E/M Coding: Is Your Hospital Compliant?

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Presentation Faculty

Duane C. Abbey, Ph.D., CFP – Dr. Abbey is a healthcare consultant and educator with over 20 years of experience. He has worked with hospitals, clinics, physicians in various specialties, home health agencies and other health care providers.

His primary work is with optimizing reimbursement under various Prospective Payment Systems. He also works extensively with various compliance issues and performs chargemaster reviews along with coding and billing audits.

Dr. Abbey is the President of Abbey & Abbey, Consultants, Inc. A wide range of consulting services is provided across the country including charge master reviews, APC compliance reviews, in-service training, physician training, and coding and billing reviews.

Dr. Abbey is the author of fourteen books on health care, including:

- "Non-Physician Providers: Guide to Coding, Billing, and Reimbursement"
- "Emergency Department: Coding, Billing and Reimbursement", and
- "Chargemasters: Strategies to Ensure Accurate Reimbursement and Compliance".

Recent books include: "Compliance for Coding, Billing & Reimbursement A Systematic Approach to Developing a Comprehensive Program", "Introduction to Healthcare Payment Systems", "Fee Schedule Payment Systems" and "Prospective Payment Systems" from Taylor and Francis. He has just finished the fourth book in the Healthcare Payment System Series; "Cost-Based, Charge-Based and Contractual Payment Systems".

E/M Coding Compliance

Warm-Up Exercise

Exercise – For this exercise consider yourself a consultant. You have been contacted by the fictitious Apex Medical Center. The hospital wants you, the consultant, to conduct a study on the use of E/M codes and modifier “-25” to determine that the hospital’s E/M coding is fully compliant. Apex codes and bills for both the hospital facility and physicians (ER and provider-based clinics) professional.

- Outline how you would conduct such an audit?
- What do you need as an auditor in order to review cases to determine compliance?
- Will you be able to assure Apex, as appropriate, that the hospital is in compliance?
E/M Coding Compliance
Introduction

- E/M – Evaluation and Management Codes
  - CPT – 99201 - 99456
  - Wide Range of Services
- E/M Used In Two Very Different Ways
  - Physician Services – Professional Coding
    - Code For What The Physician Does
  - Hospital Services – Facility Component Coding
    - Code For Resource Utilization – All Providers
- E/M Coding Guidelines
  - Physicians  Extensive Guidelines – Controversy
    - Need Basic Understanding of Physician Side
      - History
      - Examination
      - Medical Decision Making
  - Hospitals  Very Little Guidance!! – Controversy
    - April 7, 2000 Federal Register – Develop Mapping and Use It!
    - What constitutes a proper mapping?
    - CMS (Theoretically) Developing Guidelines – 2015(??)  No! Yes!
    - E/M Coding System Principles - 2008

E/M Coding Compliance
Introduction

- Related Topics
  - Physician vs. Hospital E/M Levels
    - E/M Levels Do Not Need To Match – Different Bases for Coding
  - CMS Physician Global Surgical Package
    - Pre-Operative
    - Intra-Operative
    - Post-Operative – 0-Day, 10-Days, 90-Days
  - Modifier Utilization  “-25” & “-59”
    - “-25” Has Become a MAJOR Issue Recently  Future RAC Issue
  - Special CPT Bundling Rules
    - Apply to Physicians Only (?) – Be careful that what is known on the physician side may not carry over to the hospital side.
  - Special Situations
    - Provider-Based Rule (PBR)
    - Provider-Based Clinics  E/M Codes
    - Provider-Based Clinical Services Within a Hospital Department  E/M Codes
  - HIPAA TSC – Are E/M codes utilized by hospitals outside the definitions and requirements from CPT appropriate? Legal?
E/M Coding Compliance

Objectives

- To review the E/M codes as they appear in the CPT Manual.
- To compare and contrast E/M coding for the physician professional component versus the hospital facility component.
- To appreciate the difference between ‘new’ versus ‘established’ patients for physicians and hospitals.
- To understand the differences in E/M coding for ER physicians and provider-based clinic physicians both primary care and specialty.
- To appreciate the physician E/M documentation guidelines versus the lack of guidance for hospital use of E/M codes.
- To review the facility component E/M coding system principles as enunciated by CMS.
- To explore the compliance challenges faced by both physicians and hospitals for E/M coding and the “-25” modifier.
- Recognize how to make changes to accommodate CMS’s dropping the use of the consultation codes.

E/M Coding Compliance

Acronyms

- CMS – Centers for Medicare & Medicaid Services
- E/M – Evaluation and Management (E&M, also)
- HCPCS - Healthcare Common Procedure Coding System
- NPP – Non-Physician Practitioner (Provider)
- ED – Emergency Department
- AHA – American Hospital Association
- AHIMA – American Health Information Management Association
- ACEP – American College of Emergency Physicians
- H&P – History and Physical
- SOS – Site of Service Differential
- PBR – Provider-Based Rule
- IPPE – Initial Preventative Physical Examination
- MDA – M.D. Anesthesiologist
- CRNA – Certified Registered Nurse Anesthetists
E/M Coding Compliance
Synopsis of Recent Changes

- Consultation E/M Codes
  - Hospital Outpatient – OP Consultation Codes Dropped by Medicare starting CY2009
  - Physician Consultation – IP and OP Consultation Codes Dropped by Medicare Starting in CY2010
  - Exception – Telehealth → See G0425, G0426, G0427 and G0406-G0408
    - See Transmittals 118 MBPM and 1881 MCPM
- Facility Component E/M National Guidelines
  - Doubtful that CMS will ever issue national guidelines. AMA??
  - Difficulty with developing different guidelines for ED, primary care provider-based clinics and specialty provider-based clinics.
- Type B Emergency Departments
  - CMS continues to refine the use of the special G-Codes for Type B EDs.
- Modifier for ‘Admitting Physician’ – Al
- ‘New’ vs. ‘Established’
  - Physician – 3-year rule – Same Physician/Group
  - Hospital – 3-year rule – Hospital Registration
- “-25” Modifier – No Additional Guidance
  - Will this be a RAC issue? Physician and/or Hospital Side

Exercise – Discuss how physicians will need to reorient their billing and documentation of services in situations that previously involved consultations (at least for Medicare). For instance,
- Primary Care Physician request to specialty physician.
- Attending Physician request to specialist for inpatient visit.
- Hospitalist working with attending physician.

Exercise – How can hospitals be certain that their facility component E/M level mappings are compliant?
- ED
- Primary Care Provider-Based Clinics
- Specialty Provider-Based Clinics
E/M Coding Compliance
APC – CMS Discussions

- Facility Component E/M Coding
  - New Patient Definition – 3-Year Definition Relative to Registration
  - Continue Use of Both New Patient and Established Patient
    - For APCs, Consultation Codes Are Gone
    - “Because hospital claims data continue to show significant cost differences between new and established patient visits, we continue to believe it is necessary and appropriate to recognize the CPT codes for both new and established patient visits and, in some cases, provide differential payment for new and established patient visits of the same level.” (Page 815 CMS-1414-FC)
  - Type B ED Visits – “In addition, we are adopting new APC 0630 (Level 5 Type B Emergency Visits) and will pay for level 5 Type B emergency department visits through this new APC. We are assigning HCPCS codes G0380, G0381, G0382, G0383, and G0384 (the levels 1, 2, 3, 4, and 5 Type B emergency department visit Level II HCPCS codes) to APCs 0626, 0627, 0628, 0629, and 0630, respectively, for CY 2010.” (Page 829 CMS-1414-FC)

- Nurse’s ED Triage Billing
  - While CMS discussed this question, quite obviously CMS missed the point of the question. The question raised is what happens, relative to billing, when a patient is triaged by an ER nurse (resources utilized), the patient then leaves before being seen by a physician (or other qualified medical person)? Because there are no services ‘incident-to’ those of a physician, the Medicare program generally cannot pay. So what should hospitals do?
  - Facility Component E/M Guidelines
    - “As a result of our updated analyses, we are encouraging hospitals to continue to report visits during CY 2010 according to their own internal hospital guidelines. In the absence of national guidelines, we will continue to regularly reevaluate patterns of hospital outpatient visit reporting at varying levels of disaggregation below the national level to ensure that hospitals continue to bill appropriately and differentially for these services.” (Page 836 CMS-1414-FC)
Facility Component E/M Coding

- Facility Component E/M Guidelines – Continued
  - “We [CMS] acknowledge that it would be desirable to many hospitals to have national guidelines. However, we also understand that it would be disruptive and administratively burdensome to other hospitals that have successfully adopted internal guidelines to implement any new set of national guidelines while we address the problems that would be inevitable in the case of any new set of guidelines that would be applied by thousands of hospitals.” (Page 839 CMS-1414-FC)

  ✓ This is a fascinating response! Because CMS has failed to provide national guidelines, hospitals are so entrenched in their own mappings that it would be disruptive to go to national guidelines.
  ✓ Of course, nobody knows if the mappings being used by all the hospitals are compliant!!

For CY2012 CMS Continues There Stance of Not Issuing Facility Component Coding Guidelines

- From the November 30, 2011 Federal Register, Page 74346:
  - “After consideration of the public comments we received, we are continuing to encourage hospitals to use their own internal guidelines to determine the appropriate reporting of different levels of clinic and emergency department visits. We note that it remains our goal to ensure that OPPS national or hospital-specific visit guidelines continue to facilitate consistent and accurate reporting of hospital outpatient visits in a manner that is resource-based and supportive of appropriate OPPS payments for the efficient and effective provision of visits in hospital outpatient settings.” (76 FR 74346)

  - For compliance purposes, hospitals are very much on their own.
  - At some point, sooner rather than later, the RACs will get into the area. Most likely the RACs will maintain that the hospital mapping involve upcoding and thus overpayments. See Extrapolation.
For CY2013, CMS continues to maintain that it would be burdensome to hospitals to move to E/M coding standards.

“We agree with the commenter that we should not move to national guidelines for visits in CY 2013. As we have in the past (76 FR 74345 through 74346), we acknowledge that it would be desirable to many hospitals to have national guidelines. However, we also understand that it would be disruptive and administratively burdensome to other hospitals that have successfully adopted internal guidelines to implement any new set of national guidelines while we address the problems that would be inevitable in the case of any new set of guidelines that would be applied by thousands of hospitals. As we have also stated in the past (76 FR 74346), if the AMA were to create facility-specific CPT codes for reporting visits provided in HOPDs [based on internally developed guidelines], we would consider such codes for OPPS use.” (77 FR 68402 – 11-15-12)

Question: Will it be any less burdensome when the RACs and other auditors come in and allege that hospitals have incorrectly used the E/M levels and the “-25” modifier?

E/M Coding Compliance
APC Background

August 1, 2000 – APCs – Ambulatory Patient Classifications

- CMS Hospital Outpatient Prospective Payment System
- Implementation Repeatedly Delayed
- CMS Decision to Pay Separately for E/M Facility Component
  - Major Departure from APGs – Ambulatory Patient Groups – E/M Codes Bundled Unless Used Alone
- Need to Use “-25” Modifier in Certain Cases

Office and Other Outpatient Services Grouping + ED Groupings

- CY2000-CY2006
  - New Patient & Established Patient Map To Three Clinic APCs
  - ED Encounters Map to Three ED APCs
- CY2007
  - New Patient & Established Patient Map to Five Clinic APCs
  - Type A ED Encounters Map to Five ED APCs
  - Type B ED Encounter Map to Five Clinic APCs (G0380-G0384)
- CY2008 & CY2009
  - Consultation Codes Dropped & 99212/99213 Map to Level II
  - Type B ED – G0384 Included for Observation Criterion
  - “New” vs. “Established” Language

Note: In theory, G0379, Direct Admit to Observation, Maps To Level I Clinic APC

However, G0379 now drives the composite APC 8002 that pays separately for observation services. See reporting Observation for less than 8 hours.
Exercise: The Apex Medical Center has a dozen provider-based clinics both primary care and specialty. The decision has been made to use the physician’s E/M code as the hospital E/M code. What impact will these changes for CY2008 have on the Apex Medical Center.

“-25” Modifier – Now a Major Compliance Issues

- “-25” Modifier Description in CPT– “Significant, Separately Identifiable”
- Minimal CMS Guidance → Documentation requirements
  - PM A-00-40 – June 20, 2000
  - PM A-01-80 – June 29, 2001
- DOJ Studies – Western Pennsylvania
- Suddenly ‘New’ Language is Appearing (As A ‘Reminder’)
  - Medicare Alert Bulletin 2255, February 17, 2009, pages 9-10, issued by Georgia Medicare
  - “Only in those instances where a medical visit (E&M) on the same date as a diagnostic or therapeutic procedure (‘S’ or ‘T’ APC status indicator code) is separately identifiable service for an unrelated problem should the facility receive separate reimbursement for the evaluation and management service.”

Chargemaster Involvement

- Actual chargemaster setup is not that difficult
  - Emergency Department – 99281-99285
  - Provider-Based Clinics – 99201-99205 (New) and 99211-99215 (Established)
  - “-25” Modifier – In the chargemaster?
- Must establish appropriate charge capture and thus the proper interface into the chargemaster itself.
- Chargemaster Coordinators are drawn into extended discussions of documentation and compliance issues surrounding the facility component E/M coding and the use of the “-25” modifier.
  - Thus Chargemaster Coordinators must fully understand all aspects of facility component E/M coding.
- Examples –
  - When should the “-25” modifier be placed in the chargemaster?
  - What about non-emergency cases in the ED, should we have regular E/M codes versus the ED emergency E/M codes?
  - Who should be determining the level and capturing the charges to input through the chargemaster?
Office or Other Outpatient Services
- New Patient → 99201-99205
- Established Patient → 99211-99215
Questions:
  - What is a ‘new’ patient?
    - Physician Clinic
    - Hospital or Provider-Based Setting
    - Could this affect coding between the physician and the hospital?
  - What is special about 99211?
    - Nursing Services Only??
    - How should this E/M level be used on the hospital side?

Hospital Observation Services
- Discharge → 99217
- Initial → 99218-99220
- Subsequent → 99224-99226
Questions:
  - What if other E/M services provided by the physician in the course of observation services?
  - Should hospitals be using these E/M codes?

Hospital Inpatient Services
- Initial → 99221-99223
- Subsequent → 99231-99233
Questions
  - What does the ‘per day’ mean?
  - What if other E/M services provided by the physician during the inpatient admission?
  - Do hospitals use these codes?
E/M Coding Compliance
Review of E/M Categories

Exercise – Sam, an elderly resident of Anywhere, USA has presented to the ED. A workup in the ED indicates that he should be placed in observation. His attending physician is called to the ED. On Monday afternoon he is placed in observation. His attending physician sees him on Tuesday and then on Wednesday morning the attending physician discharges Sam from observation.

- Discuss how this would be coded and paid.

- What about the ER physician?

- What about the hospital?

Observation or Inpatient Care Services

- Admitted & Discharged Same Date of Service
  - 99234-99236
- Questions:
  - How can you properly identify and correctly use these codes?
  - Are these codes of interest to hospitals?
  - What if there is less than 8 hours between admit and discharge?

Hospital Discharge Services

- 99238 ➔ 30 Minutes or Less
- 99239 ➔ More Than 30 Minutes

Hospital Facility Component E/M Code

- Multiple Physicians/Multiple Providers
  - There may be multiple providers who render services. On the professional side, these providers or practitioners do their own E/M billing.
  - The hospital must accumulate resources consumed by all providers (physicians, practitioners, nurses, etc.) for mapping to correct level.
**E/M Coding Compliance**

Review of E/M Categories

- **Consultations**
  - The use of the consultation codes on the part of physicians is a major compliance area! CMS has discontinued the use of these codes for both hospitals and physicians! (Still available for non-Medicare.)
  - General Criteria
    - A Consultation Must Be Requested
    - The Consulting Physician Must Render Advice or Opinion
    - There Should Be A Written Report
    - Consulting Physician May Take Over Care of Patient After Consultation Is Completed
  - 99241-99245 → Office or Other Outpatient Consultations
  - 99251-99255 → Initial Inpatient Consultations
  - 99261-99263 → Follow-Up Inpatient Consultations
    - AMA Discontinued CY2006
  - 99271-99275 → Confirmatory Consultations
    - AMA Discontinued CY2006
  - Question – Does ‘new’ or ‘established’ have any meaning for consultations?
  - Question → Which of these codes would hospitals use for facility component E/M coding?

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**E/M Coding Compliance**

Review of E/M Categories

- Exercise – The Apex Medical Center has several provided-based clinics including family practice, orthopedics, internal medicine and surgery. Hospital coding and billing staff code and bill for both the professional and facility components including E/M. Consider what impact this Medicare change (i.e., discontinuing the Consultation codes) will have on coding and billing.
  - Family practice physician admits patient to hospital and then requests a consultation from one of the orthopedic surgeons.
  - Family practice physician sees a patient and sends the patient to the orthopedic clinic for a consultation on an outpatient basis.
  - An ER physician requests that an Internal Medicine physician come to the ED for a consultation on a patient. After the assessment by the IM physician, the patient is released home.
  - An ER physician calls a family practice physician to see the FP’s patient in the ED. Both physicians see the patient before the patient is discharged.
E/M Coding Compliance
Review of E/M Categories

- Emergency Department Services
  - 99281-99285 – Standard Five Levels
  - 99288 – Physician Direction EMS
- Critical Care Services
  - 99291 ➔ 30-74 Minutes
  - 99292 ➔ Each Additional 30 Minutes
- Questions
  - Should 99292 be used for hospital outpatient coding?
  - To code 99292 how many minutes out of the 30 minutes must services be provided?
- Pediatric/Neonatal Codes
  - Critical Care
  - Patient Transport
  - Low Birth Weight Services

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E/M Coding Compliance
Review of E/M Categories

- Preventative Medicine
  - Categorized By Age Range
  - New Patient – 99381-99387
  - Established Patient – 99391-99397
  - Individual Counseling – 99401-99404 + 99411-99412
- Question: What if both preventative services and diagnostic services are provided at the same session?
- Question: Is preventative care a compliance issue? If so, how would you check and design and audit?
  - Note: MMA 2003 directs CMS to pay for a Medicare patients first Preventative Medicine service.
    - See G0402, G0403, G0404 and G04055
    - Who can perform the Initial Preventative Physical Examination (IPPE)?
    - Where can these be performed?
“-25” Modifier

- Used For Both Physicians and Hospitals
- Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day of 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 preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. The E/M service may be prompted by the symptom of condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date.
- Analyze this definition with particular attention to medical necessity and ‘differentiating diagnoses’.
- Must translate the language for hospital use.
- Are there any differences between physician utilization and hospital utilization?

Many Subtle Differences Between Physician and Hospital Coding For E/M Services

- E/M Levels Between Physicians and Hospitals Do Not Have to Match – But, should there be some degree of correlation?
- Special Physician Bundling Rules – ED physician assesses patient (say, 99284) and then admits patient to observation status (say, 99220). The physician can only code one E/M (most likely 99220 since it pays more). However, the hospital will code both under different RCCs (Revenue Center Codes).
- “-25” Modifier – Definition alludes to “same physician”. Thus for physicians, use the “-25” modifier only if one physician is performing both services (E/M and CPT Procedure). However, for hospital there may be more than one physician and the modifier will still need to be used on the UB-04 claim that has the E/M and medical/surgery service.
- Physician E/M Coding Documentation Guidelines have been written to accommodate physicians providing services in a “freestanding” clinic situation. The guidelines have to be reinterpreted relative to provider-based or hospital situations. (See NCCI Edit Policy Manual)
Three Different Sets of Guidelines
- 1995 ➔ Still The Official
- 1997 ➔ CMS Implemented, But Withdrew After Significant Complaints (Famous Bullet Points)
- 2000 ➔ Languishing Someplace!
- MMA 2003 ➔ Congress Orders Additional Study
  - What does this mean???

CPT Itself Contains Guidance – 7 Components
- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time
  - The first three are “Key”
  - All 7 Of These Are For Physicians

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Exercise: Dr. Brown is performing an assessment on Sam. Sam has been having some problems with hypertension and shortness of breath. Sam is quite nervous about the examination and he is also having trouble moderating his weight. Dr. Brown spends the first 15 minutes of the encounter talking with Sam about duck hunting in order to relax Sam. The actual examination takes only about 10 minutes and involves problem focused examinations for hypertension and the respiratory system. The nurse has already updated Sam’s history which Dr. Brown verifies. Dr. Brown then counsels Sam for 20 minutes concerning exercise, weight management and the possibilities of diabetes. Sam’s medications are adjusted for both the hypertension and breathing difficulties. Assuming that Sam is an established patient, what level should be coded?
- Address this for the physician ➔
- Now what about the hospital (assume provider-based clinic) ➔
E/M Coding Compliance

Physician E/M – Clinical Guidelines

- Appendix C of the CPT Manual Has Clinical Examples for Selected E/M Codes – Note: These are all physician oriented!
- 99201 – New Patient, Level 1
  - Initial office visit for a 50-year-old male who needs a prescription refill for a nonsteroidal anti-inflammatory drug.
- 99203 – New Patient, Level 3
  - Initial office visit for a 22-year-old female with irregular menses.
- 99205 – New Patient, Level 5
  - Initial office visit for a 73-year-old male with an unexplained 20 lb. weight loss.
- 99211 – Established Patient, Level 1
  - Office visit for 82-year-old female, established patient, for a monthly B12 injection with documented vitamin B12 deficiency.
  - Note: This is an interesting example that leads into a discussion of E/M coding along with the injection.

E/M Coding Compliance

Mapping Systems

- No Formal Guidance From CMS
  - CMS Working On National Facility Component E/M Coding Guidelines ➔ 2015?? 2016?? Ever?? (No, probably not!)
  - April 7, 2000 FR Entry – Develop a system that translates resources utilized to E/M level and then use it!
- Three Main Approaches
  - Point System
  - Narrative System
  - Diagnosis Mappings
  - Combination of Approaches
- Alternative Approaches – Facility E/M Level Same As Physician E/M (?)
- Hospitals Use E/M In Three Main Locations
  - Emergency Department ➔ 99281-99285
  - Separate, Provider-Based Clinics ➔ Other E/M Codes
  - Clinical Services Inside the Hospital
    - Nursing Services
    - Physician/Non-Physician Practitioners Performing Services in the Hospital
      - Professional vs. Facility Components
E/M Coding Compliance
Mapping Systems

Point System For The ED
- Nursing Assessments
  - Assessments – Initial & Discharge 15 Points
  - Assessments – 1-2 Additional Reassessments 25 Points
  - Assessments – 3-4 Additional Reassessments 35 Points
  - Assessments – More than 4 Additional Reassessments 40 Points
    Choose One Of The Above
- Admission/Discharge
  - Transfer Out 20 Points
  - Transfer In 10 Points
  - Hospital Admission 20 Points
  - Psych Admission 20 Points
  - DOA/Patient Expired 20 Points
    Choose All That Apply

Point System For The ED
- Monitoring
  - Combative/Disoriented Patient - 10 Points
  - Psych Evaluation - 10 Points
  - Isolation/Infectious - 10 Points
  - Diabetic Monitoring - 5 Points
  - Continuous Pulse Oximetry - 10 Points
    - Choose All That Apply
- Lab/Radiology
  - Simple Tests By ED Staff - 10 Points
  - Multiple Lab Collections - 10 Points
  - Assist To or With X-Ray - 10 Points
  - Assist/Monitor In X-Ray (<10 Mins) - 15 Points
  - Assist/Monitor In X-Ray (10-20 Mins) - 20 Points
  - Assist/Monitor In X-Ray (> 20 Mins) - 30 Points
E/M Coding Compliance
Mapping System

➢ Point System For The ED
  ▪ Other
    • Enema/Disimpactions - 25 Points
    • Patient Teaching - 20 Points
    • Social Services/Family Needs - 15 Points
    • Other Non-Billable Procedures - 20 Points
    • Consulting Physician (Specialist) - 20 Points
    • Additional Consulting Physician (Different Specialty) - 15 Points
  ✓ Choose All That Apply
  ➢ ED Level I 0-40 Points
  ➢ ED Level II 41-55 Points
  ➢ ED Level III 56-75 Points
  ➢ ED Level IV 76-100 Points
  ➢ ED Level V 101 Or More Points

E/M Coding Compliance
Mapping Systems

➢ Narrative Systems
  ▪ See AHA/AHIMA Recommendations – See Joint Recommendations
  ▪ See ACEP – American College of Emergency Physicians – Recommendations
  ▪ Narrative Systems Typically Provide Examples of Types of Services That Qualify for A Given Level

➢ Using Diagnosis Codes to Drive the E/M Level
  ▪ APGs (Ambulatory Patient Groups) uses diagnosis codes to drive the E/M level. Which diagnosis code or combinations of codes?

➢ Questions for Any System
  ▪ Easy To Use?
  ▪ Frequency Distribution Generate a Bell-Shaped Curve? ED? Provider-Based Clinics?
  ▪ Will hospitals across the country do it differently?
  ▪ What compliance issues arise?
E/M Coding Compliance
Mapping Systems

- **Narrative Systems – Example Criteria - ED**
  - Administration of oral, topical, rectal, PR, NG or SL medication(s)
  - Administration of single disposable enema
  - Application of preformed splint(s)/elastic
    - Preformed are off-the-shelf. If creating a splint from plaster or bandage(s)/sling(s), or immobilizer(s) for non-fracture fiberglass or other material, would have separate code. Splints are or nondislocation injuries not billed separately.
    - Splints, casting, etc. for fractures are separately billable and paid under the fracture management.
  - Cleaning and dressing of a wound, single body area not repaired (but includes butterflies)
    - Examples: steri-strips and other adhesives, eye patch
      - At Least One → Level 1; Three → Level 2
  - **Note:** This is only a partial listing.

E/M Coding Compliance
Compliance Considerations

- **CMS Has Indicated That Each Facility Must Follow Their Mapping**
  - “We will hold each facility accountable for following its own system for assigning the different levels of HCPCS codes. As long as the services furnished are documented and medically necessary and the facility is following its own system, which reasonably relates the intensity of hospital resources to the different levels of HCPCS codes, we will assume that it is in compliance with these reporting requirements as they relate to the clinic/ emergency department visit code reported on the bill. Therefore, we would not expect to see a high degree of correlation between the code reported by the physician and that reported by the facility.” (65 FR 18451)
  - Question – Separate systems for ED versus clinics?
  - Question – One mapping for different types of provider-based clinics?
Hospitals and Commenters Shared Concerns With CMS via Federal Register Process

Further CMS Comments on E/M Levels – (67 FR 66793)

“Comment: One commenter asked that CMS provide protection for hospitals against fraud and abuse allegations stemming from the current ambiguous guidelines.”

“Response: … In any case, we believe that written facility guidelines developed in accordance with the principles (which we enunciated in the proposed rule and reaffirmed in this final rule) and which are widely disseminated in the facility, accompanied by appropriate education of clinicians and coders, and made available to reviewers should address the concerns of the commenters.”

CMS Concerns and Actions For Facility Component E/M Coding

CMS Concerns and Actions For Facility Component E/M Coding

• CMS to Develop National Guidelines – When??
  • Emergency Department
  • Provider-Based Clinics (Primary Care vs. Specialty)

• CMS Concern – Proposed Guidelines Mix E/M and Procedures
  • Mapping of Resources to E/M Level Cannot Include Anything That Is Separately Codeable and Billable
  • “We were also concerned that all the proposed guidelines allow counting of separately paid services (for example, intravenous infusion, x-ray, EKG, lab tests, and so forth) as “interventions” or “staff time” in determining a level of service. We believe that, within the constraints of clinical care and management protocols, the level of service for emergency and clinic visits should be determined by resource consumption that is not otherwise separately payable.” (67 FR 66791)
For CY2008 CMS Assembled Various Federal Register Discussions Into Eleven Principles for E/M Mapping Systems

- The coding guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code (65 FR 18451).
- The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources (67 FR 66792).
- The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits (67 FR 66792).
- The coding guidelines should meet the HIPAA requirements (67 FR 66792).
- The coding guidelines should only require documentation that is clinically necessary for patient care (67 FR 66792).

Eleven Principles – Continued

- The coding guidelines should not facilitate upcoding or gaming (67 FR 66792).
- The coding guidelines should be written or recorded, well-documented, and provide the basis for selection of a specific code.
- The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.
- The coding guidelines should not change with great frequency.
- The coding guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review.
- The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.
E/M Coding Compliance
Provider-Based Clinics

➢ Provider-Based Rule
  ▪ See 42 CFR §413.65
  ▪ Difficult To Understand With Unresolved Issues
  ▪ In-Hospital versus On-Campus versus Off-Campus
  ▪ Joint Ventures
  ▪ Under Arrangements
➢ Operational Test – File a UB-04? If yes, likely provider-based.
➢ Determination/Attestation Process
  ▪ CMS Only Interested In “Facility or Organization” For Which There Is A Possible Payment Differential
  ▪ Provider-Based = Hospital-Based (Generally)
➢ Question/Exercises –
  ▪ Is the ED Provider-Based? Need Determination/Attestation?
  ▪ Is the Radiology Department Provider-Based? Determination/Attestation?
  ▪ Off-Campus Urgent Care Clinic – Provider-Based? Determination/Attestation? Any other special concerns?

E/M Coding Compliance
Provider-Based Clinics

➢ Provider-Based Clinics
  ▪ Provider-Based Clinics Part of the Hospital
  ▪ Economic Advantage
    • File Both A CMS-1500 Professional and UB-04 Facility Claims
    • Physician ‘Site-of-Service’ Differential
  ▪ Different Types of Clinics
  ▪ Multiple Clinic Visits Same Day
➢ Provider-Based Clinical Services
  ▪ Generally In Hospital Departments – Attestation In Place
  ▪ Not As Organized As ‘Clinic’
  ▪ Example – Pain Management Services versus Pain Management Clinic
  ▪ Still Bill For Professional and Facility Component Services
Case Study

Pain Management Services
- At the Apex Medical Center, an MDA (M.D. Anesthesiologist) has started taking referrals from local physicians to provide pain management injections. These services are provided in the outpatient services area. The MDA provides a consultation and then a series of injections. Nursing staff from the outpatient department provides assistance.

Pain Management Clinic
- The pain management services have grown significantly! There are now two MDAs, two CRNAs and physical therapy all involved in the pain management services. There is a dedicated area, reception desk, dedicated nursing staff, a separate encounter form and a separate charge master section.
  ✓ Question: What is the difference between the two cases above?
  ✓ Coding/Billing versus Compliance?

E/M Coding Compliance
Provider-Based Clinics

- Develop Facility Component E/M Mapping
  - Must be a written document.
  - Must be readily available in case of audit
  - Should properly translate resources utilization to the E/M levels.
  - Update as various situations are encountered.

- Mapping for Emergency Department

- Mapping for Provider-Based Clinics

- Auditing For Proper Utilization of Mappings

- Statistical Analysis of E/M Levels Relative to Mappings
Exercise: In the ED will there always be an E/M level?
  - Be certain to justify your answer!
    - Hint: Think about the EMTALA mandated medical screening examination (MSE).

In the ED a patient presents with a small laceration on the finger. The ED nurse performs both the triage and EMTALA required MSE (Medical Screening Examination). Additionally, the nurse cleanses the wound. The ED physician sees the patient and sutures the wound only.
  - Will there be an E/M code for the hospital?
  - Will there be a surgical code for the hospital?
  - Will there be an E/M code for the ED physician?
  - Will there be a surgical code for the ED physician?
  - What about modifiers? (See next section).

See NCCI Coding Guidelines for additional information.

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Exercise: Sarah is coming in today for her monthly B12 injection. She is seen by a nurse and the injection is provided. (Note: A physician is at the clinic when this service is provided).
  - If this is a physician’s, freestanding clinic, how will this be coded?
  - If this is a hospital, provider-based clinic, how will this be coded?
    - Note: This is an advanced exercise! Simply note the solution.
    - Note: See also Transmittals 82 and 87 to Publication 100-02, Medicare Benefit Policy Manual (87 has been withdrawn).

Exercise: Sarah, unfortunately, suffered a broken leg in a fall. She was seen at the Apex Medical Center’s ED on Monday. Due to pain and swelling only a splint was applied. It is now Wednesday and she presents to the ED to have a cast applied.
  - How will this be coded for the ED physician?
  - How will this be coded for the hospital?
    - Note: This is an advanced exercise! Simply note the solution.
 Modifier “-57” – Decision for Surgery
- A surgeon may be called to the ED to provide a consultation (assessment). If the surgeon decides that surgery is necessary, then the surgeon will still be paid for the consultation, but a “-57” modifier must be used.
- This modifier is only for physicians.

Modifier “-25” – Significant, Separately Identifiable E/M Service by the Same Physician on the Same Day of the Procedure or Other Service
- Use by both physicians and hospitals, but for hospitals the “Same Physician” language has no meaning.
  - In the hospital setting the E/M service may be performed by one physician and the surgery by another physician. The hospital will still need to use the “-25” modifier.
- If an E/M service and a surgery are performed on the same day, then the E/M code will be bundled into the surgery.

Exercise: Dr. Clark, a surgeon, has just been called over to the Apex Medical Centers ED. An elderly patient has fallen and may have a ruptured spleen. Dr. Clark assesses the situation and recommends immediate surgery.
- Discuss appropriate E/M coding strategies.

Exercise: The Apex Medical Center has hired a Nurse Practitioner to provide pre-surgery H&Ps in the mornings. AMC has experienced a number of patients presenting for surgery without the mandatory pre-surgery H&P. The NP performs the H&Ps and then the surgeons perform surgery.
- Can the NP bill an E/M level professionally?
- Can the hospital bill an E/M level on the facility side?
- Will the NP need to use the “-25” modifier?
- Will the hospital need to use the “-25” modifier?
Exercise: Controversy has arisen at the Apex Medical Center concerning the proper coding and billing for closed fracture treatment in the ED. The issue centers around a patient who presented with an uncomplicated, non-displaced fracture of one rib. The patient was assessed, given pain medication and instructions and then sent home.

- Use Fracture Care Code + E/M?
- Put This Service Into the E/M Level?

Exercise: At the Apex Medical Center the ED nursing staff has just learned that all of the point-of-care (POC) laboratory tests that they perform (e.g., CLIA waived tests such blood glucose) and not being billed at all.

- Should these services go into the E/M mapping?
- Should these services be separately coded and billed?

E/M Coding Compliance
Summary & Conclusions

- Fairly Wide Range of E/M Codes
- Primary Concerns
  - Office Visits & Other Outpatient Services
  - Consultation Codes → Provider-Based Clinics?
  - Preventative Medicine Codes
- General Guidelines in CPT
  - History/Examination/Medical Decision Making
    - Doesn’t Fit Hospitals – Neither ED nor Clinics
- Physician Professional Component E/M Coding
  - Specific Guidelines
  - Guidelines Are Controversial
- Hospital Facility Component E/M Coding
  - No Guidelines → On The Way – 2014??
  - ED versus Provider-Based Clinic Situation
  - Point Systems versus Narrative Systems versus Other Approaches
- Special Modifiers – “25” and “-57”
- Compliance Issues
  - Rapidly Evolving Issue with the “-25” Modifier ← RAC Extrapolation
E/M Coding Compliance
Additional Materials

- 1995 E/M Coding Documentation Guidelines (Still Official) – 1997 Guidelines Also At This Site
- AHA/AHIMA Proposed Facility Component E/M Coding Guidelines
  - See AHA or AHIMA Websites
- ACEP ED Facility Component E/M Narrative System
  - See ACEP Website
- “-25” Modifier
  - PM A-00-40
  - PM A-01-80
    - There has been no further guidance from CMS on the “-25” since these to program memorandums in 2000 and 2001.