Stanford HEALTH CARE

# Professional Services
# Documentation and Coding Guidelines

## Resident
## Training and Education

# Agenda

- Program Overview
- Signature Requirements
- Evaluation and Management (E&M) Services
- Teaching Physician Guidelines
- Global Surgical Package
- ICD-10-CM Coding

# Professional Services Billing Integrity Program
# Purpose and Goals

- To foster continuous performance improvement
- To promote accurate documentation, coding, and billing practices through auditing and provider education

# Professional Services Billing Integrity Program

- This program is a collaborative effort between the Hospitals and the School of Medicine, with approval from the Audit and Compliance Committees of the Boards of Directors.
- Developed to address the Office of Inspector General (OIG)'s core requirements and expectations for an effective professional fee compliance program, including:
  - Baseline specialty-specific education and training
  - Baseline retrospective audits; looking only at claims for services provided post-education

# Professional Services Billing Integrity Program

- Audits are run in Cycles of 3 rounds each and are performed retrospectively (after the claim is billed).

- In order to meet the standard, a score of 95% or higher is needed, using a risk-based audit scoring system.

- Physicians or APP's not meeting the standard move onto the next round.

# Signature Requirements

The purpose of a rendering/treating/ordering practitioner's signature in patients' medical records, etc., is to demonstrate the services have been accurately and fully documented, reviewed, and authenticated. Furthermore, it confirms the provider has certified the medical necessity and reasonableness for the service(s) submitted to the Medicare program for payment consideration.

- Medicare accepts handwritten, electronic, digitized, and digital signatures.

# Signature Requirements cont'd

Handwritten signatures:

- If the signature is not legible, and/or does not identify the author, a printed version should also be recorded.

- Per CMS, "*Signature stamps alone* (without accompanying legibly handwritten signature) *in medical records are no longer recognized as valid authentication for signature purposes, and may result in payment denials by Medicare.*"

# Medically Necessary Services

Per the Center for Medicare and Medicaid Services (CMS), medical necessity is defined as:

- Reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member.
- Not furnished primarily for the convenience of the patient, attending physician, or other provider.
- Medical necessity of a service is the overarching criterion for payment, in addition to the individual requirements of a CPT code.

# Selection of Evaluation and Management Level

"It would not be medically necessary or appropriate to bill a higher level of E&M service, when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which specific level should be billed.

Documentation should support the level of service reported. The service should be documented during, or as soon as practicable, after it is provided, in order to maintain an accurate medical record."

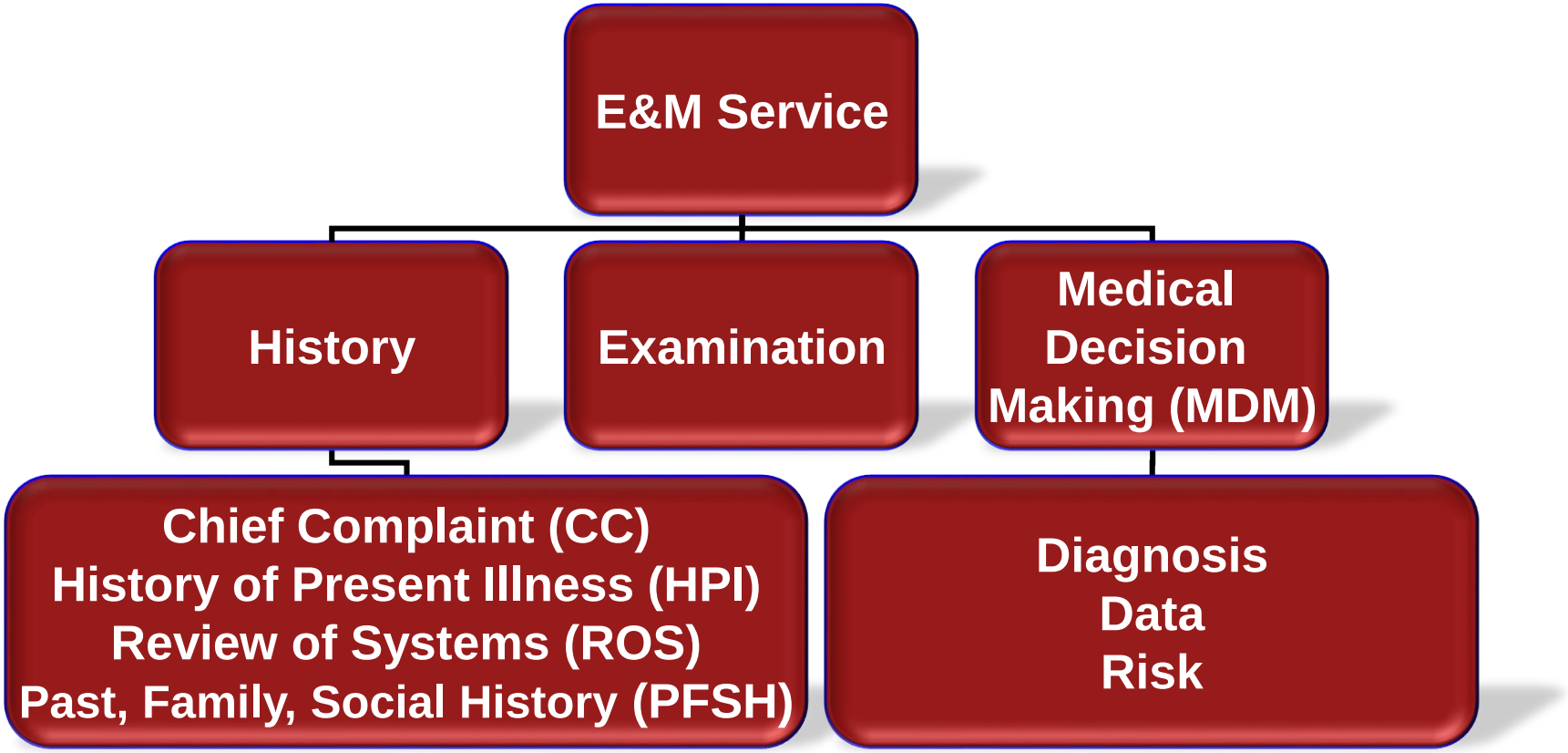
# Principles of Medial Record Documentation

The documentation of each patient encounter should include:

- A chief complaint or reason for the encounter;
- Relevant history, physical examination findings, and prior diagnostic test results;
- Assessment, clinical impression and diagnosis;
- Plan of care; and
- Date and legible identity of the observer.

- The selected CPT & ICD-10 codes must be supported by the contents of the documentation.

# Evaluation and Management Services - Key Components



# E&M - Putting it All Together

## Consultations & New Patient Visits

Requires all 3 elements to meet the level selected

| | | | | | |
|---|---|---|---|---|---|
| **History** | Problem Focused | Expanded Problem Focused | Detailed | Comprehensive | Comprehensive |
| **Exam** | Problem Focused | Expanded Problem Focused | Detailed | Comprehensive | Comprehensive |
| **Medical Decision Making** | Straight-forward | Straight-forward | Low | Moderate | High |
| **Code Level** | 99201<br>99241<br>99251 | 99202<br>99242<br>99252 | 99203<br>99243<br>99253 | 99204<br>99244<br>99254 | 99205<br>99245<br>99255 |

# E&M – Putting it All Together

## Established Patient Visits

Requires 2 out of 3 components to meet the level selected

| | | | | |
|---|---|---|---|---|
| **History** | Problem Focused | Expanded Problem Focused | Detailed | Comprehensive |
| **Exam** | Problem Focused | Expanded Problem Focused | Detailed | Comprehensive |
| **Medical Decision Making** | Straightforward | Low | Moderate | High |
| **Code Level** | 99212 | 99213 | 99214 | 99215 |

# E&M – Putting it All Together

## Hospital Admissions

Requires all 3 components to meet the level selected

| | | | |
|---|---|---|---|
| History | Detailed or Comprehensive | Comprehensive | Comprehensive |
| Exam | Detailed or Comprehensive | Comprehensive | Comprehensive |
| Medical Decision Making | Straightforward or Low | Moderate | High |
| Code Level | 99221 | 99222 | 99223 |

# E&M – Putting it All Together

Subsequent Hospital Care Visits

Requires 2 out of 3 components to meet the level selected

| History | Problem Focused Interval | Expanded Problem Focused Interval | Detailed Interval |
|---|---|---|---|
| Exam | Problem Focused | Expanded Problem Focused | Detailed |
| Medical Decision Making | Straightforward or Low | Moderate | High |
| Code Level | 99231 | 99232 | 99233 |

# Billing Based on Time

- An alternate way to bill for E&M services, when more than 50% of the total visit time is spent in counseling and/or coordination of care.
  - Topics of counseling or care coordination must be detailed in the record
  - Only attending physician time may be counted; resident's time alone with a patient is not.
- E&M service may be billed based on the level of history, examination, and medical decision making documented, OR by time.

# Billing Based on Time
# Documentation Requirements

Two ways to document time:

(V) Face-to-face time with the patient:*** minutes. (C) Counseling/Coordination of care:***minutes regarding*…(must enter a brief summary of the discussion)*

Or

XX minutes spent face-to-face with patient, over 50% in counseling regarding…*(must enter a brief summary of the discussion)*

*Either option may refer to the Assessment and Plan contents for details of what the patient was counseled on.*

# Billing Based on Time
# Documentation Requirements

- Outpatient setting: select the code based on the total face to face time spent by the attending physician with the patient for the entire visit

- Inpatient setting: select the code based on the total floor/unit time and bedside time.

All elements (times and content) must be documented by the *attending physician*; do not include time spent by resident alone

# Outpatient E&M Services (front)

## STANFORD HOSPITAL & CLINICS / LUCILE PACKARD CHILDREN'S HOSPITAL

**OUTPATIENT** Evaluation and Management Services ***(all specialties** except Ophthalmology, Psychiatry & Dermatology)*

- ❒ Include Modifier –24 (unrelated E/M service by same physician during postoperative period)
- ❒ Include Modifier –25 (separate E/M service on same day as procedure) even if procedure is at a different location
- ❒ Include Modifier –57 (E/M service involving a decision for *Major* surgery) surgery must be on the same day or next day

**NEW OUTPATIENTS & OUTPATIENT CONSULTS:** All 3 sections under the code (history, exam, medical decision making) must be met & documented.

| | New 99201 | Consult† 99241 | New 99202 | Consult† 99242 | New 99203 | Consult† 99243 | New 99204 | Consult† 99244 | New 99205 | Consult† 99245 |
|---|---|---|---|---|---|---|---|---|---|---|
| HX | **Problem Focused**<br>HPI: 1-3 Components | | **Expanded Problem Focused**<br>HPI: 1-3 Components *Both*<br>ROS: 1 system *Req'd* | | **Detailed**<br>HPI*: 4+ *All 3*<br>ROS: 2-9 systems *Req'd*<br>PFSH: 1 | | **Comprehensive**<br>HPI*: 4+ *All 3*<br>ROS: 10+ systems *Req'd*<br>PFSH: 3 | | **Comprehensive**<br>HPI*: 4+ *All 3*<br>ROS: 10+ systems *Req'd*<br>PFSH: 3 | |
| EXAM | **Problem Focused**<br>1 Organ system/<br>Body area** ('95)<br>OR<br>1-5 bullets ('97) | | **Expanded Problem Focused**<br>2-7 Organ systems/<br>Body areas (limited)** ('95)<br>OR<br>At least 6 bullets ('97) | | **Detailed**<br>2-7 Organ systems/<br>Body areas (extended)** ('95)<br>OR<br>At least 12 bullets ('97) | | **Comprehensive**<br>8+ Organ systems** ('95)<br>OR<br>General Multi-System or<br>Single System ('97) | | **Comprehensive**<br>8+ Organ systems** ('95)<br>OR<br>General Multi-System or<br>Single System ('97) | |
| MDM | **Straightforward** *2/3 Req'd*<br>Dx: 1 Data: 1<br>Risk: Minimal | | **Straightforward** *2/3*<br>Dx: 1 Data: 1 *Req'd*<br>Risk: Minimal | | **Low Complexity** *2/3*<br>Dx: 2 Data: 2 *Req'd*<br>Risk: Low | | **Moderate Complexity** *2/3*<br>Dx: 3 Data: 3 *Req'd*<br>Risk: Moderate | | **High Complexity** *2/3*<br>Dx: 4 Data: 4 *Req'd*<br>Risk: High | |

**ESTABLISHED OUTPATIENTS:** 2 of 3 sections under the code (history, exam, medical decision making) must be met & documented.

| | 99211 | 99212 | 99213 | 99214 | 99215 |
|---|---|---|---|---|---|
| HX | None | **Problem Focused**<br>HPI: 1-3 Components | **Expanded Problem Focused**<br>HPI: 1-3 Components *Both*<br>ROS: 1 system *Req'd* | **Detailed**<br>HPI*: 4+ *All 3*<br>ROS: 2-9 systems *Req'd*<br>PFSH: 1 | **Comprehensive**<br>HPI*: 4+ *All 3*<br>ROS: 10+ systems *Req'd*<br>PFSH: 2 |
| EXAM | None | **Problem Focused**<br>1 Organ system/<br>Body area** ('95)<br>OR<br>1-5 bullets ('97) | **Expanded Problem Focused**<br>2-7 Organ systems/<br>Body areas (limited)** ('95)<br>OR<br>At least 6 bullets ('97) | **Detailed**<br>2-7 Organ systems/<br>Body areas (extended)** ('95)<br>OR<br>At least 12 bullets ('97) | **Comprehensive**<br>8+ Organ systems** ('95)<br>OR<br>General Multi-System or<br>Single System ('97) |
| MDM | None | **Straightforward** *2/3*<br>Dx: 1 Data: 1 *Req'd*<br>Risk: Minimal | **Low Complexity** *2/3*<br>Dx: 2 Data: 2 *Req'd*<br>Risk: Low | **Moderate Complexity** *2/3*<br>Dx: 3 Data: 3 *Req'd*<br>Risk: Moderate | **High Complexity** *2/3*<br>Dx: 4 Data: 4 *Req'd*<br>Risk: High |

**†NOTE: Medicare no longer reimburses for consultations. See New/Established patient codes.**

# Outpatient E&M Services (back)

**SELECT E/M CODE BASED ON TIME** only when over 50% of the billing provider (Attending Physician or AHP) face to face/ encounter was spent in counseling and/or coordination of patient care. Do not include time spent by a resident

**DOCUMENT THE FOLLOWING:**

- ❒ Total face to face time (V time): _____minutes.
- ❒ Counseling/Coordination time (C time): _____minutes.
- ❒ A description of the counseling services provided.

| NEW PATIENT | | OUTPATIENT CONSULTATION† | | ESTABLISHED PATIENT | |
|---|---|---|---|---|---|
| CODE | V TIME | CODE | V TIME | CODE | V TIME |
| 99201 | 10 min | 99241 | 15 min | 99211 | 5 min |
| 99202 | 20 min | 99242 | 30 min | 99212 | 10 min |
| 99203 | 30 min | 99243 | 40 min | 99213 | 15 min |
| 99204 | 45 min | 99244 | 60 min | 99214 | 25 min |
| 99205 | 60 min | 99245 | 80 min | 99215 | 40 min |

**HISTORY OF PRESENT ILLNESS (HPI) COMPONENTS (8):**

Location Quality Severity Duration Timing Context Modifying factors

Associated signs/symptoms

* Or the status of at least three chronic or inactive conditions (1997)

**REVIEW OF SYSTEMS (ROS):** Constitutional Eyes ENT/Mouth Respiratory

Cardiovascular Gastrointestinal Genitourinary Musculoskeletal Neurologic Integumentary

Psychiatric Allergic/Immunologic Endocrine Hematologic/Lymphatic

**PFSH** = Past, Family, Social History

****EXAM BY BODY AREA(S) / ORGAN SYSTEM(S):**

**BODY AREAS:** Head/Face Neck Chest/Breasts/Axillae

Abdomen Back/Spine Genitalia/Groin/Buttocks Each Extremity

**ORGAN SYSTEMS:** Constitutional Eyes ENT/Mouth Respiratory

Cardiovascular Gastrointestinal Genitourinary Neurologic Skin

Psychiatric Musculoskeletal Hematologic/Lymphatic/Immunologic

**Attending Physicians:** Use GC modifier if a resident/fellow was involved in the service.

**†NOTE: Medicare no longer reimburses for consultations. See New/Established patient codes.**

# Inpatient E&M Services (front)

## STANFORD HOSPITAL & CLINICS / LUCILE PACKARD CHILDREN'S HOSPITAL

**INPATIENT** Evaluation and Management Services ***(all specialties** except Ophthalmology, Psychiatry & Dermatology)*

- ❒ Include Modifier –24 (unrelated E/M service by same physician during postoperative period)
- ❒ Include Modifier –25 (separate E/M service on same day as procedure) even if procedure is at a different location
- ❒ Include Modifier –57 (E/M service involving a decision for *Major* surgery) surgery must be on the same day or next day

**INITIAL HOSPITAL CARE:** All 3 sections under the code (history, exam, medical decision making) must be met & documented.

| | 99221 | 99222 | 99223 |
|---|---|---|---|
| HX | **Detailed**<br>HPI*: 4+ components *All 3 Required*<br>ROS: 2-9 systems<br>PFSH: 1 | **Comprehensive**<br>HPI*: 4+ components *All 3 Required*<br>ROS: 10+ systems<br>PFSH: 3 | **Comprehensive**<br>HPI*: 4+ components *All 3 Required*<br>ROS: 10+ systems<br>PFSH: 3 |
| EXAM | **Detailed**<br>2-7 Organ systems/Body areas (extended)** ('95)<br>OR<br>At least 12 bullets ('97) | **Comprehensive**<br>8+ Organ systems** ('95)<br>OR<br>General Multi-System or Single System ('97) | **Comprehensive**<br>8+ Organ systems** ('95)<br>OR<br>General Multi-System or Single System ('97) |
| MDM | **Straightforward (SF)** or **Low Complexity (LC)**<br>Dx: 1 (SF) or 2 (LC) *2/3 Required*<br>Data: 1 (SF) or 2 (LC)<br>Risk: Minimal (SF) or Low (LC) | **Moderate Complexity**<br>Dx: 3 *2/3 Required*<br>Data: 3<br>Risk: Moderate | **High Complexity**<br>Dx: 4 *2/3 Required*<br>Data: 4<br>Risk: High |

**SUBSEQUENT HOSPITAL CARE:** 2 of 3 sections under the code (history, exam, medical decision making) must be met & documented.

| | 99231 | 99232 | 99233 |
|---|---|---|---|
| HX | **Problem Focused**<br>HPI: 1-3 components | **Expanded Problem Focused**<br>HPI: 1-3 components *Both Required*<br>ROS: 1 system | **Detailed**<br>HPI*: 4+ components *Both Required*<br>ROS: 2-9 systems |
| EXAM | **Problem Focused**<br>1 Organ system/Body area** ('95)<br>OR<br>1-5 bullets ('97) | **Expanded Problem Focused**<br>2-7 Organ systems/Body areas (limited)** ('95)<br>OR<br>At least 6 bullets ('97) | **Detailed**<br>2-7 Organ systems/Body areas (extended)** ('95)<br>OR<br>At least 12 bullets ('97) |
| MDM | **Straightforward (SF)** or **Low Complexity (LC)**<br>Dx: 1 (SF) or 2 (LC) *2/3 Required*<br>Data: 1 (SF) or 2 (LC)<br>Risk: Minimal (SF) or Low (LC) | **Moderate Complexity**<br>Dx: 3 *2/3 Required*<br>Data: 3<br>Risk: Moderate | **High Complexity**<br>Dx: 4+ *2/3 Required*<br>Data: 4+<br>Risk: High |

# Inpatient E&M Services(back)

**SELECT E/M CODE BASED ON TIME** only when over 50% of the billing provider (Attending Physician or AHP) face to face/ and floor/unit encounter was spent in counseling and/or coordination of patient care. Do not include time spent by a resident

**DOCUMENT THE FOLLOWING:**

- ❒ Total Floor/Unit time (V time): _____minutes.
- ❒ Counseling/Coordination time (C time): _____minutes.
- ❒ A description of the counseling services provided.

| INITIAL HOSPITAL CARE | | SUBSEQUENT HOSPITAL CARE | |
|---|---|---|---|
| CODE | V TIME | CODE | V TIME |
| 99221 | 30 min | 99231 | 15 min |
| 99222 | 50 min | 99232 | 25 min |
| 99223 | 70 min | 99233 | 35 min |

**HISTORY OF PRESENT ILLNESS (HPI) COMPONENTS (8):**

Location Quality Severity Duration Timing Context Modifying factors

Associated signs/symptoms

* Or the status of at least three chronic or inactive conditions (1997)

**REVIEW OF SYSTEMS (ROS):**

Constitutional Eyes ENT/Mouth Respiratory

Cardiovascular Gastrointestinal Genitourinary Musculoskeletal Neurologic Integumentary

Psychiatric Allergic/Immunologic Endocrine Hematologic/Lymphatic

**PFSH** = Past, Family, Social History

****EXAM BY BODY AREA(S) / ORGAN SYSTEM(S):**

**BODY AREAS:** Head/Face Neck Chest/Breasts/Axillae

Abdomen Back/Spine Genitalia/Groin/Buttocks Each Extremity

**ORGAN SYSTEMS:** Constitutional Eyes ENT/Mouth Respiratory

Cardiovascular Gastrointestinal Genitourinary Neurologic Skin

Psychiatric Musculoskeletal Hematologic/Lymphatic/Immunologic

**Attending Physicians:** Use GC modifier if a resident/fellow was involved in the service.

# Inpatient Consultations (front)

## STANFORD HOSPITAL & CLINICS / LUCILE PACKARD CHILDREN'S HOSPITAL

### INPATIENT CONSULTATIONS *(**all specialties** except Ophthalmology, Psychiatry & Dermatology)*

- ❒ Include Modifier –24 (unrelated E/M service by same physician during postoperative period)
- ❒ Include Modifier –25 (separate E/M service on same day as procedure) even if procedure is at a different location
- ❒ Include Modifier –57 (E/M service involving a decision for *Major* surgery) surgery must be on the same day or next day

**All 3** sections under the code (history, exam, medical decision making) must be met & documented.

| | 99251† | 99252† | 99253† | 99254† | 99255† |
|---|---|---|---|---|---|
| **HX** | **Problem Focused**<br>HPI: 1-3 Components | **Expanded Problem Focused**<br>HPI: 1-3 Components<br>ROS: 1 system<br>*Both required* | **Detailed**<br>HPI*: 4+<br>ROS: 2-9 systems<br>PFSH: 1<br>*All 3 required* | **Comprehensive**<br>HPI*: 4+<br>ROS: 10+ systems<br>PFSH: 3<br>*All 3 required* | **Comprehensive**<br>HPI*: 4+<br>ROS: 10+ systems<br>PFSH: 3<br>*All 3 required* |
| **EXAM** | **Problem Focused**<br>1 Organ system/ Body area** ('95)<br>OR<br>1-5 bullets ('97) | **Expanded Problem Focused**<br>2-7 Organ systems/ Body areas (limited)** ('95)<br>OR<br>At least 6 bullets ('97) | **Detailed**<br>2-7 Organ systems/ Body areas (extended)** ('95)<br>OR<br>At least 12 bullets ('97) | **Comprehensive**<br>8+ Organ systems** ('95)<br>OR<br>General Multi-System or Single System ('97) | **Comprehensive**<br>8+ Organ systems** ('95)<br>OR<br>General Multi-System or Single System ('97) |
| **MDM** | **Straightforward**<br>Dx: 1<br>Data: 1<br>Risk: Minimal<br>*2/3 required* | **Straightforward**<br>Dx: 1<br>Data: 1<br>Risk: Minimal<br>*2/3 required* | **Low Complexity**<br>Dx: 2<br>Data: 2<br>Risk: Low<br>*2/3 required* | **Moderate Complexity**<br>Dx: 3<br>Data: 3<br>Risk: Moderate<br>*2/3 required* | **High Complexity**<br>Dx: 4<br>Data: 4<br>Risk: High<br>*2/3 required* |

**†NOTE: Medicare no longer reimburses for consultations. See Initial/Subsequent Hospital codes.**

# Inpatient Consultations (back)

**SELECT E/M CODE BASED ON TIME** only when over 50% of the billing provider (Attending Physician) face to face/ and floor/unit encounter was spent in counseling and/or coordination of patient care. Do not include time spent by a resident

**DOCUMENT THE FOLLOWING:**

- ❒ Total Floor/Unit time (V time): _____minutes.
- ❒ Counseling/Coordination time (C time): _____minutes.
- ❒ A description of the counseling services provided.

**INPATIENT CONSULTATION**

| CODE | V TIME |
|---|---|
| 99251 | 20 min |
| 99252 | 40 min |
| 99253 | 55 min |
| 99254 | 80 min |
| 99255 | 110 min |

**HISTORY OF PRESENT ILLNESS (HPI) COMPONENTS (8):**

Location Quality Severity Duration Timing Context Modifying factors
Associated signs/symptoms

*Or the status of at least three chronic or inactive conditions (1997)

**REVIEW OF SYSTEMS (ROS):**

Constitutional Eyes ENT/Mouth Respiratory
Cardiovascular Gastrointestinal Genitourinary Musculoskeletal Neurologic Integumentary
Psychiatric Allergic/Immunologic Endocrine Hematologic/Lymphatic

**PFSH** = Past, Family, Social History

****EXAM BY BODY AREA(S) / ORGAN SYSTEM(S):**

**BODY AREAS:** Head/Face Neck Chest/Breasts/Axillae
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**ORGAN SYSTEMS:** Constitutional Eyes ENT/Mouth Respiratory
Cardiovascular Gastrointestinal Genitourinary Neurologic Skin
Psychiatric Musculoskeletal Hematologic/Lymphatic/Immunologic

**Attending Physicians:** Use GC modifier if a resident/fellow was involved in the service.

†**NOTE: Medicare no longer reimburses for consultations. See Initial/Subsequent Hospital codes.**

# New vs. Established

## New Patient

A new patient is one that has not received any professional service (face-to-face) from any physician in the same specialty group within the last 3 years.

# Consultation Services

A visit generated by a request from another healthcare provider for the consultant to offer:

- advice
- opinions
- recommendations

Consultant must have expertise over and above that of the requesting provider.

The request from another provider drives the ability to code a consult. New or established codes should be used when no request is made (i.e. self-referrals).

# Consultation Guidelines - The 3 “R’s”

- Request – The name of the requesting physician must be clearly documented in the record.
- Reason - The diagnosis(es) prompting the consult must be documented
- Report - The consultant must send a formal letter to the requestor outlining recommendations, opinions, etc.
  - Internal requestors may receive a carbon copy through Epic chart routing

*If any one of these elements is missing, the consult guidelines are considered not to have been met.

# Inpatient Care Services

- **Initial Hospital Care (99221 – 99223); per day**
  - Report only one time per admission, by the admitting physician
  - All three components to be met (history, examination, medical decision making) unless time is a key factor

- **Subsequent Hospital Care (99231 – 99233); per day**
  - Two of the three components to be met (history, examination, medical decision making) unless time is a key factor

- **Hospital Discharge Services (99238, 99239)**
  - 99238 – 30 minutes or less
  - 99239 – 31 minutes or more

# Initial Hospital Care - CPT 99221 - 99223

- When the patient is admitted to the hospital as an inpatient in the course of an encounter in another site of service (e.g. office, ED, observation) all E/M services provided by that physician (or someone in the same group) in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission.

- Level of service reported by the admitting MD should include the services related to the admission he/she provided in the other site of service as well as in the inpatient setting.

# Hospital Discharge Day Management - CPT 99238 - 99239

- Reports the total time spent by the attending physician for final discharge services.
- The date of discharge must be different from the admission date.

Includes:

- Final examination
- Discussion of the hospital stay, even if the time spent by the physician on that date is not continuous
- Instructions for continuing care to the caregivers
- Preparation of discharge records, prescriptions and referral forms

# Teaching Physician (TP) Guidelines

According to hospital policy:

"*If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is sought only if a teaching physician is present and directly participates in the care (not merely an exercise of teaching supervision) during the key portion(s) of any service or procedure for which payment is sought.*"

- *Attending physicians who personally document the entire service are not required to append an attestation.*
- *Attestation statements shall not be defaulted into an EMR template and must be personally entered each time by the attending physician.*

# Teaching Physician Guidelines - E&M Services

TP must personally document at least the following:

- TP was present and directly participated in the visit.
- TP participated in the management of the patient
- TP reviewed and made direct reference to the resident's note.

Combined entries into the medical record by the TP and the resident constitute the documentation for the service and together must support the medical necessity and the type/level of the service.

# Examples of Unacceptable TP Documentation - E&M

- Teaching Physicians may not document:
  - “Agree with above”
  - “Discussed with resident and agree”
  - “Seen and agree”

- TP co-signature alone

- Residents and fellows may not document the presence and participation of the TP

# Medical Student Documentation - E&M Services

CMS now allows teaching physicians to use ALL student documentation provided:

- Physical presence requirements are met
- Teaching physician satisfies the performance requirements
- Teaching physician verifies the documentation

Note: Previously the only portions of the medical student note which was used to support billing:

- Reviews of Systems
- Past Medical, Family and/or Social History (PFSH)

# Medical Student Documentation - E&M Services

- The attending physician must personally perform or re-perform the physical exam and medical decision making of the E/M service being billed
- The attending no longer needs to re-document these elements but rather they MUST verify all student documentation or findings, including history , exam and/or medical decision making
- The attending physician must personally perform or re-perform the physical exam and medical decision making of the E/M service being billed
- The attending no longer needs to re-document these elements but rather they MUST verify all student documentation or findings, including history , exam and/or medical decision making

# Medical Student Documentation - TP Attestations

Two Epic smart phrases were created to assist the teaching physician with the documentation requirements when using the medical student's documentation

- Teaching physician attestation when working **with a <u>medical student only</u>**
  - ***.attmedicalstudentonly***

    *"I was present with the medical student who participated in the documentation of this note. I personally performed the physical exam and medical decision making. I have reviewed and agree with all the medical student documentation including the history , exam, medical decision making and findings, with the addition and/or exception of items documented below"*

- Teaching physician attestation when working **with a <u>medical student and a resident</u>**
  - ***.attmedicalstudentwithresident***

    *"I and /or the resident was present with the medical student who participated in the documentation of this note. I personally performed the physical exam and medical decision making. I have reviewed and agree with all the medical student and resident documentation including the history , exam, medical decision making and findings, with the addition and/or exception of items documented below"*

# Minor Procedures

- 0 or 10 day global postoperative period
- No pre-operative period
- Involve relatively little decision making once the need for the procedure is determined
- Visit on date of procedure is usually not separately billable
- Most office-based and endoscopic procedures are minor procedures
- Total global period is 11 days. Count the day of the surgery and 10 days following the day of the surgery

# Teaching Physician Guidelines - Minor Procedures

In order to bill, the attending “teaching” physician is required to be present and directly participating in the entire procedure, when performed with a resident or fellow.

- Documentation of direct participation may be made by:
  - Resident or Fellow (TP co-signature required)

  Or
  - Teaching Physician him/herself

## Major Procedures

- 90 day global postoperative period
- Usually (but not always) performed under regional or general anesthesia
- When performed with a resident or fellow, the attending "teaching" physician may decide to be:
  - present and directly participating in the entire procedure
  - or in the key portions of the procedure.

# Teaching Physician Guidelines - Major Procedures

When TP is present and directly participating during the key/critical portions only:

- The TP must **personally document** his/her presence and direct participation during the key portions of the service
  - Key/critical portions must be identified by the attending surgeon
  - Document his/her **immediate availability** to return to the operating suite during the non-key portions of the procedure
  - OR name of an alternate teaching physician who was immediately available during the remainder of the procedure

# Teaching Physician Guidelines for Diagnostic Services

If a resident prepares and signs the interpretation, the teaching physician must indicate that he or she has:

- Personally reviewed the result/image/specimen, and
- Has personally reviewed the resident's interpretation, and document if they agree with the interpretation, or edit the findings as appropriate.

Teaching physician co-signature alone is not sufficient to support professional fee billing.

# Teaching Physician Guidelines (front)

## STANFORD HOSPITAL & CLINICS / LUCILE PACKARD CHILDREN'S HOSPITAL
### TEACHING PHYSICIAN GUIDELINES
### SHC/LPCH General Standard Policy 2.01.01

"If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is sought only if a teaching physician is present and directly participates in the care (not merely an exercise of teaching supervision) during the key portion(s) of any service or procedure for which payment is sought." 2.01.01

**Evaluation and Management (E/M)**
The teaching physician (TP) must personally document at least the following:
a) That the TP performed the service or was physically present and directly participated with the resident or fellow
b) That the TP participated in the management of the patient
c) That the TP reviewed and made direct reference to the resident's note

| Teaching Physician (TP) Documentation | Resident/Fellow (R/F) Documentation |
|---|---|
| *"I saw and examined 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."*<br>***OR***<br>*"I saw and examined 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, EXCEPT...."* | Handwritten and/or dictated visit note. |
| Billing based on time, when counseling time (C) dominates the visit (V); C > 50% of V; V and C times must be documented by the attending.<br><br>Outpatient setting: attending face to face time<br>Inpatient setting: attending face to face time and floor/unit time<br><br>*"40 minutes visit/25 minutes counseling/coordination of care plus a listing of what the counseling/coordination of care consisted."*<br>***OR***<br>*"V40/C25 plus description of counseling/coordination of care."* | Time spent by the resident alone does not count. Time spent in teaching activities does not count.<br><br>Only attending's time will count. |

NOTE: In a teaching setting, the TP is responsible to ensure that the combination of TP & R/F notes supports the level and the type of service billed.

# Teaching Physician Guidelines

| Professional Service | Teaching Physician (TP) Documentation | OR | Resident/Fellow (R/F) Documentation |
|---|---|---|---|
| Endoscopy | *"I was present and directly participated in the entire viewing portion of the [name of] endoscopy, including insertion and withdrawal of the device."* | OR | *"Dr. Faculty was present and directly participated in the entire viewing portion of the [name of] endoscopy, including insertion and withdrawal of the device."* Timely TP co-signature required. |
| Minor or Major/High Risk (Entire Procedure) | *"I was present and directly participated in the entire [name of] procedure."* | OR | *"Dr. Faculty was present and directly participated in the entire [name of] procedure."* Timely TP co-signature required. |
| Major/High Risk (Key Portions) | *"I was present and directly participated in the following key portion(s) of the [name of] procedure: (list). During the non-key portions I was immediately available to return to the procedure."* ***OR*** *"I was present and directly participated in the following key portion(s) of the [name of] procedure: (list). During the non-key portions when I was unavailable, Dr. Alternate Faculty (must be specifically named) was immediately available."* | | Resident may not document key portions for the TP. |
| Preoperative and postoperative care and global billing | *"Participated and concur with the resident's note."* | OR | *"Dr. Faculty was present and directly participated in this pre/postoperative visit."* Timely TP co-signature required. |
| Pathology Radiology Diagnostic Tests | *"I have personally reviewed the specimen/image/tracing and agree with the interpretation above."* Electronic authentication by the TP, or legible signature. | | Resident prepares and signs the interpretation. TP co-signature alone will not be sufficient to support billing. |
| The documentation must be completed in a timely manner and contain a legible signature of the author. **Attending Physicians:** Use GC modifier if a resident/fellow was involved in the service. **NOTE:** Teaching guidelines do not apply when an attending physician provides the services in conjunction with an AHP. | | | |

# The Global Surgical Package

The global surgical package includes:

- After the decision for surgery has been made, E&M encounters in the same surgical specialty (including pre-op history and physicals)
- The procedure itself
- Local infiltration, topical anesthesia, digital blocks
- Immediate postoperative care, documentation of the procedure, discussions with family and/or other physicians, writing orders, evaluation of patient in PACU
- Routine postoperative evaluations, follow – up care within the 10 or 90 day global period of the surgery
- Related complications following surgery that require additional procedures
- Postsurgical pain management by the surgeon
- Supplies and miscellaneous services

# The Global Surgical Package

The surgical package also includes:

- Routine postoperative evaluations, follow – up care within the 10 or 90 day global period of the surgery
- Related complications following surgery that require additional procedures
- Postsurgical pain management by the surgeon
- Supplies and miscellaneous services (i.e., dressing changes, staple/suture removals, incisional care, and insertion/irrigation/changes/removal of urinary catheters, routine IV lines, NG and tracheostomy tubes)

# Global Surgical Package (cont'd)

**Not Included** (i.e., separately billable):

- Initial patient evaluation by surgeon to determine the need for surgery (only applies to major procedures);
- E&M visits unrelated to diagnosis for which surgery was performed;
- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery;
- Diagnostic tests/procedures, including diagnostic radiology

# Global Surgical Package (cont'd)

**Not Included**:

- Clearly distinct surgical procedures during the postoperative period that are not re-operations or treatment for complication of original surgery
- A more extensive procedure than the original surgery is required (due to failure or staging)
- Immunosuppressive therapy management for organ transplants
- Critical care services unrelated to the surgery for a critically ill, injured or burned patient requiring constant physician attendance

# ICD-10-CM Coding and Documentation

Documentation must support the ICD-10 codes reported:

- Primary reason for each encounter.
- All other diagnoses that affect the patient's plan of care at that encounter.
- All conditions, diseases, illnesses/injuries, and other problems managed should be listed in each note.
- Report diagnoses to the highest degree of specificity.

# ICD-10-CM Coding and Documentation

**DO code:**

- Signs and/or symptoms, when no definitive diagnosis is established - report ICD-10-CM codes only for what is known
- Chronic illnesses or other conditions requiring continued work-up or treatment/management
- Reason(s) for diagnostic test or treatment
- Abnormal test results

**DON'T code:**

- "Rule out", "possible", "probable", "suspected", or "questionable" as if the condition definitively exists

# Contact Information

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