse degenerative joint disease. She has one living daughter, age 50, mild hypertensive. She is a high school graduate, retired clerk. Uses alcohol sparingly, uses caffeine moderately. Regular medications include H2 blockers, Vasotec and HCTZ as noted above. She occasionally uses enteric-coated aspirin to relieve aches and pains.

Physical exam: respirations 22 and somewhat labored, temperature 99.3, pulse 96, BP 112/78. The patient is pale and somewhat dyspneic, otherwise in no acute distress.

HEENT: Eyes: PERRLA; EOMI; ears, nose, mouth and throat all clear with no signs of infection. Neck supple, trachea midline; no thyromegaly; no cervical or submandibular nodes. Neck vein distension to 14cm. Normal carotids. Breasts are negative with no masses, no nipple discharge. Lungs reveal occasional fine rales at both bases, otherwise clear to auscultation and percussion; no use of accessory muscles of respiration.

Heart: PMI, normal sinus rhythm, soft third heart sound, no murmurs. Abdomen soft, nontender, without palpable masses or organomegaly. Bowel sounds are normal. Extremities are negative with good pulses, no edema, cyanosis or clubbing. Neurological exam is grossly normal; cranial nerves intact. DTR's equal. Pelvic exam deferred. Rectal exam revealed soft, mushy black stool strongly heme positive.

- Impression:
1. Massive upper GI hemorrhage, probable secondary to reactivation of known peptic ulcer disease.
  2. Hypertension, resolved with transfusions
  3. Angina pectoris, secondary to acute anemia and hypotension
  4. Mild CHF secondary to blood transfusion overload

**RECOMMENDATIONS:**

1. Admit to IUC R/O MI protocol
2. Transfuse with RBC's to maintain hematocrit of 30 or above
3. Once the patient is stabilized, therapeutic endoscopy for management of GI bleed
4. Hold antihypertensives until needed
5. Bumetanide for fluid overload/CHF
6. Biopsy for H. Pylori during endoscopy

Thank you for asking me to see your patient.

**(General multisystem)**

## **Sample Documentation – 99261**

### **Level I Inpatient, Follow-up Consultation**

TO: Dr. Attending Physician  
FROM: Dr. Consultant  
RE: Follow-up on neurological examination of Mr. Patient for postoperative paresis, weakness of extremities.

I returned to see Mr. Patient following our workup for his numbness, tingling, weakness and paresis of his lower extremities following cholecystectomy four days ago. The patient reported the symptoms above upon attempts to have him ambulate following his procedure which was done with an epidural catheter placed for postoperative pain control. Examination on the initial evaluation showed no gross neurological or muscular deficits on testing. Review of his charts as well as his brain scan and laboratory evaluations show no evidence of neurological disorder. Both the patient and the nursing notes indicate that the patient's strength and gait have returned to normal considering his postoperative state.

Neurological examination today shows appropriate postoperative muscle strength in the lower extremities, excellent muscle tone, deep tendon reflexes within normal limits, and appropriate response to touch and pinprick. Gait and station are appropriate for a postoperative patient.

I explained to the patient that I cannot explain the symptoms that he experienced following surgery. They may represent a rare reaction to the epidural medications, but more likely there is a strong psychological component related to concerns about the subdural catheter placement as well as the overall stress of surgery. I anticipate no further problems for this patient.

Thank you for allowing me to see your patient. I will be happy to see him again in the future if any further problems arise.

**(Single organ system – neurological)**

## **Sample Documentation – 99262**

### **Level II Inpatient, Follow-up Consultation**

TO: Dr. Attending Physician

FROM: Dr. Consultant

RE: The patient is now five days postop. You have asked me to evaluate postop pneumonia. He says that he is feeling much better, chest no longer hurts except when he coughs, and he says he is having no trouble with breathing except for incisional pain which is worse when he coughs. He had been producing less sputum. He says his appetite has improved and he generally feels better. Mild fever reported by nursing.

Physical exam shows his lungs to be clearing although there is still some wheezing and rhonchi in the lung bases; no costal retractions. No submandibular, cervical or axillary adenopathy. Heart shows regular rate and rhythm. Temperature and respirations are now normal. Midline abdominal incision is healing well with no evidence of infection at the site.

Impression: pneumonia is resolving; continue with IV meds. Patient encouraged to continue to ambulate frequently, to use spirometry Q 4 Hrs., to cough, and to maintain fluid intake. Respiratory therapy will continue to see the patient daily until discharge. Patient can be switched to oral Augmentin to complete a 10 day course of Rx but is otherwise ready for discharge.

Thank you for asking me to see your patient.

**(General multisystem)**

## Sample Documentation – 99263

### Level III Inpatient, Follow-up Consultation

TO: Dr. Attending Physician  
FROM: Dr. Consultant  
RE: Reevaluation of pregnancy

History: I evaluated this patient on admission, two days ago, following an auto accident in which the patient sustained two fractured ribs and a closed head injury. On admission, the patient was known to be nine weeks pregnant and had begun prenatal care with our practice. At that time, the patient was stable from an OB viewpoint with no symptoms or injury or threat to the pregnancy. I was called because this afternoon, just prior to her scheduled discharge, the patient began complaining of cramp abdominal pain and noted small amounts of vaginal bleeding with no dysuria, urinary frequency, nausea, vomiting or fever. She said that the cramping abdominal pain had begun about two hours before she reported it to the nursing staff, and was increasing in intensity. No known drug allergies. Past, family, social history, and review of systems is as reported in my original consultation report except that the patient reports abdominal pain and cramping of increasing intensity in the lower abdominal-pelvic area, and vaginal bleeding. Symptoms relating to her original injury are somewhat relieved, although she still has some headache and chest wall pain, as well as discomfort from various abrasions and bruises. This is the patient's first pregnancy.

PHYSICAL EXAM: This is a slender, alert, female, somewhat pale and apprehensive, with stable vital signs including temperature 99.1, pulse 88, respirations 22, and blood pressure 120/80. The abdomen is soft and flat; there are no masses, no hepato- or splenomegaly; there is definite tenderness to direct palpation in the lower abdomen which does not localize to either side. No rebound or guarding; no inguinal adenopathy. On pelvic examination, external genitalia normal, no urethral tenderness; bladder is not palpable; blood is noted in the vagina; the cervix is open with blood and tissue visible; uterus is soft and boggy; adnexae not palpable.

LABORATORY DATA: White count 13,000, 8 percent bands, 74 percent neutrophils. Urinalysis is within normal limits; Serum hCG is positive.

IMPRESSION: Spontaneous abortion in a patient with rib fractures and closed head injury.

### RECOMMENDATIONS:

1. Complete spontaneous abortion with suction curettage
2. Depo-Provera 150 mg intramuscularly
3. Preoperative clearance by neurology and anesthesia relating to sedation in patient with closed head injury
4. Rx of doxycycline and Tylenol following curettage
5. Follow-up in the office in two weeks following discharge

DISCUSSION: The patient and her husband are understandably upset by this outcome to the pregnancy, and we had a lengthy discussion regarding this event and the potential for future pregnancy. (Length of visit 40 minutes/discussion 30 minutes).

**(Single organ system – genitourinary-female)**

- This brings to our attention probably the most egregious misuse of these codes, or lack of their use. Primarily because Medicare does not cover these services, providers have long had a tendency to substitute 99214 or 99215 for preventive services because the history and examinations were often similar in their breadth and depth. When two services are provided, for example an annual preventive service and the management of several chronic problems – code both. These services are notable for the fact that there is no medical decision making in their description.
- Check with other commercial or third-party payers to see if there is a protocol or method of reporting combined services of this nature. Many carriers will not pay for two such services on the same day, or their computer systems will routinely deny one of the codes. Bring the situation to their attention.

## Quick Comparison

### Preventive Medicine Services – New Patient

<b>E/M Code</b>	<b>Patient Status</b>	<b>Age</b>	<b>History</b>	<b>Exam</b>	<b>Medical Decision Making<sup>1</sup></b>
99381	No complaints	Under 1 year	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99382	No complaints	1-4 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99383	No complaints	5-11 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99384	No complaints	12-17 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99385	No complaints	18-39 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99386	No complaints	40-64 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99387	No complaints	65 and over	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures

<sup>1</sup> Includes age appropriate immunizations, laboratory/diagnostic procedures and age appropriate counseling/anticipatory guidance and risk factor reduction intervention(s).

## Quick Comparison

### Preventive Medicine Services – Established Patient

<b>E/M Code</b>	<b>Patient Status</b>	<b>Age</b>	<b>History</b>	<b>Exam</b>	<b>Medical Decision Making<sup>1</sup></b>
99391	No complaints	Under 1 year	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99392	No complaints	1-4 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99393	No complaints	5-11 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99394	No complaints	12-17 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99395	No complaints	18-39 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99396	No complaints	40-64 years	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures
99397	No complaints	65 and over	Age and gender appropriate	Age and gender appropriate	Ordering lab/diagnostic procedures

<sup>1</sup> Includes age appropriate immunizations, laboratory/diagnostic procedures and age appropriate counseling/anticipatory guidance and risk factor reduction intervention(s).

## Quick Comparison

### Preventive Medicine Services – Counseling and/or Risk Factor Reduction Intervention

<b>E/M Code</b>	<b>Patient Status</b>	<b>Intent of Service</b>	<b>Time</b>
<b>Individual Counseling</b>			
99401	No complaints	Promote health, prevent illness or injury	15 min
99402	No complaints	Promote health, prevent illness or injury	30 min
99403	No complaints	Promote health, prevent illness or injury	45 min
99404	No complaints	Promote health, prevent illness or injury	60 min
<b>Group Counseling</b>			
99411	No complaints	Promote health	30 min
99412	No complaints	Promote health	60 min
Other Preventive Medicine Services			
99420		Administer and interpret health risk assessment	N/A
99429		Unlisted preventive medicine service	

## **Code of Conduct Receipt and Acknowledgement**

I acknowledge that I have received a copy of University of Nevada School of Medicine's Code of Conduct.

I understand that each UNSOM faculty/staff member, officer, director, employee and relevant agents and independent contractors are responsible for knowing and adhering to the Code of Conduct.

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Print Name and Signature

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Date

**University of Nevada School of Medicine  
Certification of Receipt of the Billing Compliance Manual**

By my signature below, I certify that I have received the University of Nevada School of Medicine Billing Compliance Manual. I understand that I am responsible for knowing its content, and if I have any questions, I should address them promptly to the Compliance Officer or the practice plan administration. I agree to abide by the terms of the Billing Compliance Manual and understand that there may be disciplinary consequences for non-compliance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Department