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PREAMBLE

The Department of Pediatrics at the University of Utah Health Sciences Center (UUHSC) wishes to ensure that its documentation, professional fee coding and billing are conducted in accordance with all applicable laws. The purpose of this document is to provide the faculty and staff with guidelines regarding medical record documentation, the professional fee coding and billing of clinical services.

OVERVIEW

The policies and procedures set forth in this document are based upon applicable governmental regulations and other appropriate sources.

DEPARTMENTAL COMPLIANCE OVERSIGHT

Department Compliance Liaison

The Department of Pediatrics at the University of Utah Health Sciences Center appointed Dr. John Bohnsack as Departmental Compliance Liaison (single-point-of-contact with the Compliance Office) and Chairman of the Departmental Committee.

Dr. Bohnsack will have authority to direct and require (with support of the Department Chairman and the Departmental Compliance Committee) any activity necessary to assure compliance with Departmental, UUHSC and/or federal regulations concerning any departmental personnel, to include faculty, non-physician practitioners, residents and ancillary staff.

Compliance issues should be directed to the Compliance Committee Chairman for immediate attention. Every report of a potential violation will be immediately reviewed and evaluated.

Departmental Compliance Committee

The Department of Pediatrics established a Compliance Committee to oversee and supervise compliance related activities. The responsibilities of the departmental compliance committee include:

- Administer the department's compliance plan
- Review, revise and formulate policies to guide professional fee billing
- Supervise prospective internal audits to evaluate compliance
- Assist in addressing compliance issues arising from audits
- Provide overall compliance leadership for the Department
The Department of Pediatrics Compliance Committee consists of the following members:

1) John Bohnsack, MD  Chairman, Compliance Committee
2) Richard Lemons, MD, PhD  Faculty Provider
3) Patty McCarroll, MBA  Department Administrative Director
4) Rose Poll, MSHA,CPC  Manager, Revenue Cycle
5) Yvonne Rawlins, CPC  Coding & Scheduling Supervisor
6) Raoul Nelson, MD, PhD  Faculty Provider
7) Shari Combe, PA  Ancillary Provider

DEPARTMENTAL COMPLIANCE ACTIVITIES

Department of Pediatrics compliance activities include: medical record documentation, professional fee coding, internal reviews, monitoring, education and training, investigation and corrective action plans when areas of risk have been identified.

The following activities will be conducted and supervised by the Departmental Compliance Committee and coordinated with the Health Sciences Center Compliance Office.

Ensuring Faculty & Resident Compliance with Regulations

The Compliance Committee will keep the Departmental Chairman informed of current regulations relative to billing and will monitor compliance with these regulations.

Audits

- Annual audits will be mandatory for every clinician who performs billable work. These audits will be performed by the UUHSC’s Compliance Office.
- Audits will be done using the guidance provided by the Compliance Office for New Clinician, Phase I and Phase II.
- The number of encounters (E/M or procedures) audited will vary from clinician to clinician depending on the type and/or location in which encounters are performed.
- The findings from these audits will be shared with the Department Compliance Committee in order to establish an appropriate corrective action plan specific to the identified areas of risk.
- Upon implementation of the corrective action plan, follow-up efforts will be made to assure that all requirements are understood and carried out.
- Areas of risk identified on a consistent basis will be reviewed by the Department Chairman for further action.
- Regular meetings will be held for the professional fee billing staff to provide billing updates and to answer any billing questions.
Education and Training

- All departmental personnel involved in delivering clinical care, medical record documentation, and professional fee billing will be required to undertake a mandatory job specific training program. Completion of the training will be tracked to assure that employees receive proper training.
- Additional re-training may be required as a result of the audit process or when re-credentialing takes place.
- All training will be coordinated with the UUHSC Compliance Office.

Investigating Reports for Possible Compliance Issues

- Any employee may raise concerns about possible compliance issues. These questions should be brought to the attention of the Department Compliance Chairman.
- Due to the sensitivity of these issues, the Department Compliance Chairman will initiate an investigation into the problem by assigning an investigator and coordinating the plan for the investigation. The Department Compliance Chairman also has the authority to ask for assistance from the UUHSC Compliance Office if necessary.
- In the event of any confirmed problems, corrective action will be developed and implemented as quickly as possible.

The corrective actions could be but are not limited to the following:

  o Education sessions
  o Refund of payments

The circumstances and corrective action will be disclosed to the UUHSC Compliance Office in all cases.
DEPARTMENTAL GUIDING PRINCIPLE

The Department Policies and Guidance will be used by faculty members, ancillary staff and other personnel performing documentation, professional fee coding and billing of medical services.

The primary focus of the Department of Pediatrics' Compliance Plan will be on the Centers for Medicare and Medicaid (CMS) documentation guidelines which (by reference) include but are not limited to guidelines found in Current Procedural Terminology (CPT) for evaluation and management (E/M) services, procedures and other services.

As CMS uses other tools that are incorporated (by reference) into their regulations (International Classification of Diseases (ICD-9-CM), the Health Care Financing Common Procedure Coding System Level II (HCPCS) and the National Correct Coding Manual, formerly called the National Correct Coding Initiative (CCI), the Department will also follow these documentation, coding and billing guidelines.

These recognized coding systems have documentation standards and guidelines that are used by Medical Records Departments, Medical Schools, CPC & CPC-H Coders, Medicare, Medicaid, and most third party payers as the recognized way to document any service or procedure provided to any patient.

DEFINITIONS

Ancillary Staff

Ancillary staff includes any personnel who collect and record basic clinical information about the patient (e.g. vital signs and other information including, weight, height, etc.).

Attending Physician

An “attending” physician means a physician who is the major contributor of patient care and who renders sufficient personal and identifiable medical services to a patient in such a manner as to exercise full, “personal” control over the management of that patient. These would be services similar to those provided by a private physician in a private office and would be billable on a fee-for-service basis.

If the physician does not meet the “attending” physician criteria, as mentioned above, his/her activities would be considered “supervisory” only and therefore not a billable service.
Countersignature

CMS has indicated that a countersignature by a “teaching” physician does not justify the billability of a service to the Medicare Part B program.

CMS

CMS is the Centers for Medicare and Medicaid Services, formerly known as HCFA.

CPT

CPT is the Current Procedural Terminology manual published by the American Medical Association (AMA) annually.

Critical or Key Portion

For an E/M service the critical or key portions means the history, physical and medical decision making components of an E/M service.

For a procedure, the critical or key portion means that part (or parts) of a procedure determined by the teaching physician to be the critical or key portion(s) of a procedure characterizing the essential tasks necessary for the completion of that procedure.

Documentation

Documentation is a chronological record of the patient’s medical condition, care, responses to treatment, and provider rationale for treatment.

- It is a legal document that affects reimbursement from health plans and quality of care issues in a court of law.
- If it is not written and signed, it was not done.

The documentation may be dictated and typed, hand-written or computer-generated and must include the legible signature or identity the person taking the information as well as the legible signature of the attending physician, who is responsible for that record.

The medical record must provide pertinent facts, findings and observations about an individual's health history including past and present illnesses, examinations, tests, treatments and outcomes.
Encounter

Each encounter must be a stand-alone document and must facilitate:

- The ability of the physician and other health care professionals to evaluate and plan a patient’s immediate treatment, and to monitor the patient’s health care over time;
- Communication and continuity of care among physicians and other health care professionals involved in a patient’s care;
- Accurate and timely claims review and payment; and
- Appropriate utilization review and quality of care evaluations

E/M – Evaluation/Management

These services include office visits, in-patient hospital visits, outpatient hospital visits, emergency department visits, consultations, nursing home visits, and other non-hospital visits.

E/M codes encompass a wide variation of skill, effort, time, responsibility, and medical knowledge that is required for the promotion of optimal health and the prevention or diagnosis and treatment of an illness or injury.

Faculty

A faculty member is defined as an individual with a faculty appointment in the School of Medicine.

H&P – History and Physical

The term H&P is to include all components of the E/M service as defined in the CPT manual. An H&P, includes a description of the provisional diagnosis, chief complaint, present illness or injury, impression and treatment plan and a history and a physical exam to the appropriate level, based on the presenting illness/problem.

House Staff

The term house staff is interchangeable with a house officer. Interns, residents, and clinical fellows are other terms for house staff/house officer. The house staff is an individual at any level of graduate medical education (GME) in a program accredited by the ACGME.

For the purpose of this manual, this term shall apply to all trainees appointed as residents and fellows in any accredited training program or to any trainee in a subspecialty program.
ICD-9

International Classification of Diseases, Version 9, Clinical Modification (also known as ICD-9-CM).

The term “clinical” is used to emphasize the modification’s intent:

- To serve as a useful tool to classify morbidity data
- To index medical records
- To assist in medical care reviews and ambulatory and other medical care programs and
- To identify a patient’s basic health status

To describe the clinical picture of the patient, the ICD-9-CM code must be more precise, to the fourth of fifth digit when applicable, than those needed only for statistical groupings and trend analysis.

Immediate Availability

Although CMS has not defined immediate availability in terms of geographic location vis-à-vis, the operating room, patient care room or office/clinic examination room, UUHSC considers immediately available to mean, “within easy walking distance of the patient care unit.”

Key Elements/Components

The CPT recognizes seven specific element or components that make up an E/M service, six of which are used in defining the level of E/M service. These components are:

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

Of the seven elements that make up any level of E/M service, the HISTORY, the EXAMINATION and the MEDICAL DECISION MAKING are considered the “key components.”

To determine the level of service, it is the key components that drive the selection unless the visit consists predominantly of counseling or coordination of care. In these cases, the time spent with the patient must be documented.
Medical Record

The medical record is a composite of information detailing a patient's medical care, including both paper and electronic records.

Modifiers

For coding and billing purposes, a modifier provides the means by which the reporting physician can indicate that a service has been altered by some specific circumstance but not changed in definition or code.

The documentation must show why the modifier was used. Modifiers can be found in the CPT and HCPCS coding manuals.

**CPT Modifiers** – These are two digit modifiers, recognized by most third party payers and usually have some kind of payment consideration attached.

Examples:  
-22 Unusual Procedural Services – When the service(s) provided is greater than that usually required for the listed procedure.

-52 Reduced Services – When a service or procedure is partially reduced or eliminated at the physician discretion.

-59 Distinct Procedural Service – When a service or procedure was distinct or independent from other services performed on the same day.

**HCPCS Modifiers** – These modifiers are two digit alpha or alpha-numeric and are also recognized by most third party payers. However, these codes, unlike the CPT modifiers, are primarily informative in nature and have no payment consideration.

Examples:  
-LT Left
-RT Right
-F&R Right hand, third digit
-GC A service has been performed in part by a resident under the direction of a teaching physician

**PATH – Physicians at Teaching Hospitals**

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) announced what is described as "a series of nationwide reviews of compliance with rules governing physicians at teaching hospital (PATH) and other Medicare payment rules."
As described by the OIG these PATH audits focused on two issues: 1) compliance with the Medicare rule affecting payment for physician service provided by resident; and 2) whether the level of the physician services was coded properly.

Currently, no new PATH audits have been initiated by the OIG. Institutions remain vulnerable to whistleblower suits being filed on “PATH-like” issues, such as whether the teaching physician was present for a service or procedure and whether services were properly coded.

It is the Policy of the Department of Pediatrics to comply with Supervising Physicians in Teaching Setting regulations.

**Physically Present**

Physically present means that the teaching physician must be in the same room and directly involved in providing or supervising the patient care.

**Same Room**

This term is defined as a patient’s room partitioned or curtained or any patient subdivided area that can accommodate multiple patients.

**Referral**

A referral is a transfer of the care of a patient from one health care professional to another. Some general rules that may help identify a transfer of care patient:

- The diagnosis of the patient is usually known upon referral;
- When referred, the referring doctor generally asks the receiving physician to assume the management of the patient’s care;
- An encounter is provided with a course of treatment or management already in mind for the patient;
- The patient will return for additional management and treatment; and
- The receiving physician assumes complete care of the patient and need not discuss the case further with the referring physician.

A transfer and acceptance note must be written in the medical record and must contain the names of the responsible attending physicians approving the transfer and the acceptance of the patient.

**Supervising Physician**

A “supervising” physician is one who “signs off” on the work ancillary personnel provides to patients in medical settings. These include, but are not limited to, medical assistants, physician assistants, nurses, medical students, interns and residents.
By countersigning the patient record, the “supervising” physician assures that appropriate medical treatment has taken place, meets the necessary requirements for Graduate Medical Education (GME) funding, meets the necessary ACGME certification for the teaching programs and meets the necessary JCAHO requirements for hospital accreditation.

**Supervision**

Physician “supervision” has various degrees of responsibility, depending on the actual service provided.

**General Supervision**

General supervision means that a service or procedure is furnished under the overall direction and control of a teaching physician but his/her presence is not required during the performance of the procedure or service.

**Direct Supervision**

Direct supervision means that the teaching physician must be present in the office suite or patient care area and must remain “immediately available” to furnish assistance and/or direction throughout the performance of the service or procedure.

**Personal Supervision**

Personal supervision means that the teaching physician must be in the room during the performance of the service or procedure.

**Teaching Physician**

A teaching physician is a physician (other than another resident) who involves residents in the care of his/her patients.

**Resident Moonlighting**

Residents are not approved to moonlight in the subspecialty of training. Residents may moonlight in general pediatric clinics with the approval of the GME Director.

**DEPARTMENTAL POLICY GUIDELINES**

These guidelines establish departmental policy and procedures that will be followed by faculty members, ancillary staff and any other personnel working with issues that relate to documentation, professional fee coding and billing of medical services.

The standards for documentation, professional fee coding and billing should be equally important as quality of care standards.
GENERAL DOCUMENTATION POLICIES

Adequate documentation in the patient medical record is mandatory. It must contain all details regarding a patient’s plan and treatment of care for a particular disease or injury.

**Departmental Recognized Fundamentals of Documentation**

1. The medical record must be complete and legible.

2. The documentation of each patient encounter should include:
   
   a. The reason for the encounter (chief complaint);
   b. A relevant (pertinent) history of the presenting problem or illness;
   c. A relevant (pertinent) physical examination and findings;
   d. A review of diagnostic tests, if applicable;
   e. The assessment, clinical impression, diagnosis;
   f. The plan of care; and
   g. The date and the legible identity of the observer.

3. If not specifically documented, the rationale for ordering diagnostic or other ancillary services should be easily inferred.

4. The 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 treatments, or any 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.

8. Specific tests or procedures ordered or provided, while necessary to the physician for excellence of care, must be clearly identified as medically necessary within the documentation of that encounter.

**Definition, Terms and Tools Associated with E/M Services**

The definitions and terms used in this section have been compiled using the CPT, HCFA newsletters and updates (Medicare & Medicaid) and Specialty Societies with their published interpretations of Evaluation and Management services.
New Patient

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

Established Patient

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

Level of Service

Each level of service is intended to reflect the work involved in providing the evaluation and management (E/M) service.

Due to the fact that each level of service is dependent on two or three "key" components, the performance and the documentation of one (e.g. medical decision making) at the highest level does not necessarily mean that the encounter entirely qualifies for the billing of the highest level of service.

History

This KEY component encompasses the identification of the chief complaint (CC) (the reason for the encounter), the history of the presenting illness or problem (HPI), a review of the patient’s history as related to each body system (ROS), a past personal history (medical and social) and a family history (PFSH).

The following explains each of these elements and how they are used in the four types of history that make up the HISTORY component as defined in CPT.

Chief Complaint (CC)

The chief complaint (CC) (reason for the encounter) is a concise statement describing the symptom(s), problem(s), condition(s), diagnosis or other reason for the patient encounter and is required for each type of history.
History of the Presenting Illness or Problem (HPI)

The history of the presenting illness or problem (HPI) is a chronological description of the development of the patient’s presenting illness/problem. It includes all the signs, symptoms and conditions that significantly relate to the presenting illness/problem. The following are identified in CPT as the HPI.

- Location (position or site of the presenting problem)
- Quality (characteristics of the presenting problem)
- Severity (the precise condition)
- Duration (the length of time the patient has had this problem)
- Timing (precise moment of the presenting problem began)
- Context (circumstances about the presenting problem)
- Modifying factors
- Associated signs and symptoms

A Brief HPI is the documentation of 1-3 of the above items in the patient record. An Extended HPI is the documentation of 4 or more of the above items in the patient record.

Review of Systems (ROS)

A review of systems (ROS) is an inventory of the patient body systems obtained through a series of questions. This is NOT the examination; it is the patient’s history concerning their body systems.

The review of systems (ROS) helps define the problem, clarify the differential diagnosis, identify needed testing or serves as baseline data on other systems that might be affected by any possible management options.

For documentation purposes the following are recognized as part of the ROS:

- Constitutional symptoms (fever, weight loss, etc.)
- 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* is the documentation of a review of a single system directly related to the problem or illness identified in the HPI. Document the patient’s positive or negatives for the system related to the presenting problem or illness.

An *Extended ROS* is the documentation of the patient’s positive responses and the pertinent negatives of 2 –9 of the above body systems.

A *Complete ROS* requires documented inquiries about the system(s) that are directly related to the presenting problem(s) or illness identified in the HPI plus all additional body systems. Document the ROS of at least 10 organ systems with individually documented positive or pertinent negative responses. For the remaining systems, a notation indicating “all other systems are negative” is permissible.

**Past, Family and/or Social History (PFSH)**

The past, family and/or social history (PFHS) is the documented review of three different areas:

- The *patient’s past history* with illness, injury, trauma, hospitalization, operations, allergies, medications, growth and/or development and functional status. It may include other elements when applicable.
- The *patient’s family history* which is a review of medical events in the patient’s family including diseases which may be hereditary or place the patient at risk.
- The *patient’s social history* is an age specific appropriate review of his/her past and current activities that may include marital status, tobacco/alcohol/drug use, employment status, housing or home environment or other relevant social factors.

A *Pertinent PFSH* is a documented review of the history area(s) directly related to the problem or illness identified in the HPI. For any new patient encounter, 2 of the 3 PFHS (patients past, social, family history) must be documented. For any established patient encounter, only 1 PFHS (patients past, social, family history) must be documented.

A *Complete PFSH* is a documented review of at least two or in some cases all three of the PFHS areas. A documented review of all three of these areas is required for services that by their nature include a comprehensive assessment or re-assessment of a patient. For any new patient encounter, at least one notation is required in all three PFHS areas. For any established patient encounter, at least one notation is required in any two PFHS areas.
### Selection Table: Type of History

<table>
<thead>
<tr>
<th>Type of History</th>
<th>Definitions</th>
<th>CC</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>A brief history of the present illness or problem</td>
<td>Required</td>
<td>Brief</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>A brief history of the present illness or problem and a problem pertinent system review</td>
<td>Required</td>
<td>Brief</td>
<td>Problem Pertinent</td>
<td>N/A</td>
</tr>
<tr>
<td>Detailed</td>
<td>A pertinent (directly related to the patient’s problem) past, family and/or social history</td>
<td>Required</td>
<td>Extended</td>
<td>Extended</td>
<td>Pertinent</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>An extended history of the present illness or problem and a complete past, family and social history</td>
<td>Required</td>
<td>Extended</td>
<td>Complete</td>
<td>Complete</td>
</tr>
</tbody>
</table>

### Examination

The extent of the examination is dependent on the clinical judgment and on the nature of the patient’s presenting problem(s). An examination can be performed on any of the following body areas:

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

The following organ systems are recognized:

- Eyes
- Ears, Nose, Mouth, and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/Lymphatic/Immunologic
### Selection Table: Type of Examination

<table>
<thead>
<tr>
<th>Type of Examination</th>
<th>Definition</th>
<th>Systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>A limited examination of the affected body area or organ system</td>
<td>1-5</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>A limited examination of the affected body area or organ system and any other symptomatic or related body area or organ system</td>
<td>2-4</td>
</tr>
<tr>
<td>Detailed</td>
<td>An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s)</td>
<td>5-7</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>A general multi-system examination or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s)</td>
<td>8 or more</td>
</tr>
</tbody>
</table>

### Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option for the patient as measured by the following:

1. The documentation of the number of possible diagnoses and/or the number of management options that must be considered for this patient during or directly related to this encounter.

2. The documentation of the amount and/or complexity of the medical records, diagnostic tests, and/or any other information that must be obtained, reviewed and analyzed that must be considered for this patient during or directly related to this encounter.

3. The documentation of the risk of significant complications, morbidity and/or mortality, as well as co-morbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options that must be considered for this patient during or directly related to the encounter.
### Selection Table: Type of Medical Decision Making (MDM)

<table>
<thead>
<tr>
<th>Type of MDM</th>
<th>Description</th>
<th>Amount of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straight forward</td>
<td>Number of diagnoses or management options</td>
<td>-Minimal</td>
</tr>
<tr>
<td></td>
<td>Amount and complexity of data to be reviewed</td>
<td>-None/Minimal</td>
</tr>
<tr>
<td></td>
<td>Risk of complications &amp;/or co-morbidity or mortality</td>
<td>-Minimal</td>
</tr>
<tr>
<td>Low Complexity</td>
<td>Number of diagnoses or management options</td>
<td>-Limited</td>
</tr>
<tr>
<td></td>
<td>Amount and complexity of data to be reviewed</td>
<td>-Limited</td>
</tr>
<tr>
<td></td>
<td>Risk of complications &amp;/or co-morbidity or mortality</td>
<td>-Low</td>
</tr>
<tr>
<td>Moderate Complexity</td>
<td>Number of diagnoses or management options</td>
<td>-Multiple</td>
</tr>
<tr>
<td></td>
<td>Amount and complexity of data to be reviewed</td>
<td>-Moderate</td>
</tr>
<tr>
<td></td>
<td>Risk of complications &amp;/or co-morbidity or mortality</td>
<td></td>
</tr>
<tr>
<td>High Complexity</td>
<td>Number of diagnoses or management options</td>
<td>-Extensive</td>
</tr>
<tr>
<td></td>
<td>Amount and complexity of data to be reviewed</td>
<td>-Extensive</td>
</tr>
<tr>
<td></td>
<td>Risk of complications &amp;/or co-morbidity or mortality</td>
<td>-High</td>
</tr>
</tbody>
</table>

### Counseling

Counseling is a discussing with a patient and/or family concerning one or more of the following areas:

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

A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for an encounter with or without a diagnosis being established at the time of the encounter.

Selection Table: Type of Nature of Presenting Problem

<table>
<thead>
<tr>
<th>Type of Nature of Presenting Problem</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>A problem that may not require the presence of the physician, but is a service provided under the physician’s supervision</td>
</tr>
<tr>
<td>Self Limited or Minor</td>
<td>A problem that runs a definite and prescribed course, is transient in nature and is not likely to permanently alter the health status of the patient. This patient has a good prognosis with management and/or compliance.</td>
</tr>
<tr>
<td>Low Severity</td>
<td>A problem where the risk of morbidity (dreadful outcome) without treatment is low. A problem that has little to no risk of mortality (death) without treatment. A patient is expected to have a full recovery without functional impairment.</td>
</tr>
<tr>
<td>Moderate Severity</td>
<td>A problem where the risk of morbidity (dreadful outcome) without treatment is moderate. A problem that has a moderate risk of mortality (death) without treatment. The patient has an uncertain prognosis or an increased probability of prolonged functional impairment.</td>
</tr>
<tr>
<td>High Severity</td>
<td>A problem where the risk of morbidity (dreadful outcome) without treatment is high to extreme. A problem that has a moderate to high risk of mortality (death) without treatment or has a high probability of severe, prolonged functional impairment.</td>
</tr>
</tbody>
</table>

Although CPT has only defined five types of presenting problems, the AAMC has expanded this list to include terms associated with emergency and inpatient conditions.

- Stable or Recovering
- Responding Poorly
- Significant Complication(s) or Unstable
- Urgent Evaluation Required
- Life Threatening Problem(s)
**Time**

The time element of an E/M service is difficult to define as the specific times identified in the CPT descriptors for E/M services are averages, and therefore represent a range of times which may be higher or lower depending on actual clinical circumstances.

To incorporate time as a defining element of the E/M service this department defines time to be face-to-face time for office and other outpatient visits and as unit/floor time for hospital and other inpatient visits.

This distinction is necessary because most of the work of typical office visits takes place during the face-to-face time with the patient, while most of the work of typical hospital visits takes place during the time spent on the patient’s floor or unit.

When time is used as an element of billing, documentation of the amount of time spent is required. When the majority of time is spent counseling and/or coordinating care, the note must reflect the time spent. In order to bill by time, the note must also state that greater than 50% of the visit was spent counseling and/or coordinating care.

**Site of Service**

A site of service is identified by CMS and other third party payers as the location in which a service or procedure is provided. (Examples: -11 physician office; -21 hospital; -22 hospital outpatient; -23 emergency department)

This is an important issue when it comes to Medicare patients due to the fact that 1) CMS reduces the physician payment by the “site of service differential”; and 2) incident to services are not billable by physicians when services are provided in a -22 hospital outpatient area.

**Site of Service Differential**

When a physician service or procedure which is routinely furnished in a physician’s office is performed in a hospital outpatient location, CMS will reduce the physician reimbursement by what is defined as a site of service differential which is approximately 50% of the practice expense RVU.

**Incident to Services**

An incident to service is defined as any service or supply furnished as an integral, although incidental part of the physician’s personal professional service which is provided in the course of diagnosis or treatment of an illness or injury.
In order to bill for this type of service it must be provided in an 11 site of service, the personnel performing these services must be employed by the department (SOM) and the service must be performed under the direct supervision of the billing physician.

The highest level of services that may be billed by nurses (Not NP’s or PA/s) is a 99211. NP’s or PA’s are licensed providers that can bill for documented services under their own provider numbers. The Department of Pediatrics policy is for mid-level providers to bill "incident to" the physician in a SOS 11, or, in a SOS 22 setting, to bill shared services (see below). Medicare does not allow for NPs or PAs to see any new patients without direct involvement of the physician. New patient visits and consultations require face-to-face contact between the physician and patient. Follow-up care may be provided by the NP or PA without physician face-to-face contact if the treatment is carried out according to an established care plan for the patient’s condition(s). Physician contact is also required at an encounter where a treatment plan for a new condition is initiated. Medicaid requires the physicians be immediately available by pager, but do not require them to be in the suite.

Shared Services

Shared services require the physician to have face to face service with the patient. The patient can see the patient before, during or later than the visit by the NP/PA. Without face to face service with the physician the billing is submitted under the NP/PA’s number. The notes may be combined for the physician and the NP/PA to select the level of service. Shared services should be billed in the hospital, inpatient, outpatient or emergency department (SOS 22). The MD and NP/PA must be in the same provider group with the same tax ID. The services for a shared visit can be billed using the physician number and paid at 100% of fee schedule.

General Documentation Requirements

The documentation of an E/M service must be in accordance with CPT documentation standards.

Key Elements

When providing a new or initial patient encounter the “key” components, of the seven that make up an E/M service (history, examination medical decision making, counseling, coordination of care, mature of presenting problem and time), are the HISTORY, the EXAMINATION and the MEDICAL DECISION-MAKING.

When providing a subsequent, follow-up or an established patient encounter, two (2) of the three (3) key components (HISTORY, EXAMINATION and MEDICAL DECISION-MAKING) are required.
Level of Service

It is the combination of the house staff note and the teaching physician note that must support the medical necessity of the level of service selected and billed.

Medical Necessity

To prove the medical necessity of any E/M service, the documentation in the patient medical record must identify the sign(s), symptom(s) or condition(s) of the presenting illness or problem, specific to this particular encounter. Based on the documentation found in the patient medical record, the appropriate ICD-9-CM diagnostic code should be selected. It should be to the greatest specificity (4th or 5th digit).

Teaching Physician Documentation

The physical presence of the teaching physician during the “key” elements of E/M visits can only be demonstrated by personally written or dictated notes done by the teaching physician that briefly describe his/her direct involvement in the encounter.

Teaching Physician’s Presence

In order to bill for an E/M service, the teaching physician must be in the same room and directly involved in providing or supervising the patient care.

Exception for E/M Services Furnished in Certain Primary Care Centers

Teaching physicians who provide 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 listed below, teaching physicians may submit claims for services furnished by a resident in the absence of a teaching physician.

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

If a service, other than those listed above needs to be furnished, then the general teaching physician policy 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 the resident in patient care activities is included in determining direct GME payment to a teaching hospital by the hospital's fiscal intermediary. This requirement is not met when a resident is assigned to a physician's office away from the center or makes home visits.

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.