Health Law Webinar

Legal Issues Associated with Medical Coding and Billing

May 11, 2022

Fredrikson & BYRON, P.A.

Our Agenda

- Introduction: Overview of Medicare/Medicaid/private insurance and research.
- How to Use The CPT Book.
- Quirky Medicare Billing Rules:
  - E&M
  - Teaching Physician Rule
  - Incident to
  - Two Midnight Rule
  - Orders/signatures

What is Coding?

- The way we describe a service, including what was done, who did it, where it was done and why it was done.
- Is “billing” a synonym for coding?
- “Is there coverage, and if so, how?”

Preliminary Thoughts

- Who do you believe?
- There are more laws and policies than we can cover in an hour, or even a day.
- This is more about policy than law.
- Never forget individual payors or state law can flip everything.

Conceptualizing the Law

- Think of Fruit Loops!

Conceptualizing the Law

- Two cans: Can we do it vs. Can we bill for it?
- Today we are focused solely on billing.
- Whose rule?
- Payor variability: Is discrimination ok?
- Contract vs. Law.

Conceptualizing the Law

- Note the Medicare legal hierarchy.
  - Constitution, statute, regulation, NCD.
  - LCD, preamble, manual, carrier guidance.
- Proposed Rule vs. Final Rule.
- Never forget state law. Some are mighty hard to find!! (Is local counsel an advantage???)

Medicare 101

- Mostly over 65, also disability.
- Medicare Part A (providers) vs. Part B (suppliers), Part C (Medicare Advantage) and Part D (Drugs).
- CMS Baltimore/Regional Offices.
- Medicare Administrative Contractors (“MACs”).
- Contracted Auditors (RACs, UPIC, ZPIC, BISC).

Medicare Advantage

- While “Medicare” is in the name, it is more like a private insurer.
- Some rules, like Stark, and the False Claims Act, may still apply.
- Most reimbursement rules do NOT.
- BUT Medicare Advantage must provide coverage at least as generous as Medicare.

Medicare 101

- Understand if reimbursement is fee for services (FFS), prospective payment (PPS) or something else.
- Beware of the “combo.” DRG is prospective, but don’t forget outliers.
- Professional and technical components, facility fees. Graduate medical education.

Names Matter

- Part A: Providers (42 CFR 400.202):
  - Hospital.
  - CAH: Critical Access Hospital.
  - SNF: Skilled Nursing Facility.
  - CORF: Comprehensive Outpatient Rehab Facility.
  - HHA: Home Health Agency.
  - Hospice.
  - Rehab agency to furnish PT or SLP.
  - CMHC: Community Mental Health Clinic/PHP: Partial Hospitalization Program.

Names Matter

- Part B: Suppliers (42 CFR 400.202):
  - Physician.
  - Other practitioner.
  - “Entity other than a provider that furnishes health care services under Medicare.”
    - IDTF: Independent Diagnostic Testing Facility.
    - DMEPOS: Durable Medical Equip. Prosthetics Orthotics Supplier.
    - ASC: Ambulatory Surgery Center.
    - Clinic.

Billing Differences

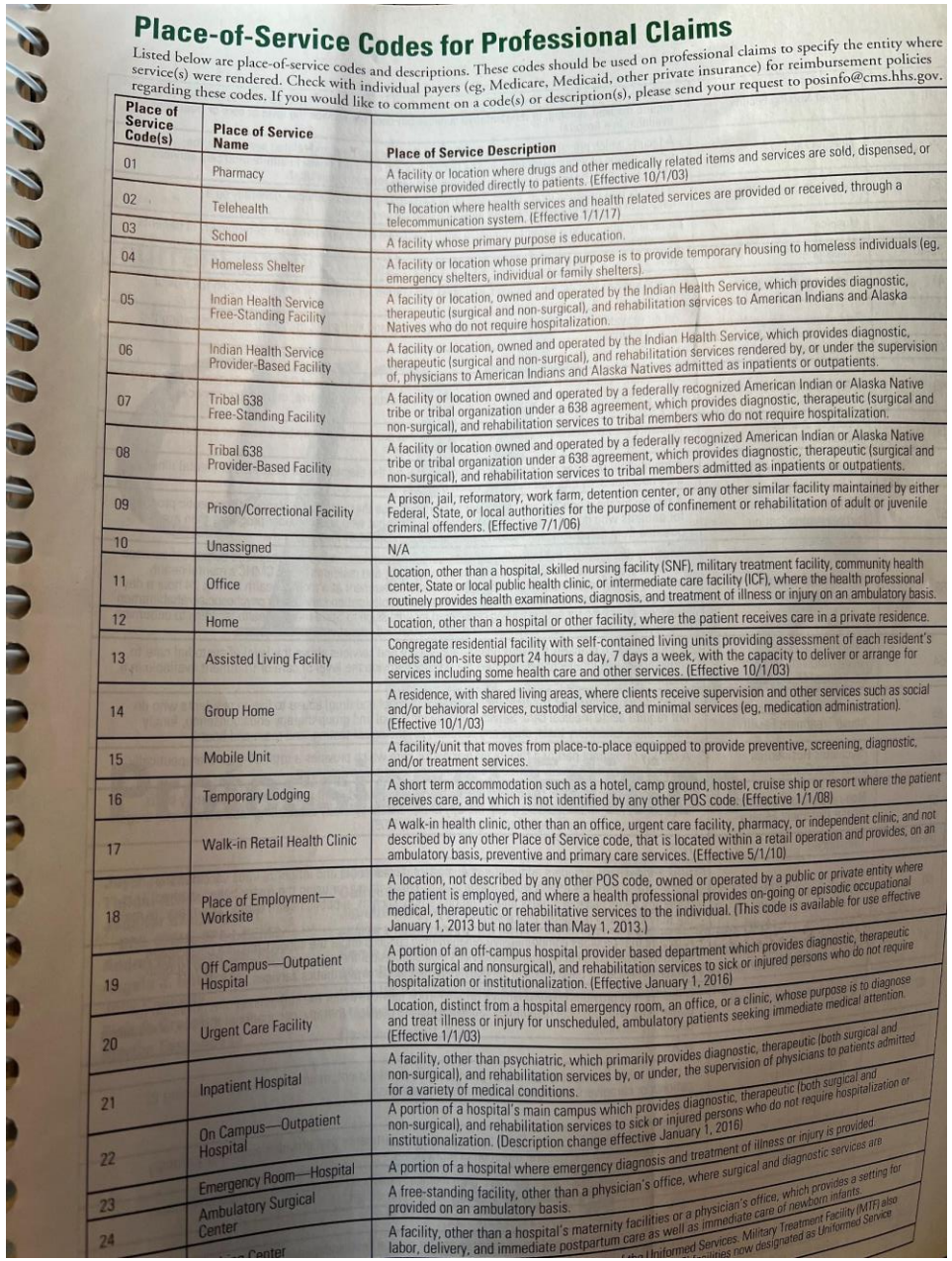
- Part A:
  - Typically on a UB-04.
  - Likely to be prospective (but may be cost based, like critical access hospital).
- Part B:
  - Typically on a 1500.
  - Typically on a fee schedule.

One Event, Two Bills

- Patient presents in the ED.
- Physician's professional component billed on a 1500, listing a "Place of Service" outpatient hospital.
- Hospital facility fee on a UB-04.
- Note that the "levels of service" may differ!

Location, Location, Location?

- Does place of service matter?
- Hospital vs. Clinic? Yes. There is a “facility fee” and lower professional reimbursement.
- Clinic vs. Urgent Care? Probably not.



Place-of-Service Codes for Professional Claims

Listed below are place-of-service codes and descriptions. These codes should be used on professional claims to specify the entity where service(s) were rendered. Check with individual payers (eg, Medicare, Medicaid, other private insurance) for reimbursement policies regarding these codes. If you would like to comment on a code(s) or description(s), please send your request to posinfo@cms.hhs.gov.

Place of Service Code(s)	Place of Service Name	Place of Service Description
01	Pharmacy	A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients. (Effective 10/1/03)
02	Telehealth	The location where health services and health related services are provided or received, through a telecommunication system. (Effective 1/1/17)
03	School	A facility whose primary purpose is education.
04	Homeless Shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (eg, emergency shelters, individual or family shelters).
05	Indian Health Service Free-Standing Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-Based Facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-Standing Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-Based Facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09	Prison/Correctional Facility	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (Effective 7/1/06)
10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (Effective 10/1/03)
14	Group Home	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (eg, medication administration). (Effective 10/1/03)
15	Mobile Unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16	Temporary Lodging	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code. (Effective 1/1/08)
17	Walk-in Retail Health Clinic	A walk-in health clinic, other than an office, urgent care facility, pharmacy, or independent clinic, and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services. (Effective 5/1/10)
18	Place of Employment—Worksite	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. (This code is available for use effective January 1, 2013 but no later than May 1, 2013.)
19	Off Campus—Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Effective January 1, 2016)
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. (Effective 1/1/03)
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	On Campus—Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization. (Description change effective January 1, 2016)
23	Emergency Room—Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A free-standing facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
		A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate postpartum care as well as immediate care of newborn infants.

Fredrikson & BYRON, P.A.

	...n/Correctional Facility	...and rehabilitation services to tribal members admitted as inpatients or outpatients.
10	Unassigned	A prison, jail, reformatory, work farm, detention center, or any other similar facility maintained by either Federal, State, or local authorities for the purpose of confinement or rehabilitation of adult or juvenile criminal offenders. (Effective 7/1/06)
11	Office	N/A
12	Home	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
13	Assisted Living Facility	Location, other than a hospital or other facility, where the patient receives care in a private residence.
4	Group Home	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services. (Effective 10/1/03)
5	Mobile Unit	A residence, with shared living areas, where clients receive supervision and other services such as social and/or behavioral services, custodial service, and minimal services (eg, medication administration). (Effective 10/1/03)
6	Temporary Lodging	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
7	Walk-in Retail Health Clinic	A short term accommodation such as a hotel, camp ground, hostel, cruise ship or resort where the patient receives care, and which is not identified by any other POS code. (Effective 1/1/08)
8	Place of Employment—Worksite	A walk-in health clinic, other than an office, urgent care facility, pharmacy, or independent clinic, and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services. (Effective 5/1/10)
	Off Campus—Outpatient	A location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides on-going or episodic occupational medical, therapeutic or rehabilitative services to the individual. (This code is available for use effective January 1, 2013 but no later than May 1, 2013.)
		A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require ...institutionalization. (Effective January 1, 2016)

Medicaid 101

- Generally low income or disability.
- Combined state/federal.
- Rules are state driven.
- Increasingly involves managed care.
- Federal reporting requirements:
  - 42 CFR Part 455 (Medicaid Program Integrity)

Key Players

- State Agency.
- Surveillance and Utilization Review (SURS).
- Medicaid Fraud Control Unit (MFCU).
- OIG (Federal and perhaps state).
- State AG.

Private Insurance

- Is there a contract?
- If not, industry norms control.
- If yes, the terms control. Does it incorporate a manual?
- Really, truly, don’t forget state law, which may prevent the insurer from doing what it wants! (Insurance commissioner/Commerce may be your ally!)

Research Strategies

Hierarchy of Authority

- Constitution (due process, contracts clause, enumerated powers).
- Statutes (Social Security Act).
- Regulations (42 CFR).
- National Coverage Determinations.
- Local Coverage Determinations.
- Program guidance (manuals, bulletins, FAQs, regulatory preambles).

SSSSSources of Authority??

- OIG Work Plan.
- Contractor publications.
- Trade group statements.
- Law firm/consultant newsletters/webinars.

What are the Medicare Manuals?

- Sub-regulatory guidance.
- CMS's instructions for administration of the Medicare program.
- Examples:
  - Medicare Claims Processing Manual.
  - Medicare Benefit Policy Manual.
  - National Coverage Determinations Manual.

Manuals/Guidance Cannot Limit Coverage

42 U.S.C. § 1395hh(a)(1) says nothing other than an NCD may change benefits unless promulgated as a regulation.

42 U.S.C. § 1395hh(a)(2): Manuals/Guidance Cannot Limit Coverage

No rule, requirement, or other statement of policy (**other than a national coverage determination**) that establishes or changes a substantive legal standard governing…the payment for services…under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

U. S. Department of Justice

Office of the Associate Attorney General

The Associate Attorney General

Washington, D.C. 20530

January 25, 2018

MEMORANDUM FOR: HEADS OF CIVIL LITIGATING COMPONENTS
UNITED STATES ATTORNEYS

CC: REGULATORY REFORM TASK FORCE

FROM: THE ASSOCIATE ATTORNEY GENERAL

SUBJECT: Limiting Use of Agency Guidance Documents
In Affirmative Civil Enforcement Cases

On November 16, 2017, the Attorney General issued a memorandum ("Guidance Policy") prohibiting Department components from issuing guidance documents that effectively bind the public without undergoing the notice-and-comment rulemaking process. Under the Guidance Policy, the Department may not issue guidance documents that purport to create rights or obligations binding on persons or entities outside the Executive Branch (including state, local, and tribal governments), or to create binding standards by which the Department will determine compliance with existing statutory or regulatory requirements.

The Guidance Policy also prohibits the Department from using its guidance documents to coerce regulated parties into taking any action or refraining from taking any action beyond what is required by the terms of the applicable statute or lawful regulation. And when the Department issues a guidance document setting out voluntary standards, the Guidance Policy requires a clear statement that noncompliance will not in itself result in any enforcement action.

Azar v. Allina, 139 S.Ct. 1804, 1809 (2019)

"Notably, Congress didn't just adopt the APA's notice-and-comment regime for the Medicare program. That, of course, it could have easily accomplished in just a few words. Instead, Congress chose to write a new, Medicare-specific statute. The new statute required the government to provide public notice and a 60-day comment period (twice the APA minimum of 30 days) for any "rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under [Medicare]." 42 U.S.C. § 1395hh(a)(2)."

Manuals/Guidance Can't Limit Coverage

- "Thus, if government manuals go counter to governing statutes and regulations of the highest or higher dignity, a person 'relies on them at his peril.' " Government Brief in Saint Mary's Hospital v. Leavitt.
- "[The Manual] embodies a policy that itself is not even binding in agency adjudications…. Manual provisions concerning investigational devices also 'do not have the force and effect of law and are not accorded that weight in the adjudicatory process.' " Government Brief in Cedars-Sinai Medical Center v. Shalala.

42 cfr 410.32

Search

All Maps Shopping News Videos More Settings Tools

About 8,740 results (0.47 seconds)

[PDF] 42 CFR Ch. IV (10–1–03 Edition) § 410.32 - CMS.gov

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/.../410_32.pdf

252. **42** CFR Ch. IV (10–1–03 Edition). § **410.32** central or peripheral) to permit moni- toring of beneficiaries in the future if the initial test was performed with a.

42 CFR § 410.32 - Diagnostic x-ray tests, diagnostic laboratory tests ...

https://www.law.cornell.edu › ... › Subpart B. Medical and Other Health Services

(a)Ordering diagnostic tests. All diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the ...

You've visited this page 4 times. Last visit: 8/1/19

42 CFR 410.32 - Diagnostic x-ray tests, diagnostic laboratory tests ...

https://www.gpo.gov/fdsys/granule/CFR-2011.../CFR-2011-title42-vol2-sec410-32

Oct 1, 2011 - **42 CFR 410.32** - Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

You've visited this page 3 times. Last visit: 7/20/18

42 CFR 410.32 - Diagnostic x-ray tests, diagnostic ... - GovRegs

https://www.govregs.com/.../title42_chapterIV_part410_subpartB_section410.32

Provides the text of the **42 CFR 410.32** - Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions. (CFR).

Google with Caution!

[PDF] 42 CFR Ch. IV (10–1–03 Edition) § 410.32 - CMS.gov

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/.../410_32.pdf ▼

252. **42** CFR Ch. IV (10–1–03 Edition). § **410.32** central or peripheral) to permit moni- toring of beneficiaries in the future if the initial test was performed with a.

Google with Caution!

central or peripheral) to permit monitoring of beneficiaries in the future if the initial test was performed with a technique that is different from the proposed monitoring method.

(d) *Beneficiaries who may be covered.* The following categories of beneficiaries may receive Medicare coverage for a medically necessary bone mass measurement:

(1) A woman who has been determined by the physician (or a qualified nonphysician practitioner) treating her to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings.

(2) An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of osteoporosis, osteopenia, or vertebral fracture.

(3) An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to 7.5 mg of prednisone, or greater, per day for more than 3 months.

(4) An individual with primary hyperparathyroidism.

(5) An individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy.

sonable and necessary (see § 411.15(k)(1) of this chapter).

(1) *Chiropractic exception.* A physician may order an x-ray to be used by a chiropractor to demonstrate the subluxation of the spine that is the basis for a beneficiary to receive manual manipulation treatments even though the physician does not treat the beneficiary.

(2) *Mammography exception.* A physician who meets the qualification requirements for an interpreting physician under section 354 of the Public Health Service Act as provided in § 410.34(a)(7) may order a diagnostic mammogram based on the findings of a screening mammogram even though the physician does not treat the beneficiary.

(3) *Application to nonphysician practitioners.* Nonphysician practitioners (that is, clinical nurse specialists, clinical psychologists, clinical social workers, nurse-midwives, nurse practitioners, and physician assistants) who furnish services that would be physician services if furnished by a physician, and who are operating within the scope of their authority under State

Links to Official Versions

- Current CFR: https://gov.ecfr.io/cgi-bin/ECFR
- Federal Register: https://www.federalregister.gov/
- Manuals: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html?redirect=/manuals/

Pay Attention to Effective Dates

20.1.2.1 - Cost to Charge Ratios
(Rev. 2111, Issued: 12-03-10, Effective: 04-01-11, Implementation: 04-04-11)

Retro, But Not In the Good Way

10 - Covered Inpatient Hospital Services Covered Under Part A
(Rev. 234, Issued: 03-10-17, Effective: 01-01-16, Implementation: 06-12-17)

Patients covered under hospital insurance are entitled to have payment made on their behalf for inpatient hospital services. (Inpatient hospital services do not include extended care services provided by hospitals pursuant to swing bed approvals. See Pub. *100-02*, Chapter 8, §*10.3*, "Hospital Providers of Extended Care Services."). However, both inpatient hospital and inpatient SNF benefits are provided under Part A - Hospital Insurance Benefits for the Aged and Disabled, of Title XVIII).

Additional information concerning the following topics can be found in the following chapters *of this manual*:

- Benefit Period is found in Chapter 3
- *Counting Inpatient* Days is found in Chapter *3*
- Lifetime reserve days is found in Chapter 5
- Related payment information is housed in the Provider Reimbursement Manual

U.S. ex rel. Dunn v. North Memorial Health

- Relator alleged that certain supervision and documentation requirements for pulmonary and cardiac rehab services had not been met.
- But the regulation creating these requirements did not go into effect until after the relevant time period!

Is the Manual Up-to-Date?

Medicare Claims Processing Manual

Chapter 3 - Inpatient Hospital Billing

Table of Contents

(Rev. 4337, 07-18-19)

National vs. Local Coverage Determinations

- NCDs are binding
- They are also less restrictive than most people think.

NCDs Are Complicated

Where an item, service, etc. is stated to be covered, but such coverage is **explicitly limited to specified indications** or specified circumstances, all limitations on coverage of the items or services because they do not meet those specified indications or circumstances are based on § 1862(a)(1) of the Act. **Where coverage of an item or service is provided for specified indications or circumstances but is not explicitly excluded for others, or where the item or service is not mentioned at all in the CMS Manual System the Medicare contractor is to make the coverage decision, in consultation with its medical staff, and with CMS when appropriate, based on the law, regulations, rulings and general program instructions.**

- Medicare National Coverage Determination Manual, CMS Pub. 100-03, Chapter 1, Foreword, Paragraph A

Operationalizing NCDs

Indications and Limitations of Coverage
B. Nationally Covered Indications

Effective for services performed on or after February 15, 2018, CMS has determined that the evidence is sufficient to conclude that the use of ICDs, (also referred to as defibrillators) is reasonable and necessary:

1. Patients with a personal history of sustained Ventricular Tachyarrhythmia (VT) or cardiac arrest due to Ventricular Fibrillation (VF). Patients must have demonstrated:
   - An episode of sustained VT, either spontaneous or induced by an Electrophysiology (EP) study, not associated with an acute Myocardial Infarction (MI) and not due to a transient or reversible cause; or
   - An episode of cardiac arrest due to VF, not due to a transient or reversible cause.

2. Patients with a prior MI and a measured Left Ventricular Ejection Fraction (LVEF) ≤ 0.30. Patients must not have:
   - New York Heart Association (NYHA) classification IV heart failure; or,
   - Had a Coronary Artery Bypass Graft (CABG), or Percutaneous Coronary Intervention (PCI) with angioplasty and/or stenting, within the past

malfunction.

C. Nationally Non-Covered Indications

N/A

D. Other

For patients that are candidates for heart transplantation on the United Network for Organ Sharing (UNOS) transplant list awaiting a donor heart, coverage of ICDs, as with cardiac resynchronization therapy, as a bridge-to-transplant to prolong survival until a donor becomes available, is determined by the local Medicare Administrative Contractors (MACs).

All other indications for ICDs not currently covered in accordance with this decision may be covered under Category B Investigational Device Exemption (IDE)

LCDs

- Issued by contractor.
- Apply to limited contractor's geographic territory.
- Subject to notice-and-comment (Program Integrity Manual 13.2.4.2).

Role of LCDs

- An LCD is a coverage determination issued by a contractor, not promulgated by the agency, and is not even binding on an administrative law judge. See 42 U.S.C. § 1395ff(c)(3)(B)(ii)(II) (QICs).
- 42 C.F.R. 405.1062(a) (ALJs).
- "The district court correctly stated in its instructions to the jury that LCDs are 'eligibility guidelines' that are not binding and should not be considered "the exact criteria used for determining" terminal illness."
  - *United States v. Aseracare, Inc.*, et al., 938 F.3d 1278, 1288 (11th Circ. 2019).

Coding Basics

- Procedure vs. Diagnostic.
- CPT Coding: CPT & CPT Assistant.
- HCPCS Codes (Healthcare Common Procedure Coding System).
- Category 3 Codes: New Technology.
- 1500 versus UB-04.

Coding Basics

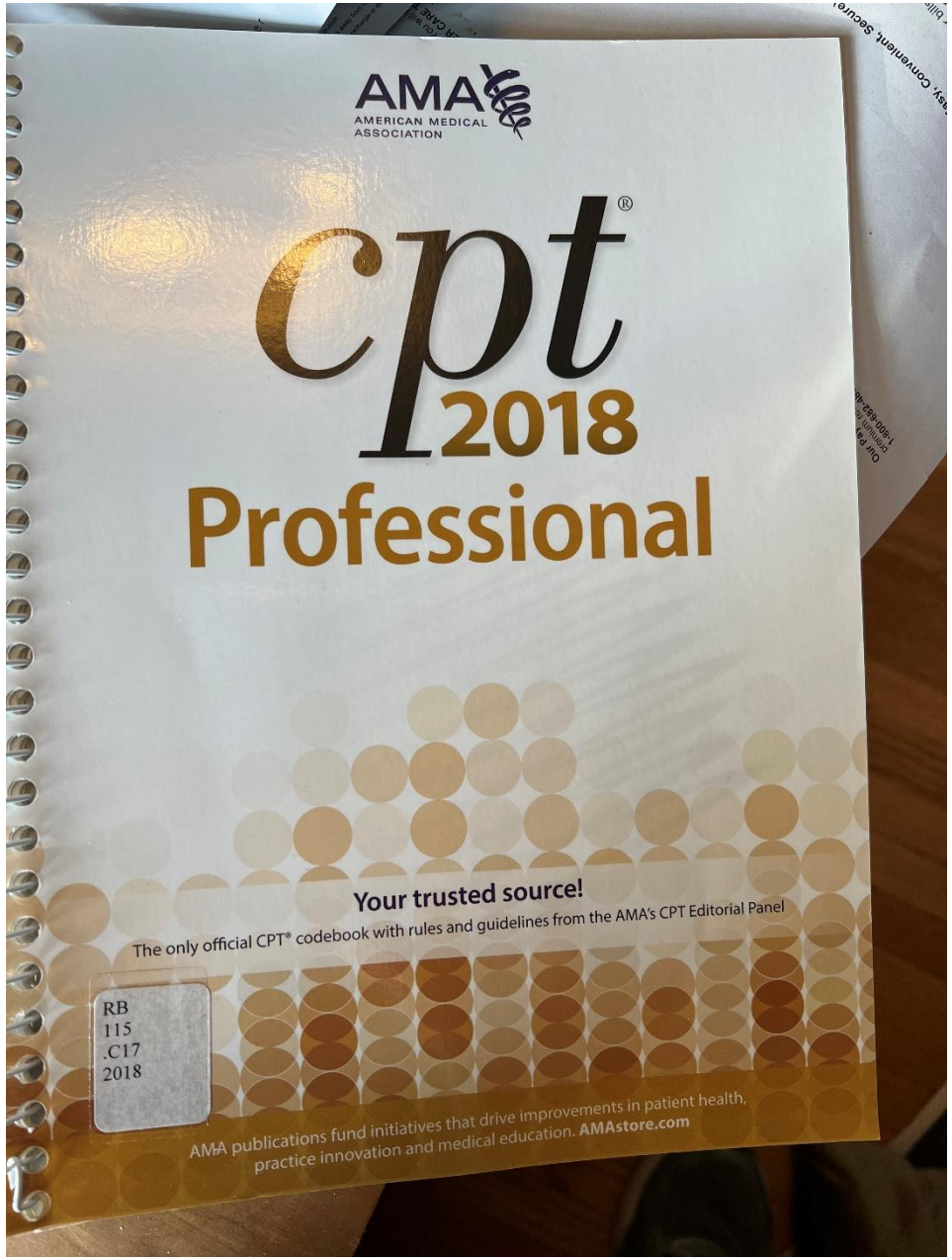
- Diagnostic coding is based on the International Classification of Diseases (ICD) now in version 10.
- Diagnostic coding can be either definitive or suspected.
- There are often debates about who “should” assign codes.

Bundled Billing

- DRG (72-hour rule).
- APC.
- Home Health.
- SNF Consolidated billing.
- Programs like BPCI, CJR, EPM.

Choosing A Code

- CPT is organized by specialty.
- Read the introductory text.
- If the service doesn’t fit EVERY word in a code, you likely want a different code.
- There are unlisted codes.
- There are many pitfalls.


AMA
AMERICAN MEDICAL ASSOCIATION
cpt®
2018
Professional
Your trusted source!
The only official CPT® codebook with rules and guidelines from the AMA's CPT Editorial Panel
RB
115
.C17
2018
AMA publications fund initiatives that drive improvements in patient health, practice innovation and medical education. AMAstore.com

Appendix A

Modifiers

This list includes all of the modifiers applicable to CPT 2018 codes.

A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities.

22 **Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). **Note:** This modifier should not be appended to an E/M service.

→ *CPT Changes: An Insider's View* 2008

→ *CPT Assistant* Jan 09:8, Apr 09:8, Jun 09:8,10, Aug 13:4

23 **Unusual Anesthesia:** Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

24 **Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period:** The

Modifiers

- 2 digits appended to a CPT code to additional information.
- -25, a separate and identifiable service.
- -59, a distinct procedure.
- -52, an incomplete procedure.
- -GC Teaching physician service.
- -26/TC Professional/technical only.

Appendix B

Summary of Additions, Deletions, and Revisions

►Appendix B shows the actual changes that were made to the code descriptors. New codes appear with a bullet (●) and are indicated as "Code Added." Revised codes are preceded with a triangle (▲). Within revised codes, the deleted language appears with a ~~strikethrough~~, while new text appears underlined. The symbol ⌅ is used to identify codes for vaccines that are pending FDA approval (see **Appendix K**).The symbol # is used to identify codes that have been resequenced (see **Appendix N**). CPT add-on codes are annotated by the symbol + (see **Appendix D**). The symbol ⊘ is used to identify codes that are exempt from the use of modifier 51 (see **Appendix E**). The symbol ★ is used to identify codes that may be used for reporting telemedicine services (see **Appendix P**).◄

Appendix C

Clinical Examples

As described in the CPT 2018 code set, clinical examples of the CPT codes for Evaluation and Management (E/M) services are intended to be an important element of the coding system. The clinical examples, when used with the E/M descriptors contained in the full text of the CPT code set, provide a useful tool and guidance for individuals to report the services provided to their patients. Clinical examples of the codes for E/M services are provided to assist physicians in understanding the meaning of the descriptors and selecting the correct code. Each example was developed by physicians in the specialties shown.

The same problem, when seen by physicians in different specialties, may involve different amounts of work. Therefore, the appropriate level of encounter should be reported using the descriptors rather than the examples.

The American Medical Association is pleased to provide you with these clinical examples for the CPT 2018 code

exclude that patient encounter from a particular level of service. The three components (history, examination, and medical decision making) must be met, consistent with the Nature of Presenting Problem, and documented in the medical record to report a particular level of service.

Office or Other Outpatient Service

New Patient

99201 Initial office visit for a 50-year-old male from out-of-town who needs a prescription refill for a nonsteroidal anti-inflammatory drug. (Anesthesiology)

Initial office visit for a 40-year-old female, new patient, requesting information about local pain clinics. (Anesthesiology/Pain Medicine)

Initial office visit for a 10-year-old female for determination of visual acuity as part of a summer camp physical (does not include determination of refractive

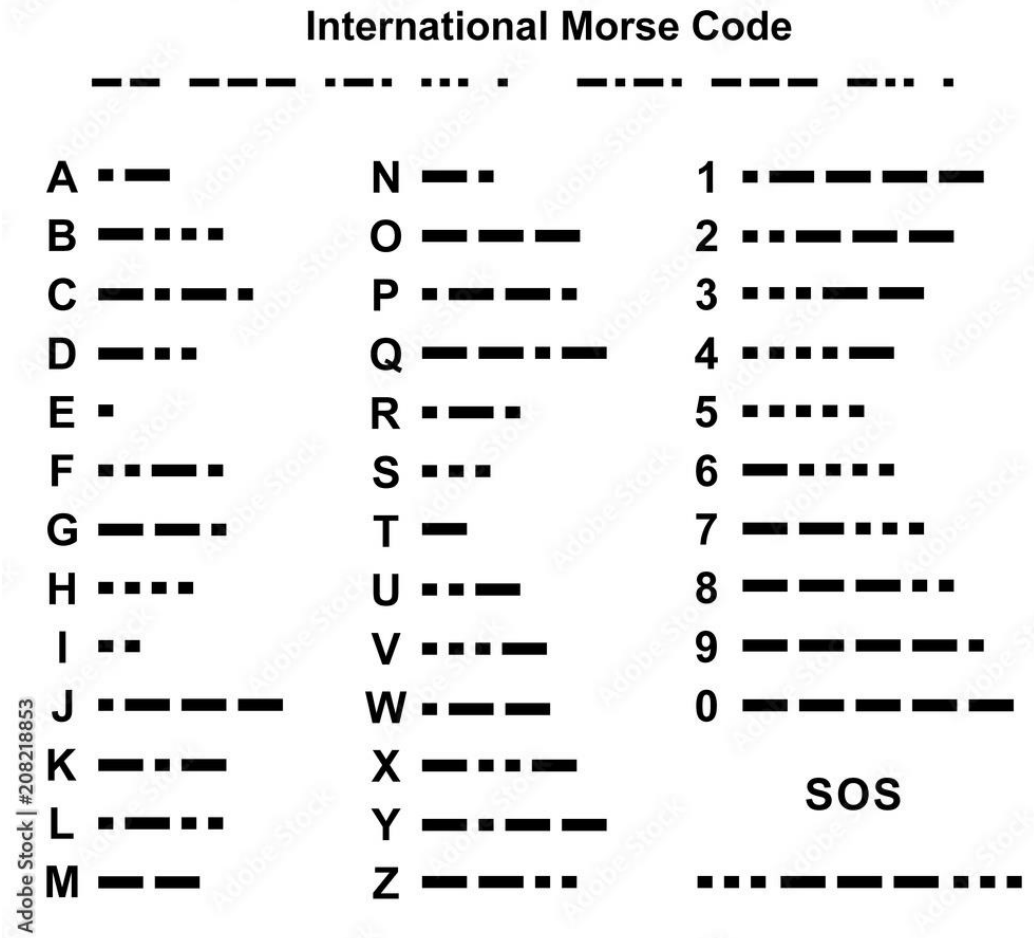
Appendix M

Renumbered CPT Codes–Citations Crosswalk

This listing is a summary of crosswalked deleted and renumbered codes and descriptors with the associated *CPT Assistant* references for the deleted codes. This listing includes codes deleted and renumbered from 2007 to 2009. Additional codes will not be added, since the principle of deleting and renumbering is no longer being utilized in the CPT code set.

Current Code(s)	Deleted/Former Code	Year Code Deleted	Citations Referencing Former Code—Applicable to Current Code(s)
89240	0058T	2009	Jun 04:8 CPT Changes: An Insider's View 2004
89240	0059T	2009	CPT Changes: An Insider's View 2004
41530	0088T	2009	May 05:7, Sep 05:9 CPT Changes: An Insider's View 2005
95803	0089T	2009	Jun 05:6, Feb 06:1 CPT Changes: An Insider's View 2006
22856	0090T	2009	Jun 05:6, Feb 06:1 CPT Changes: An Insider's View 2006, 2007
22864	0093T	2009	Jun 05:6, Feb 06:1 CPT Changes: An Insider's View 2006, 2007
[illegible]	[illegible]	2009	Jun 05:6, Feb 06:1 CPT Changes: An Insider's View 2006, 2007

Choosing A Code



82270 Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)

- *CPT Changes: An Insider's View* 2002, 2006
- *CPT Assistant* Sep 03:15, Feb 06:7, Apr 08:5

82271 other sources

- *CPT Changes: An Insider's View* 2006
- *CPT Assistant* Feb 06:7

82272 Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening

- *CPT Changes: An Insider's View* 2006, 2008
- *CPT Assistant* Feb 06:7, Apr 08:5, Jun 09:10

(Blood urea nitrogen [BUN], see 84520, 84525)

82274 Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations

- *CPT Changes: An Insider's View* 2002

Hemicorpectomy

- AANS said to use Code 63081 you must remove at least 1/3 of the vertebrae.
- The CPT definition: Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment.

Hemicorpectomy

- AANS said to use Code 63081 you must remove at least 1/3 of the vertebrae.
- The CPT definition: Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment.
- Their 33% test was made up. But…..

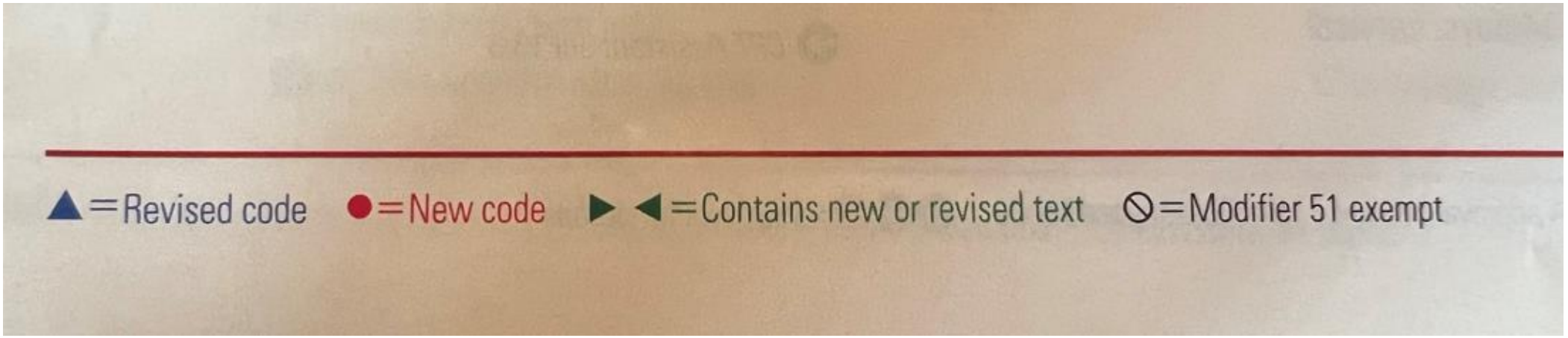
63101 Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (eg, for tumor or retropulsed bone fragments); thoracic, single segment

- *CPT Changes: An Insider's View* 2004
- *CPT Assistant* Jul 13:3

63102 lumbar, single segment

Lateral Extracavitary Approach for Extradural Exploration/Decompression

►For vertebral corpectomy, the term **partial** is used to describe removal of a substantial portion of the body of the vertebra. In the cervical spine, the amount of bone removed is defined as at least one-half of the vertebral body. In the thoracic and lumbar spine, the amount of bone removed is defined as at least one-third of the vertebral body.◄



Two More Tumors?

- Codes for bladder tumors (52234-40) are broken into “SMALL bladder tumors(s) (0.5 up to 2.0 cm)” “MEDIUM bladder tumor(s) (2.0 to 5.0 cm) and LARGE bladder tumor(s).
- A few questions: How do you code a 2 cm tumor? How do you code two 1.5 cm tumors? How do you measure? Is it diameter? Circumference?? Volume???

Can I Round Up?

Can I Round Up?

Time

The CPT code set contains many codes with a time basis for code selection. The following standards shall apply to time measurement, unless there are code or code-range–specific instructions in guidelines, parenthetical instructions, or code descriptors to the contrary. Time is the face-to-face time with the patient. Phrases such as "interpretation and report" in the code descriptor are not intended to indicate in all cases that report writing is part of the reported time. A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes). A second hour is attained when a total of 91 minutes have elapsed. When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used. See also the

typical time closest to the actual time is used. See also the **Evaluation and Management (E/M) Services Guidelines**. When another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service. Some services measured in units other than days extend across calendar dates. When this occurs a continuous service does not reset and create a first hour. However, any disruption in the service does create a new initial service. For example, if intravenous hydration (96360, 96361) is given from 11 PM to 2 AM, 96360 would be reported once and 96361 twice. For facility reporting on a single date of service or for continuous services that last beyond midnight (ie, over a range of dates), report the total units of time provided continuously.

What Day Do I Use if a Service Crosses Midnight?

What Day Do I Use If a Service Crosses Midnight?

Counseling

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

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

(For psychotherapy, see 90832-90834, 90836-90840)

Family History

A review of medical events in the patient's family that includes significant information about:

- The health status or cause of death of parents, siblings, and children
- Specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review
- Diseases of family members that may be hereditary or place the patient at risk

History of Present Illness

A chronological description of the development of the patient's present illness from the first sign and/or symptom to the present. This includes a description of location, quality, severity, timing, context, modifying factors, and associated signs and symptoms significantly related to the presenting problem(s).

Levels of E/M Services

Within each category or subcategory of E/M service, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient.

The levels of E/M services include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services, such as the determination of the need and/or location for appropriate care. Medical screening includes the history, examination, and medical decision-making required to determine the need and/or location for appropriate care and treatment of the patient (eg, office and other outpatient setting, emergency department, nursing facility). The levels of E/M services encompass the wide variations in skill, effort, time, responsibility, and medical knowledge required for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. Each level of E/M services may be used by all physicians or other qualified health care professionals.

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

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

The first three of these components (history, examination, and medical decision making) are considered the **key** components in selecting a level of E/M services. (See "Determine the Extent of History Obtained," page 9.)

The next three components (counseling, coordination of care, and the nature of the presenting problem) are considered **contributory** factors in the majority of encounters. Although the first two of these contributory factors are important E/M services, it is not required that these services be provided at every patient encounter.

Coordination of care with other physicians, other health care professionals, or agencies without a patient encounter on that day is reported using the case management codes.

The final component, time, is discussed in detail on page 7.

Any specifically identifiable procedure (ie, identified with a specific CPT code) performed on or subsequent to the date of initial or subsequent E/M services should be reported separately.

The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of E/M services. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician's interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code with modifier 26 appended.

The physician or other health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service above and beyond other services provided or beyond the usual preservice and postservice care associated with the procedure that was performed. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

Nature of Presenting Problem

A presenting problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for encounter, with or without a diagnosis being established at the time of the encounter. The E/M codes recognize five types of presenting problems that are defined as follows:

Minimal: A problem that may not require the presence of the physician or other qualified health care professional, but service is provided under the physician's or other qualified health care professional's supervision.

Self-limited or minor: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status OR has a good prognosis with management/compliance.

Low severity: A problem where the risk of morbidity without treatment is low; there is little to no risk of mortality without treatment; full recovery without functional impairment is expected.

Moderate severity: A problem where the risk of morbidity without treatment is moderate; there is moderate risk of mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment.

High severity: A problem where the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment OR high probability of severe, prolonged functional impairment.

Past History

A review of the patient's past experiences with illnesses, injuries, and treatments that includes significant information about:

- Prior major illnesses and injuries
- Prior operations
- Prior hospitalizations
- Current medications
- Allergies (eg, drug, food)
- Age appropriate immunization status
- Age appropriate feeding/dietary status

Social History

An age appropriate review of past and current activities that includes significant information about:

- Marital status and/or living arrangements
- Current employment
- Occupational history
- Military history
- Use of drugs, alcohol, and tobacco
- Level of education
- Sexual history
- Other relevant social factors

System Review (Review of Systems)

An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced. For the purposes of the CPT codebook the following elements of a system review have been identified:

- 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

The review of systems 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.

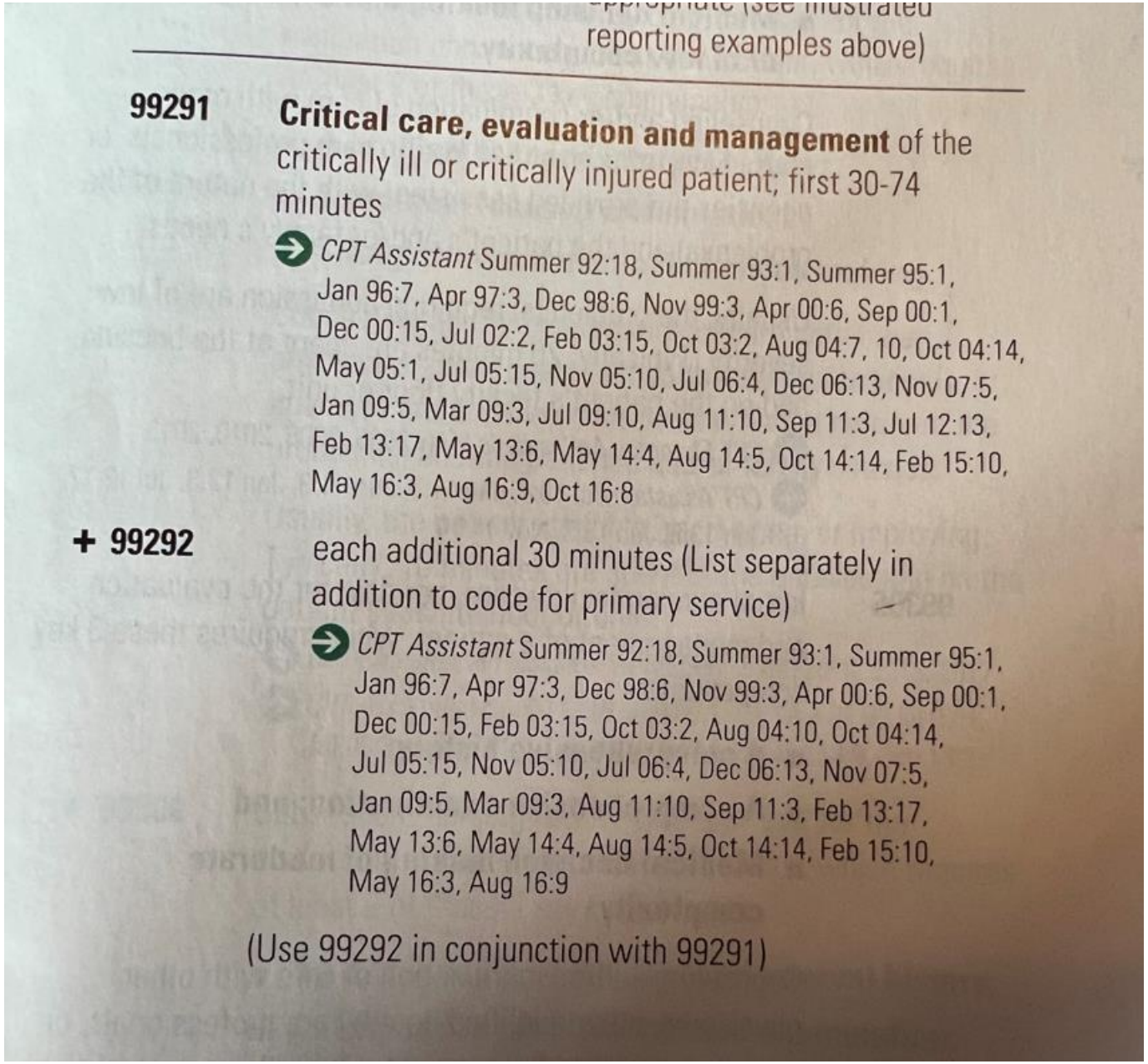
Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in *CPT 1992* is done to assist in selecting the most appropriate level of E/M services. It should be recognized that the specific times expressed in the visit code descriptors are averages and, therefore, represent a range of times that may be higher or lower depending on actual clinical circumstances.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency

Can I Round Up?

- What is the CPT answer?
  - It varies. For most E/M you round.
  - But you have to check the code.
- Does your payor have the authority to vary from CPT? If so, have they?



appropriate (see illustrated reporting examples above)

99291 **Critical care, evaluation and management** of the critically ill or critically injured patient; first 30-74 minutes

CPT Assistant Summer 92:18, Summer 93:1, Summer 95:1, Jan 96:7, Apr 97:3, Dec 98:6, Nov 99:3, Apr 00:6, Sep 00:1, Dec 00:15, Jul 02:2, Feb 03:15, Oct 03:2, Aug 04:7, 10, Oct 04:14, May 05:1, Jul 05:15, Nov 05:10, Jul 06:4, Dec 06:13, Nov 07:5, Jan 09:5, Mar 09:3, Jul 09:10, Aug 11:10, Sep 11:3, Jul 12:13, Feb 13:17, May 13:6, May 14:4, Aug 14:5, Oct 14:14, Feb 15:10, May 16:3, Aug 16:9, Oct 16:8

+ 99292 each additional 30 minutes (List separately in addition to code for primary service)

CPT Assistant Summer 92:18, Summer 93:1, Summer 95:1, Jan 96:7, Apr 97:3, Dec 98:6, Nov 99:3, Apr 00:6, Sep 00:1, Dec 00:15, Feb 03:15, Oct 03:2, Aug 04:10, Oct 04:14, Jul 05:15, Nov 05:10, Jul 06:4, Dec 06:13, Nov 07:5, Jan 09:5, Mar 09:3, Aug 11:10, Sep 11:3, Feb 13:17, May 13:6, May 14:4, Aug 14:5, Oct 14:14, Feb 15:10, May 16:3, Aug 16:9

(Use 99292 in conjunction with 99291)

30-74 minutes (30 minutes - 1 hr. 14 min.)	99291 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	99291 X 1 AND 99292 X 1
105-134 minutes (1 hr. 45 min. - 2 hr. 14 min.)	99291 X 1 AND 99292 X 2
135-164 minutes (2 hr. 15 min. - 2 hr. 44 min.)	99291 X 1 AND 99292 X 3
165-194 minutes (2 hr. 45 min. - 3 hr. 14 min.)	99291 X 1 AND 99292 X 4

Can I Bill for Something the Patient Didn't Get?

- Sometimes! Drug waste billing is a great example of why it is so hard to generalize coding rules.
- You can often bill for the amount of drug in a vial if it can't be used and you used the smallest vial containing the needed dose.

Evaluation and Management

- Physician services in the clinic and hospital.
- Coding rules now differ based on setting. In the clinic: medical decision-making or time.
- In the hospital: key components (History, exam, medical decision-making) or time if counselling.

★ 99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

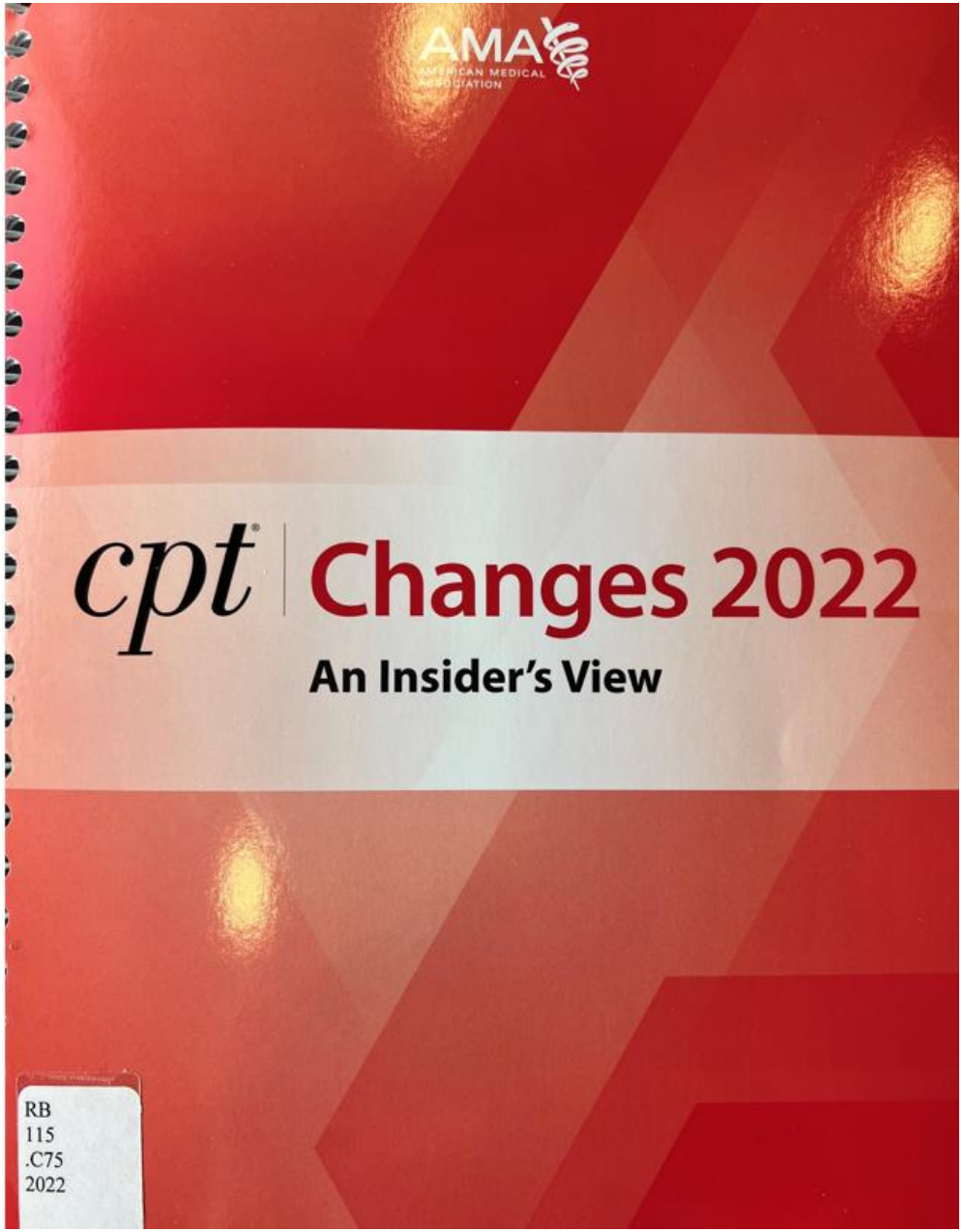
- **A detailed history;**
- **A detailed examination;**
- **Medical decision making of moderate complexity.**

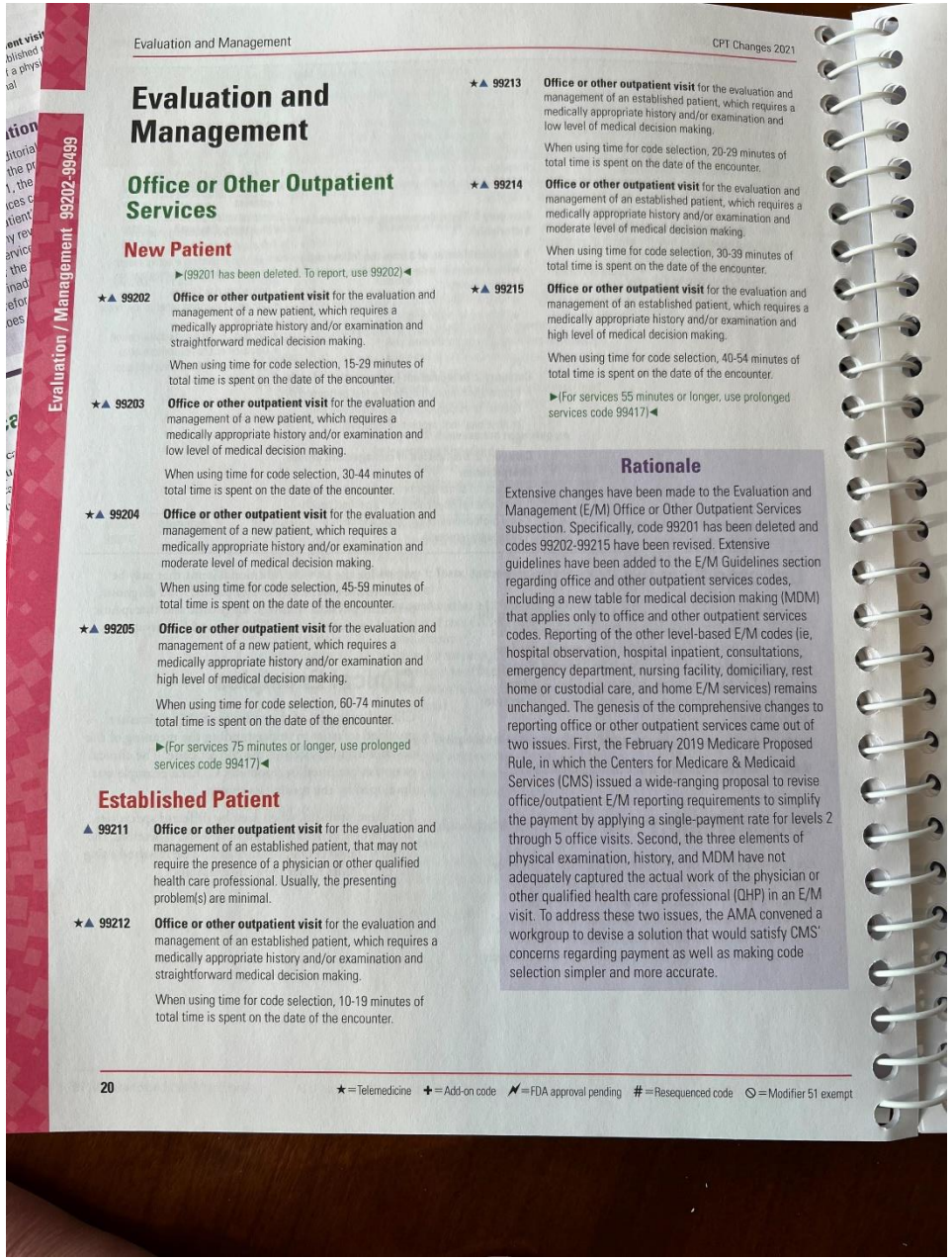
Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

CPT Changes: An Insider's View 2013, 2017

CPT Assistant Winter 91:11, Spring 92:15, 24, Summer 92:1, 24, Spring 93:34, Summer 93:2, Fall 93:9, Spring 95:1, Summer 95:4, Fall 95:9, May 97:4, Jul 98:9, Sep 98:5, Aug 01:2, Jan 02:2, May 02:1-2, Oct 03:5, Apr 04:14, Oct 04:10, Apr 05:1, 3, Jun 05:11, Dec 05:10, May 06:1, Jun 06:1, 11, Sep 06:8, Oct 06:15, Apr 07:11, Jul 07:1, Sep 07:1, Mar 08:3, Mar 09:3, Aug 09:5, Sep 10:4, Jan 11:3, Jun 11:3, Mar 12:4, 8, Jan 13:9, Mar 13:13, Jun 13:3, Aug 13:13, 14, Jan 15:12, Oct 15:3, Mar 16:11, Sep 16:6


AMA
AMERICAN MEDICAL ASSOCIATION
cpt
Changes 2022
An Insider's View
RB
115
.C75
2022



Evaluation and Management

Office or Other Outpatient Services

New Patient

►(99201 has been deleted. To report, use 99202)◄

★▲ 99202 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★▲ 99203 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★▲ 99204 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★▲ 99205 **Office or other outpatient visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

►(For services 75 minutes or longer, use prolonged services code 99417)◄

Established Patient

▲ 99211 **Office or other outpatient visit** for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

★▲ 99212 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

★▲ 99213 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

★▲ 99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

★▲ 99215 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

►(For services 55 minutes or longer, use prolonged services code 99417)◄

Rationale

Extensive changes have been made to the Evaluation and Management (E/M) Office or Other Outpatient Services subsection. Specifically, code 99201 has been deleted and codes 99202-99215 have been revised. Extensive guidelines have been added to the E/M Guidelines section regarding office and other outpatient services codes, including a new table for medical decision making (MDM) that applies only to office and other outpatient services codes. Reporting of the other level-based E/M codes (ie, hospital observation, hospital inpatient, consultations, emergency department, nursing facility, domiciliary, rest home or custodial care, and home E/M services) remains unchanged. The genesis of the comprehensive changes to reporting office or other outpatient services came out of two issues. First, the February 2019 Medicare Proposed Rule, in which the Centers for Medicare & Medicaid Services (CMS) issued a wide-ranging proposal to revise office/outpatient E/M reporting requirements to simplify the payment by applying a single-payment rate for levels 2 through 5 office visits. Second, the three elements of physical examination, history, and MDM have not adequately captured the actual work of the physician or other qualified health care professional (QHP) in an E/M visit. To address these two issues, the AMA convened a workgroup to devise a solution that would satisfy CMS' concerns regarding payment as well as making code selection simpler and more accurate.

★ 99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

- *CPT Changes: An Insider's View* 2013, 2017, 2021
- *CPT Assistant* Winter 91:11, Spring 92:15, 24, Summer 92:1, 24, Spring 93:34, Summer 93:2, Fall 93:9, Spring 95:1, Summer 95:4, Fall 95:9, May 97:4, Jul 98:9, Sep 98:5, Aug 01:2, Jan 02:2, May 02:1-2, Oct 03:5, Apr 04:14, Oct 04:10, Apr 05:1, 3, Jun 05:11, Dec 05:10, May 06:1, Jun 06:1, 11, Sep 06:8, Oct 06:15, Apr 07:11, Jul 07:1, Sep 07:1, Mar 08:3, Mar 09:3, Aug 09:5, Sep 10:4, Jan 11:3, Jun 11:3, Mar 12:4, 8, Jan 13:9, Mar 13:13, Jun 13:3, Aug 13:13-14, Jan 15:12, Oct 15:3, Mar 16:11, Sep 16:6, Apr 18:10, Sep 18:14, Jan 19:3, Jan 20:3, Feb 20:3, Mar 20:3, May 20:3, Jun 20:3, Sep 20:14, Oct 20:14, Nov 20:12, Jan 21:3, Feb 21:8, Apr 21:13

Case:_____ Provider:_____

1995/1997 E/M REVIEW – General Multi-system

HISTORY

Coded as:_____ **Reviewer:** ☐agree ☐disagree:_____

	Problem Focused	Exp. Problem Focused	Detailed	Comprehensive
Chief Complaint: ☐yes ☐no **HPI (history of present illness) elements:** ☐Location ☐Severity ☐Timing ☐Modifying factors ☐Quality ☐Duration ☐Context ☐Associated signs & symptoms	**Brief** *1-3 elements*	**Brief** *1-3 elements*	**Extended** *≥ 4 elements*	**Extended** *95 & 97 ≥ 4 elements* *97 Only - Status of ≥ 3 chronic or inactive conditions*
ROS (review of systems): ☐Constitutional (wt. loss, etc.) ☐Card/vasc ☐GU ☐Neuro ☐Hem/lymph ☐Eyes ☐Resp ☐Musculo ☐Psych ☐All/imm ☐ENT, mouth ☐GI ☐Integumentary (skin, breast) ☐Endo ☐"All others negative"	**None**	**Pertinent to problem** *1 system*	**Extended** *2-9 systems*	**Complete** *≥ 10 systems, or some systems with statement "all others negative"*
PFSH (past medical, family, social history) areas: ☐Past history (the patient's past experiences with illnesses, operations, injuries and treatments) ☐Family history (review of medical events in patient's family, includes diseases which may be hereditary or place patient at risk) ☐Social history (an age-appropriate review of past and current activities)	**None**	**None**	**Pertinent** *1 history area*	**Complete*** *2 or 3 history areas*

If physician is unable to obtain history, the record should describe circumstances which preclude obtaining it.

No PFSH required: a) Subsequent hospital care b) Follow-up inpt. consults c) Subsequent nursing facility care

***Complete PFSH:** 2 hx areas: a) Established pt. office (outpt.) care; domiciliary care; home care b) Emergency dept.
3 hx areas: a) New pt. office (outpt.) care; domicil. care; home care b) Consults c) Initial hosp. care d) Hosp. observ. e) Compre. nursing fac. assessments

95 EXAM

(SEE BACK FOR 97 EXAM)

A limited exam of the affected body area or organ system *(one body area or system related to problem)*.	PROBLEM FOCUSED
A limited exam of the affected body area or organ system and other symptomatic or related organ system(s) *(additional systems up to a total of 7)*.	EXP. PROB. FOCUSED
An extended exam of the affected body area(s) and other symptomatic or related organ system(s) *(additional body areas or systems up to a total of 7—more in-depth)*.	DETAILED
A general multi-system exam *(8 or more systems)* or complete exam of a single organ system.	COMPRE-HENSIVE

Notes:

95 Exam Data

Body areas: ☐ Head, including face ☐ Chest, including breasts and axillae ☐ Abdomen ☐ Back, including spine ☐ Neck ☐ Genitalia, groin, buttocks ☐ Each extremity

Organ systems: ☐ Constitutional (e.g. vital signs, general appearance) ☐ Ear, nose, mouth, throat ☐ Genitourinary ☐ Psychiatric ☐ Cardiovascular ☐ Musculoskeletal ☐ Respiratory ☐ Skin ☐ Eyes ☐ Gastrointestinal ☐ Neurologic ☐ Hem/Lymph/Imm

MEDICAL DECISION-MAKING (MDM)

A Number of Diagnoses or Treatment Options

Problems Addressed	Number	X Points = Result	
Self-limited or minor: stable, improved or worsening		1	*Max = 2*
Established problem (to examiner): stable, improved		1	
Established problem (to examiner): worsening		2	
New problem (to examiner): no additional workup planned		3	*Max = 3*
New problem (to examiner): additional workup planned		4	
Bring total to line A in Final Result for Complexity		**Total**	

B Amount and/or complexity of Data to be Reviewed

Data to Be Reviewed	Points
Review and/or order of clinical lab test(s)	1
Review and/or order of test(s) in the radiology section of CPT	1
Review and/or order of test(s) in the medicine section of CPT	1
Discussion of test results with performing physician	1
Decision to obtain old records and/or obtain history from someone other than patient	1
Review & summarization of old records &/or obtaining history from someone other than patient and/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
Bring total to line B in Final Result for Complexity	**Total**

C Risk of Complications and/or Morbidity or Mortality

C Risk of Complications and/or Morbidity or Mortality

Bring total to line B in Final Result for Complexity — Total

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
MIN	• One self-limited or minor problem, e.g. cold, insect bite, tinea corporis	• Lab tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, e.g. echo • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
LOW	• Two or more self-limited or minor problems • One stable chronic illness, e.g. well controlled hypertension, non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, e.g. cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, e.g. pulm. funct. tests • Non-cardiovascular imaging studies w/contrast, e.g. barium enema • Superficial needle biopsies • Clinical lab tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV Fluids without additives
MODERATE	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem w/uncertain prognosis, e.g. lump in breast • Acute illness w/systemic symptoms, e.g. pyelonephritis, pneumonitis, colitis • Acute complicated injury, e.g. head inj. w/brief loss of consciousness	• Physiologic tests under stress, e.g. cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, e.g. arteriogram, cardiac cath • Obtain fluid from body cavity, e.g. lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
HIGH	• One or more chronic illnesses with severe exacerbation, progression, or side effects of tx • Acute or chronic ill. or inj. that may pose a threat to life or bodily function, e.g. multi. trauma, acute MI, pulmon. embolus, severe resplrat. distress, prog. severe rheumatoid arthritis, psychiatric illness w/potential threat to self or others, peritonitis, acute renal failure • Abrupt change in neurologic status, e.g. seiz., TIA, weakness, or sensory loss	• Cardiovascular imaging studies with contrast w/identified risk factors • Cardiac electrophysiologic tests • Diagnostic endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

FINAL RESULT FOR COMPLEXITY OF MDM *(2 of 3 must be met or exceeded)*

A	# diagnoses or management options	≤ 1 - Minimal	2 - Limited	3 - Multiple	≥ 4 - Extensive
B	Amount and complexity of data	≤ 1 - Minimal or low	2 - Limited	3 - Moderate	≥ 4 - Extensive
C	Highest Risk	Minimal	Low	Moderate	High
	Type of decision-making	STRAIGHTFORWARD	LOW COMPLEXITY	MODERATE COMPLEXITY	HIGH COMPLEXITY

Know the Score


Chief Complaint: ☐yes ☐no
HPI (history of present illness) elements:
☐Location ☐Severity ☐Timing ☐Modifying factors ☐Quality ☐Duration ☐Context ☐Associated signs & symptoms

- Patient has had intermittent pain in the arm during exercise for a while.
- How many HPI elements?

“D” Tales Matter?

Admission Review Rule

To perform an admission review, both the SI rule and the IS rule from the same criteria subset must be met on admission.

Review Type	Review Time	Review Rule
Admission	Review data derived from first 12 hours of admission	Apply Severity of Illness (SI) and Intensity of Service (IS and/or *IS).

Admission Review Steps

1. Identify the level of care based on the patient's current or proposed level.
2. Obtain and review the clinical information which may include, emergency department record, admission history and physical, admission note, laboratory, imaging, ECG findings, and physician orders.
3. Select the most appropriate criteria subset based on the patient's predominant presenting clinical findings. For example, a patient is admitted with vomiting that was unresponsive to antiemetics, you would use the criteria subset that best covers vomiting (e.g., Gastrointestinal / Biliary / Pancreatic).

> ***Tip:*** *The Index can help you identify the criteria subset where the appropriate SI criterion is located.*

4. Apply SI rule.
   - Select SI criteria based on patient's clinical findings and determine if greater than or equal to **One SI** is met.
   - Document the SI criteria point(s) met.

Preadmission Review Rule

The preadmission rule for InterQual Acute Criteria applies only to a planned admission for a surgical procedure or induction of an obstetrical patient performed as an inpatient at the acute care level.

> ***Tip:*** *To review appropriateness of the surgery / procedure, refer to InterQual Procedures Criteria.*

Review Type	Review Time	Review Rule
Preadmission	Before an elective surgery / procedure	Elective surgery / invasive procedure, ≥ **one**:[3] • Designated inpatient setting ***and*** performed same day as admission • High risk for thromboembolism[4]
	Before due date	• C-section / Induction ***and*** scheduled same day as admission, ≥ **one**: ➢ At term / Post term ➢ Fetal demise

Preadmission Review

1. Go to the appropriate criteria subset (Acute Surgery / Trauma or OB/GYN/GU).
2. Apply the SI criterion relating to elective (scheduled) surgery or invasive procedure located under Clinical Findings or Obstetrics.
3. Confirm that either:
   - The admission date is the same as scheduled procedure date and the procedure appears on an approved list of inpatient procedures.
   - The patient is at a high risk for thromboembolism. Review the attached note to determine if the patient qualifies as high risk.
   - The admission date is the same as the C-section or Induction date.
4. Continue according to the following recommended actions.

“If it isn’t written, it wasn’t done.”

- Good advice, but not the law.
- Medicare payment is determined by the content of the service, not the content of the medical record.
- The documentation guidelines are just that: guidelines (although the carrier won’t believe that).
- Watch our webinar: https://www.youtube.com/watch?v=7c3REpkbPLw&list=PLyjeM-paimEeqo2KRcc26MEHs5nAWhBn2&index=2

Role of Documentation: The Law

"No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period."

– Social Security Act § 1833(e)

Role of Documentation: Guidance from CMS/HCFA

- The CPT Assistant explains: “It is important to note that these are *Guidelines,* not a law or rule. Physicians need not modify their record keeping practices at all.”

  – CPT Assistant Vol. 5, Issue 1, Winter 1995

- CMS has publicly stated that physicians are not required to use the Documentation Guidelines.

Role of Documentation: Guidance from CMS/HCFA

- **Documentation Guidelines for Evaluation and Management Services Questions and Answers**
- These questions and answers have been jointly developed by the Health Care Financing Administration (CMS/HCFA) and the American Medical Association (AMA) March 1995.

1. Are these guidelines required?

No. Physicians are not required to use these guidelines in documenting their services.

Guidance from CMS/HCFA

“However, it is important to note that all physicians are potentially subject to post payment review. In the event of a review, Medicare carriers will be using these guidelines in helping them to determine/verify that the reported services were actually rendered. Physicians may find the format of the new guidelines convenient to follow and consistent with their current medical record keeping. Their usage will help facilitate communication with the carrier about the services provided, if that becomes necessary. Varying formats of documentation (e.g., SOAP notes) will be accepted by the Medicare carrier, as long as the basic information is discernible.”

Guidance from CMS/HCFA

“6. How will the guidelines be utilized if I am reviewed by the carrier?

If an evaluation and management review is indicated, Carriers will request medical records for specific patients and encounters. The documentation guidelines will be used as a template for that review. If the documentation is not sufficient to support the level of service provided, the Carrier will contact the physician for additional information.”

Role of Documentation: Guidance from CMS/HCFA

"7. What are my chances of being reviewed?

Review of evaluation and management services will only occur if evidence of significant aberrant reporting patterns is detected (i.e., based on national, carrier or specialty profiles). Our reviews are conducted on a 'focused' basis--there is no random review."

- **Documentation is relevant only if there is doubt that the services were truly rendered**.

Key Tips

- Avoid “over-coded” or “under-coded” unless you KNOW the service varied from the code.
- Use “wasn’t documented as billed” or “was documented at a higher level.”
- Avoid the term “audit” when you do a “review.

Communicating Deficiencies

- Characterizing problems accurately is key.
- “Scaring” people into compliance can and will be used against you in a court of law.
- Don’t exaggerate (or lie) to encourage compliance.

Describing A Review

“Our chart reviews are not audits designed to determine whether we have been overpaid or underpaid.” First, they are not a statistically valid sample. Moreover, they only review the documentation, without attempting to determine the amount of work you actually performed. Therefore, these figures are far from scientific.

Describing A Review

“However, since a Medicare review would base the initial overpayment determination solely on the documentation, these figures give you some idea of how your charts would fare in the first phase of a Medicare review.”

Physicians at Teaching Hospitals (PATH) Audits, GAO Report, No. GAO/ HEHS-98-174, July 1, 1998, page 22

One-level differences, however, may indicate legitimate differences in judgment. HCFA, OIG, and carrier staff with whom we spoke acknowledged that coding discrepancies can be subjective and do not necessarily reflect fraud or abuse.

Teaching Physician Services

- Medicare pays hospitals to train residents.
- Therefore, it would be “double-dipping” to count the resident’s work.
- Act as if the resident didn’t exist.

42 C.F.R. § 415.172

(a) General rule. If a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made only if a teaching physician is present during the key portion of any service or procedure for which payment is sought. In residency training sites that are located outside a metropolitan statistical area, physician fee schedule payment may also be made if a teaching physician is present during the key portion of the service, including for Medicare telehealth services, through audio/video real-time communications technology for any service or procedure for which payment is sought. For all teaching settings during the Public Health Emergency, as defined in § 400.200 of this chapter, for the COVID-19 pandemic, if a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made if a teaching physician is present during the key portion of the service including for Medicare telehealth services, through audio/video real-time communications technology for any service or procedure for which payment is sought.

42 C.F.R. § 415.172

(1) In the case of surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure.

42 C.F.R. § 415.172

(i) In the case of surgery, the teaching physician's presence is not required during opening and closing of the surgical field.

(ii) In the case of procedures performed through an endoscope, the teaching physician must be present during the entire viewing.

42 C.F.R. § 415.172

(2) In the case of evaluation and management services, except as otherwise provided in this paragraph (a)(2), the teaching physician must be present in person during the portion of the service that determines the level of service billed. (However, in the case of evaluation and management services furnished in hospital outpatient departments and certain other ambulatory settings, the requirements of § 415.174 apply.)

42 C.F.R. § 415.172

(i) In residency training sites that are located outside of a metropolitan statistical area, the teaching physician may be present through audio/video real-time communications technology during the portion of the service that determines the level of service billed. (However, in the case of evaluation and management services furnished in hospital outpatient departments and certain other ambulatory settings, the requirements of § 415.174 apply.)

(ii) For all teaching settings during the Public Health Emergency, as defined in § 400.200 of this chapter, for the COVID-19 pandemic, the teaching physician may be present through audio/video real-time communications technology during the portion of the service that determines the level of service billed. (However, in the case of evaluation and management services furnished in hospital outpatient departments and certain other ambulatory settings, the requirements of § 415.174 apply.)

An Explicit Documentation Requirement

(b) Documentation. Except as otherwise provided in this paragraph (b), except for services furnished as set forth in § 415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), § 415.176 (concerning renal dialysis services), and § 415.184 (concerning psychiatric services), the medical records must document that the teaching physician was present at the time the service (including a Medicare telehealth service) is furnished. The presence of the teaching physician during procedures and evaluation and management services may be demonstrated by the notes in the medical records made by the physician or as provided in § 410.20(e) of this chapter.

Who Can Write in the Medical Record?

- Historically, anyone.
- Be careful what you wish for…

42 CFR § 410.20(e)

Medical record documentation: The physician may review and verify (sign/date), rather than re-document, notes in a patient's medical record made by physicians; residents; nurses; medical, physician assistant, and advanced practice registered nurse students; or other members of the medical team including, as applicable, notes documenting the physician's presence and participation in the services.

“Incident to” Billing

- Clinic can bill for “incident to” services only if:
  - Clinic pays for the expenses of the ancillary person.
  - Clinic is the sole provider of medical direction.
  - The first visit for the course of treatment is with a physician (later visits may be with the non-physician provider). Note the “new problem” myth.

“Incident to” Billing

- Clinic can bill for “incident to” services only if:
  - The service is something typically done in an office.
  - The service is not in a hospital or nursing home (may be a “shared visit”).
  - A clinic physician must be in the “office suite.”
  - The services should be billed under the supervising physician.

Not Everything is Incident to…

Depending on the particular tests, the supervision requirement for diagnostic tests or other services may be more or less stringent than supervision requirements for services and supplies furnished incident to physician's or other practitioner's services. Diagnostic tests need not also meet the incident to requirement in this section. Likewise, pneumococcal, influenza, and hepatitis B vaccines are covered under § 1861(s)(10) of the Act and need not also meet incident to requirements.

Not Everything is Incident to…

"Physician assistants, nurse practitioners, clinical nurse specialists, certified nurse midwives, clinical psychologists, clinical social workers, physical therapists and occupational therapists all have their own benefit categories and may provide services without direct physician supervision and bill directly for these services."

– Medicare Benefit Policy Manual, Chapter 15 § 60A

What Is “Direct Supervision”?

- 410.32(b)(3)(ii): “Direct supervision in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.”
- Defined more by what it is NOT, rather than what it IS. Not “in the room.” But where?

Office Suite?

"We are not proposing that there must be any particular configuration of rooms for an office to qualify as an office "suite." However, direct supervision means that a physician must be in the office suite and immediately available to provide assistance and direction. Thus, a group of contiguous rooms should in most cases satisfy this requirement. We have been asked whether it would be possible for a physician to directly supervise a service furnished on a different floor. We think the answer would depend upon individual…

Office Suite?

…circumstances that demonstrate that the physician is close at hand. The question of physician proximity for physician referral purposes, as well as for incident to purposes, is a decision that only the local carrier could make based on the layout of each group of offices. For example, a carrier might decide that in certain circumstances it is appropriate for one room of an office suite to be located on a different floor, such as when a physician practices on two floors of a townhouse."

– 63 Fed. Reg. 1685, Jan. 9, 1998

What Does in the “Office Suite” Mean?

- An excellent question.
- We know what it is not, not what it is.
- The 30 second test is often popular.
- Same building??
- MAC discretion.

“Course of Treatment*”
MBPM Chapter 15 § 60.1.B

This does not mean, however, that to be considered incident to, each occasion of service by auxiliary personnel (or the furnishing of a supply) need also always be the occasion of the actual rendition of a personal professional service by the physician. Such a service or supply could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment*.

*What happened to diagnosis???

What is a “Course of [Diagnosis or] Treatment”?

- Patient receiving chemo develops an infection.
- Child has a series of ear infections. What if they now get strep throat?
- Is the course of diagnosis broader?
- **NEITHER THE REGS NOR THE MANUAL MENTION “NEW PROBLEM.”**

This Talk In One Example

- If some makes an assertion (you can't do "incident to" for a patient with a new problem):
  - Make them show you the rule.
  - Read what they give you carefully. Does it say what they think it says?
  - Consider the hierarchy. Is what they provided truly binding?

We Billed under the Wrong Person, We're SOL, Right?

- Wrong!
- Medicare Claims processing Manual Chapter 1, 30.2.2.1: "An otherwise correct Medicare payment made to an ineligible recipient under a reassignment or other authorization by the physician or other supplier does not constitute a program overpayment."

Shared Visits: 42 CFR § 415.140

- Replaces guidance with a regulation.
- Applies where “incident to” billing is prohibited.
- Requires a modifier on the claim.
- Only the professional doing the “substantive portion” may bill.

Shared Visits: Substantive Portion

- 2022 more flexible than 2023 for all but Critical Care.
- In 2022, “substantive portion” of the visit means the professional performed any one of the three key components (history, exam or medical decision-making) or more than 50 percent of the time.
- In 2023, whoever does the most time. (CMS has indicated informally that if both professionals are there, they may decide which gets the time.)

Two-Midnight Rule 42 CFR § 412.3

(a) For purposes of payment under Medicare Part A, an individual is considered an inpatient of a hospital, including a critical access hospital, if formally admitted as an inpatient pursuant to an order for inpatient admission by a physician or other qualified practitioner in accordance with this section and § § 482.24(c), 482.12(c), and 485.638(a)(4)(iii) of this chapter for a critical access hospital. ~~***This physician order must be present in the medical record***~~ **~~and~~** ~~*be supported by the physician admission and progress notes*~~, ~~in order for the hospital to be paid for hospital inpatient services under Medicare Part A.~~ In addition to these physician orders, inpatient rehabilitation facilities also must adhere to the admission requirements specified in § 412.622 of this chapter.

Two-Midnight Rule 42 CFR § 412.3

(d)(1)Except as specified in paragraphs (d)(2) and (3) of this section, an inpatient admission is generally appropriate for payment under Medicare Part A when the admitting physician expects the patient to require hospital care that crosses two midnights.

(i) The **expectation** of the physician should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration.

(D)(2) and (3) Expand Coverage a Bit

(2) An inpatient admission for a surgical procedure specified by Medicare as inpatient only under § 419.22(n) of this chapter is generally appropriate for payment under Medicare Part A regardless of the expected duration of care. Procedures no longer specified as inpatient only under § 419.22(n) of this chapter are appropriate for payment under Medicare Part A in accordance with paragraph (d)(1) or (3) of this section. Claims for services and procedures removed from the inpatient only list under § 419.22 of this chapter on or after January 1, 2020 are exempt from certain medical review activities.

(i) For those services and procedures removed on or after January 1, 2020, the exemption in this paragraph (d)(2) will last for 2 years from the date of such removal.

(ii) For those services and procedures removed on or after January 1, 2021, the exemption in this paragraph (d)(2) will last until the Secretary determines that the service or procedure is more commonly performed in the outpatient setting.

(D)(2) and (3) Expand Coverage A Bit

(3) Where the admitting physician expects a patient to require hospital care for only a limited period of time that does not cross 2 midnights, an inpatient admission may be appropriate for payment under Medicare Part A based on the clinical judgment of the admitting physician and medical record support for that determination. The physician's decision should be based on such complex medical factors as patient history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event. In these cases, the factors that lead to the decision to admit the patient as an inpatient must be supported by the medical record in order to be granted consideration.

Bottom Line

- Physician expectation controls. Is a two-midnight stay anticipated? (Possible exception for intense care.)
- Government can assert that physician order and supporting documentation are required.

IDTFs

- “Independent Diagnostic Testing Facility.”
- Independent from a hospital or physician office.
- Special medical director, supervision, and practice location requirements.
- They teach us written orders are NOT always required!!

IDTFs Are Different

Ordering of tests. All procedures performed by the IDTF must **be specifically ordered in writing** by the physician who is treating the beneficiary, that is, the physician who is furnishing a consultation or treating a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem. (Non-physician practitioners may order tests as set forth in § 410.32(a)(3).) The order must specify the diagnosis or other basis for the testing.

– 42 CFR 410.33

IDTFs Are Different

"Some commenters have requested the rationale for requiring specific written orders for tests performed by IDTFs while not imposing the same requirement on testing in physician offices. The rationale for requiring testing by IDTFs to be ordered in writing by the treating physician is based in our (and, more specifically, HCFA's contractors') experience with IPLs. There have been instances in which IPLs have offered 'free' screening to Medicare beneficiaries in shopping…

IDTFs Are Different

…malls and senior citizen centers, which meant the IPL accepted the carrier payment for the procedure and waived billing the beneficiary for the co-insurance…We believe that our experience with waste and abuse in IPL justify these requirements, including requiring the treating physician's order for a procedure."

– 62 Fed. Reg. 59048, 59072

Supervision of Diagnostic Tests

- Medicare has three levels of supervision:
  - Personal
  - Direct
  - General
- Each year the fee schedule lists the required level of supervision.

Supervision of Diagnostic Tests

- *Personal supervision* means a physician must be in attendance in the room during the performance of the procedure.
- *Direct supervision* in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

Supervision of Diagnostic Tests

- *General supervision* means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure. Under general supervision, the training of the non-physician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the physician.

– 42 CFR 410.32

What Does It Mean to Provide "General" Supervision?

- Who would the tech ask?
- When multiple groups are involved, beware.
- Leased techs merit extra attention.

Presenter

David Glaser
612.492.7143
dglaser@fredlaw.com