"No FUNDS Left Behind":

Maximizing Inpatient Revenue Capture Through Better Understanding and Use of Documentation and Coding Guidelines

Workshop A01: SGIM 31st Annual National Meeting

Thursday April 10th, 2008

10:30 AM – noon

Sponsored by the SGIM Clinical Practice Committee

Faculty: Emily Boohaker, Yvette M. Cua, Jeanine Engel, John Goodson, Stephen Sigworth, Thomas Staiger

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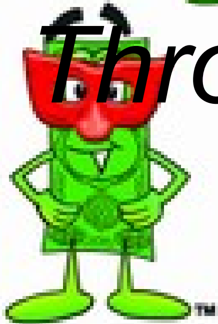

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Objectives

This workshop will enhance participants' skills and confidence in:

1. Demonstrating *efficient* and *compliant* application of E/M guidelines
2. Accurately identifying and coding for *obs vs. full admit*
3. Using *effective terminology* to support optimal level of coding
4. Selecting the *optimal discharge code* and supporting it with compliant documentation
5. Recognizing appropriate occasions for *prolonged service* codes and for *aggregating time*
6. Coding for E/M visits AND procedures on the same calendar day

Agenda

- Review of components of documentation and correlation to billing criteria
- Billing “pearls”
- Breakout session case studies in…
  - ✓ Observation vs. full admission
  - ✓ Subsequent hospital visits
  - ✓ Discharges, prolonged services, aggregate time
  - ✓ Critical care, procedures, modifiers
- Wrap-up
- Evaluations

Whirlwind review of E & M Guidelines

Guidelines: H&P *(Need all 3 of 3)*

Complexity MDM (need 2 of 3)	Straightforward 1	Moderate 3	High 4
Diagnoses	Anything a consultant doesn't bill for	ES + EW -or- N	2 EW -or- ES + N -or- NW
Data points	0	3	4
Risk level	Minimal	Moderate	High
Inpatient admit	99221	99222	99223
Observation	99218	99219	99220
Obs/same day D/C	99234	99235	99236
History (need 3 of 3)	4 HPI 2 ROS 1 PFSH	4 HPI 10 ROS 3 PFSH	4 HPI 10 ROS 3 PFSH
Physical(system/area)	5	8	8
Time (min)	30	50	70

Guidelines: H&P *(Need all 3 of 3)*

Complexity MDM (need 2 of 3)			
Diagnoses			
Data points			
Risk level			
Inpatient admit			
Observation			
Obs/same day D/C			
History (need 3 of 3)			
Physical(system/area)			
Time (min)	30	50	70

3 Key E/M Components

- History
- Physical Exam
- Medical Decision Making

Guidelines: H&P *(Need all 3 of 3)*

- **Chief complaint**
- **History of present illness**
- **Review of systems**
- **Past medical, family, social history**

Inpatient admit	99221	99222	99223
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Time (min)	30	50	70

Guidelines: H&P *(Need all 3 of 3)*

8 elements of HPI

- **Location**
- **Quality**
- **Severity**
- **Duration**
- **Timing**
- **Context**
- **Modifying factors**
- **Associated S/Sx**

History (need 3 of 3)	4 HPI 2 ROS 1 PFSH	4 HPI 10 ROS 3 PFSH	4 HPI 10 ROS 3 PFSH
Physical(system/area)	5	8	8
Time (min)	30	50	70

Guidelines: H&P *(Need all 3 of 3)*

14 recognized organ systems

- Constitutional
- Eyes
- Head/Ears/Nose/Throat
- CV
- Resp
- GI
- GU
- Musculoskeletal
- Skin/Hair
- Neuro
- Psych
- Heme/Lymph
- Endocrine
- Allergy/Immunology

History (need 3 of 3)	4 HPI 2 ROS 1 PFSH	4 HPI 10 ROS 3 PFSH	4 HPI 10 ROS 3 PFSH
Physical(system/area)	5	8	8
Time (min)	30	50	70

Guidelines: H&P *(Need all 3 of 3)*

Past Medical History

Family History

Social History

History (need 3 of 3)	4 HPI 2 ROS 1 PFSH	4 HPI 10 ROS 3 PFSH	4 HPI 10 ROS 3 PFSH
Physical(system/area)	5	8	8
Time (min)	30	50	70

Guidelines: H&P *(Need all 3 of 3)*

Documentation PEARLS

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Time (min)	30	50	70

Guidelines: H&P *(Need all 3 of 3)*

No chief complaint or < 4 modifiers of HPI: Non-billable

Inpatient admit	99221	99222	99223
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Time (min)	30	50	70

Guidelines: H&P *(Need all 3 of 3)*

< 10 ROS:
Maximum code is level 1

Inpatient admit	99221	99222	99223
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History (need 3 of 3)	4 HPI 2 ROS 1 PFSH	4 HPI 10 ROS 3 PFSH	4 HPI 10 ROS 3 PFSH
Physical(system/area)	5	8	8
Time (min)	30	50	70

Guidelines: H&P *(Need all 3 of 3)*

Forget to document Family History: Maximum code is level 1

Inpatient admit	99221	99222	99223
Observation	99218	99219	99220
Obs/same day D/C	99234	99235	99236
History (need 3 of 3)	4 HPI 2 ROS 1 PFSH	4 HPI 10 ROS 3 PFSH	4 HPI 10 ROS 3 PFSH
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- Eyes
- Head/Ears/Nose/Throat
- CV
- Resp
- GI
- GU
- Musculoskeletal
- Skin/Hair
- Neuro
- Psych
- Heme/Lymph
- Endocrine
- Allergy/Immunology

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Physical (system/area)	5	8	8
Time (min)	30	50	70

Guidelines: H&P *(Need all 3 of 3)*

14 recognized organ systems; can only examine 12

- Constitutional
- Eyes
- Head/Ears/Nose/Throat
- CV
- Resp
- GI
- GU
- Musculoskeletal
- Skin/Hair
- Neuro
- Psych
- Heme/Lymph
- *Endocrine*
- *Allergy/Immunology*

History (need 3 of 3)	4 HPI 2 ROS 1 PFSH	4 HPI 10 ROS 3 PFSH	4 HPI 10 ROS 3 PFSH
Physical(system/area)	5	8	8
Time (min)	30	50	70

Guidelines: H&P *(Need all 3 of 3)*

Failure to document ≥ 8 organ systems limits your billing to a level 1

History (need 3 of 3)	4 HPI 2 ROS 1 PFSH	4 HPI 10 ROS 3 PFSH	4 HPI 10 ROS 3 PFSH
Physical(system/area)	5	8	8
Time (min)	30	50	70

Guidelines: H&P *(Need all 3 of 3)*

Complexity MDM (need 2 of 3)	Straightforward 1	Moderate 3	High 4
Diagnoses	Anything a consultant doesn't bill for	ES + EW -or- N	2 EW -or- ES + N -or- NW
Data points	0	3	4
Risk level	Minimal	Moderate	High
Inpatient admit	99221	99222	99223

Diagnoses

Data points

Risks involved with Dx, evaluation, treatment recommendations

Guidelines: H&P *(Need all 3 of 3)*

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Diagnoses	Anything a consultant doesn't bill for	ES + EW -or- N	2 EW -or- ES + N -or- NW
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(S)	Self limited, minor	1 (max 2 pts)
(ES)	Established – stable	1
(EW)	Established – worse	2
(N)	New (-) w/u	3 (max 3 pts)
(NW)	New (+) w/u	4

Points ***per*** problem

Guidelines: H&P *(Need all 3 of 3)*

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Inpatient admit	99221	99222	99223

1 Order –OR– review: labs

1 (+2) radiology (Independent review)

1 (+2) other tests (Independent review)

1 Discuss test results w/ performing provider

1 Decide to get records or hx from someone else

2 Review old records, obtain hx from someone else, discuss case w/another provider

Guidelines: H&P *(Need all 3 of 3)*

Complexity MDM (need 2 of 3)	Straightforward 1	Moderate 3	High 4
Diagnoses	Anything a consultant doesn't bill for	ES + EW -or- N	2 EW -or- ES + N -or- NW
Data points	0	3	4
Risk level	Minimal	Moderate	High
Inpatient admit	99221	99222	99223

Level of Risk is determined by HIGHEST level of risk incurred by ANY ONE ITEM in ANY of 3 the categories:

Risk levels

	Presenting Problem	Diagnostics Ordered	Management Options
LOW	≥2 self limited	ABG, PFT's	OTC meds
	1 stable chronic	CT contrast, BE	Minor surg, (-)RF
	Uncomplicated	FNA, skin bx	PT/OT, IVF
INTERMEDIATE	≥2 Stable chronic	Stress tests	Rx meds
	Unstable, undx'ed	Endoscopy (-)RF	Minor surg (+)RF
		Cath (-)RF	Elect maj surg (-)RF
		LP, p'/thoracentesis	IVF w/ additives
HIGH	Severe exacerbation	Cath(+)RF	Elect maj surg (+)RF, Emergent surg
	Life threatening problem	EP study	IV meds, DNR/DNI
	Acute change in neuro status	Endoscopy (+)RF	Intense drug Rx monitoring
		Discography	

Guidelines: Inpatient follow-up visits

Complexity MDM (need 2 of 3)	Straightforward 1	Moderate 3	High 4
Diagnoses	Anything a consultant doesn't bill for	3 ES -or- ES + EW -or- N	4 ES -or- 2 EW -or- ES + N -or- NW
Data points	1	3	4
Risk level	Minimal	Moderate Prescription med 2 chronic prob.	High Severe exacerbation Life threatening Coumadin, DNR
E/M code	99231	99232	99233
History	1 HPI	1 HPI 1 ROS	4 HPI / 3 status 2 ROS
Physical(system/area)	1	2	5
Time (min)	15	25	35

Guidelines: Inpatient follow-up visits

No chief complaint or < 4 modifiers of HPI: Non-billable

E/M code	99231	99232	99233
History	1 HPI	1 HPI 1 ROS	4 HPI / 3 status 2 ROS
Physical(system/area)	1	2	5
Time (min)	15	25	35

Guidelines: Inpatient follow-up visits

Complexity (need 2 of			High
Diagnoses			4 4 ES -or- 2 EW -or- ES + N -or- NW
Data points			4
Risk level			High Severe exacerbation Life threatening Coumadin, DNR
E/M code	99231	99232	99233
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Physical(system/area)	1	2	5
Time (min)	15	25	35

< 5 PE systems:

BP= 120/70 RRR CTA
NABS, NTND, no edema

Guidelines: Inpatient follow-up visits

< 5 PE systems:

VS = 1

BP= 120/70 RRR CTA
NABS, NTND, no edema

Complexity (need 2 of			High
Diagnoses			4 4 ES -or- 2 EW -or- ES + N -or- NW
Data points			4
Risk level			High Severe exacerbation Life threatening Coumadin, DNR
E/M code	99231	99232	99233
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Guidelines: Inpatient follow-up visits

Complexity (need 2 of			High
Diagnoses			4 4 ES -or- 2 EW -or- ES + N -or- NW
Data points			4
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E/M code	99231	99232	99233
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Physical(system/area)	1	2	5
Time (min)	15	25	35

<u>< 5 PE systems:</u>

CV = 2

BP= 120/70 RRR CTA
NABS, NTND, no edema

Guidelines: Inpatient follow-up visits

Complexity (need 2 of			High 4
Diagnoses			4 ES -or- 2 EW -or- ES + N -or- NW
Data points			4
Risk level			High Severe exacerbation Life threatening Coumadin, DNR
E/M code	99231	99232	99233
History	1 HPI	1 HPI 1 ROS	4 HPI / 3 status 2 ROS
Physical(system/area)	1	2	5
Time (min)	15	25	35

< 5 PE systems:

Resp = 3

BP= 120/70 RRR CTA
NABS, NTND, no edema

Guidelines: Inpatient follow-up visits

< 5 PE systems:

GI = 4

BP= 120/70 RRR CTA

NABS, NTND, no edema

Complexity (need 2 of			High
Diagnoses			4 4 ES -or- 2 EW -or- ES + N -or- NW
Data points			4
Risk level			High Severe exacerbation Life threatening Coumadin, DNR
E/M code	99231	99232	99233
History	1 HPI	1 HPI 1 ROS	4 HPI / 3 status 2 ROS
Physical(system/area)	1	2	5
Time (min)	15	25	35

Guidelines: Inpatient follow-up visits

Complexity (need 2 of			High
Diagnoses			4 4 ES -or- 2 EW -or- ES + N -or- NW
Data points			4
Risk level			High Severe exacerbation Life threatening Coumadin, DNR
E/M code	99231	99232	99233
History	1 HPI	1 HPI 1 ROS	4 HPI / 3 status 2 ROS
Physical(system/area)	1	2	5
Time (min)	15	25	35

< 5 PE systems:

Neuro = 5

BP= 120/70 RRR CTA
NABS, NTND, no edema,
A/O x 3

Documentation Billing Pearls

Learning from our pitfalls

Pitfalls in documentation

- Not documented = Not done
- Diagnosis is missing
- Poor choice of wording
- Failing to comment on concurrent care
- Billing for same diagnosis as a specialist
- Discharges – wrong date

Pitfalls in documentation

- Not documented = Not done
- **Diagnosis is missing**
- Poor choice of wording
- Failing to comment on concurrent care
- Billing for same diagnosis as a specialist
- Discharges – wrong date

Pitfalls in documentation

- **Diagnosis is missing**

“Pt no c/o. Foot slightly less erythema, warmth. Continue Vanco day 2.

Non-billable

Pitfalls in documentation

- **Diagnosis is missing**

"Pt no c/o. Foot slightly less erythema, warmth. **Cellulitis -** Continue Vanco day 2.

99231 = $ 37. 17

Pitfalls in documentation

- Not documented = Not done
- Diagnosis is missing
- **Poor choice of wording**
- Failing to comment on concurrent care
- Billing for same diagnosis as a specialist
- Discharges – wrong date

Pitfalls in documentation

- **Poor choice of wording**

S: Pt no c/o. Levophed titrated up last PM. Re-cultured for T=40

O: BP=80/40 T=38 tachy CTA NABS slow mentation

A: Sepsis – stable on levophed, DA, IVF wide open, day 2 ABx.

DM – glc 40 nadir. Insulin held

P: Cont supportive care

5 PE:
VS, CV, resp, GI, neuro

MDM
4 Dx pts: Sepsis = 2, DM = 2

High risk patient – life threatening condition

99233

Pitfalls in documentation

- **Poor choice of wording**

S: Pt no c/o. Levophed titrated up last PM. Re-cultured for T=40

O: BP=80/40 T=38 tachy CTA NABS slow mentation

A: Sepsis – stable on levophed, DA, IVF wide open, day 2 ABx.

DM – glc 40 nadir. Insulin held

P: Cont supportive care

Poor choice of words: stable

Failure to state DM uncontrolled

Failure to write "patient is high risk"

99233 (crossed out with X)

99231

Pitfalls in documentation

- **Better choice of wording**

S: Pt no c/o. Levophed titrated up last PM. Re-cultured for T=40

O: BP=80/40 T=38 tachy CTA NABS slow mentation

A: Sepsis –hemodynamically unstable on levophed, DA, IVF wide open, day 2 ABx.

DM – severe hypoglycemia = 40. Insulin held.

P: Cont supportive care. Pt is high risk MDM.

Pitfalls in documentation

- **Poor choice of wording of A/P:**

?ACS – await pthall

Questionable lung cancer

R/O PE

Non-billable

Pitfalls in documentation

▸ **Poor choice:**	**Good choice:**
?ACS – await pthall	**Chest Pain**
Questionable lung cancer	**Lung mass**
R/O PE	**SOB - ?embolus**

Billable

Pitfalls in documentation

- **Failing to comment on concurrent care**

S: Still 5/10 sharp CP at rest, last episode this AM. Hungry NPO for pthall

O: BP = 150/90

Labs: glc = 180-240 x 24 hr, LDL=140. EKG TWI

A/P: Chest pain unimproved on ASA, b-blocker, zocor, lisinopril. Pt. with MCRF. Await pthall today. Pt. is high risk.

99231

Pitfalls in documentation

- **Failing to comment on concurrent care**

S: Still 5/10 sharp CP at rest, last episode this AM. Hungry NPO for pthall

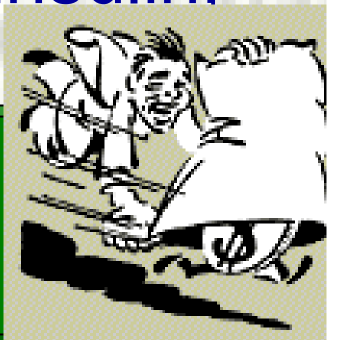
O: BP = 150/90

Labs: glc = 180-240 x 24 hr, LDL=140. EKG TWI

A/P: Chest pain unimproved on ASA, b-blocker, zocor, lisinopril. Pt. with MCRF. Await pthall today.

HTN, DM, hi chol – uncontrolled, ↑Lisinopril, insulin, zocor. Pt. is moderate risk.

99232



Pitfalls in documentation

- **Billing same diagnosis as specialist**

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99232

Pitfalls in documentation

- **Discharges – wrong date**
  - ✓ Honest mistake
  - ✓ Patient ended up with complication and stayed

Key concepts to keep in mind
for breakouts

Observation vs. full admissions

- Observation, same day discharge
  - ✓ > 12 hrs on the same *CALENDAR DATE*
  - ✓ Check with your hospital what is considered "admission time"

- Observation, next day discharge
  - ✓ Based on *CALENDAR DATE*, not # hours*

    **check with local medicare/medicaid rules*

- Full inpatient admission – based on *NEED*, not any length of time

Time based codes

- Time =
  - ✓ time spent on activity by **TP**, NOT resident, nurse, NP/PA
  - ✓ “face:face” or “unit/floor” time
- Time does NOT have to be continuous
- Restrictions on allowable phone conversations

Time based codes

- Inpatient admissions, observations
- Inpatient follow-up visits
- Consults
- Discharge from *full admission*
- Critical care
- Prolonged services
- Interdisciplinary team meeting
- Care Plan Oversight

Discharge from full admission

CPT	Time (min) spent preparing D/C
99238	≤ 30
99239	> 30

Discharge from full admission

CPT	Time (min)	RVUs	$$
99238	≤ 30	[1.76]	$ 66.54
99239	> 30	[2.55]	$ 96.46

+ $ 30.00

Discharge from full admission

Allowable tasks

Final physical exam

Discussion of admission

Instructing pt/care givers

Writing / dictating note

Preparing D/C forms

Writing prescriptions

Referral forms

Setting up F/U appts

Discharge from full admission

Causes of uncaptured $$

Forget to write > 30 min spent

Wrote *"30 min spent…"*

Prolonged services

99356 (30-59 min)

99357 (each add'l 30 min)

- Add-on code used when at least 30 minutes of time is spent beyond the usual time per E&M visit
- Required documentation
  - ✓ Total time/additional time spent with visit
  - ✓ Medical necessity for spending the additional time

Aggregate billing

- Only ONE bill may be submitted per physician/billing group per patient per calendar day
- If multiple visits by different physicians occur on one calendar day, total visit time may be added together to achieve a higher level of billing

Critical Care

2 Components

- Direct delivery by MD, critically ill pt
  - ✓Treat ≥ 1 vital organ system(s) failure

    -or-

  - ✓Prevent their further deterioration
- High complexity MDM

Critical Care

Requirements

- MD gives pt full attention
- Medical necessity criteria
  - ✓ Clinical – *high risk sudden, clinically significant, or life threatening deterioration; ↑ readiness urgently intervene*
  - ✓ Tx - *MD provides life/organ supporting intervention*

Critical Care

Anything that compels you to be at/near bedside

- Hemodynamic instability
- Impending respiratory failure
- Overwhelming infection

- Acute liver failure, renal failure, CHF exac
- HTN emergency, stroke
- Post-op complications

Critical Care

99291 **[5.86]**	1st 31-74 min
99292 **[2.96]**	each additional 30 min

Time (min)	
≤ 30	use another E/M code
31-74	99291
75-104	99291, 99292
105-134	99291, 99292 x 2
135-164	99291, 99292 x 3….etc…

Critical Care

Things that count toward CrC time

- ✓ Review of test results
- ✓ Discussions with staff, consultants*, family*
- ✓ Documentation

Critical Care

Things that count toward CrC time

- ✓ Review of test results – on the floor
- ✓ Discussions with staff, consultants*, family*
- ✓ Documentation

Critical Care

Things that count toward CrC time

- ✓ Review of test results
- ✓ Discussions with staff, consultants*, family* on the case

Not curbsides

Critical Care

Things that count toward CrC time

- ✓ Review of test results
- ✓ Discussions with staff, consultants*, family*

If…

- ✓ Pt is unable to participate in discussions
- ✓ conversation bears directly on the medical decision making

Not…

- ✓ Routine updates on pt

Critical Care

Things that *cannot* count toward CrC time

- ✓ Resident time with pt activities
- ✓ Teaching rounds
- ✓ Time off unit
- ✓ Time managing other pt
- ✓ Time doing unbundled services*

Bundled critical care services

- Interpretation of C.O. indices (93561-2)
- Transvenous pacing (92953)
- Gastric intubation (91105)
- Ventilator mngmt (94656-7, 94660, 94662)
- Vascular access procedures (36000, 36410, 36600)

Dispelling critical care myths

- ~~You can only bill CrC in an ICU~~
- ~~Only intensivists can bill CrC~~
- ~~You cannot bill CrC on same day as another E/M code~~
- ~~You cannot bill critical care as the consultant~~
- ~~Care must be delivered continuously by 1 MD~~

Lost revenue

- Critical care vs. 99233

	RVUs	$$
99233	2.54	$ 96.23
99291	5.54	$ 210.03

+ $ 114.00

CrC Documentation Pearls

- Write *“I provided “# min” critical care to pt…”*
- Write *“Pt is critically ill”*
- Make sure ICD-9 reflects critical illness
- If billing for a procedure the same day, specifically write *“Time spent in procedure NOT included in CrC time”* -plus- *“modifier –25”*

Modifiers

- *What is a modifier?*

  2 digit code to further describe a service

Modifier -25

Significant, Separately Identifiable Evaluation and Management Service by the Same Physician is provided on the same calendar day of a procedure or other service

- Only used after E/M code

Modifier –25 example

- I provided 60 min of critical care to pt – reviewed EKG, CXR, discussed with daughter who consented to central line placement, discussed with ID who suggest Vanco. Pt septic on pressors, IVF, Xigris. High risk MDM.
- Procedure Note: I was present for the entire IJ placement by resident and agree with his above note.

99291 – 25, 36489

Modifier - 59

More than one distinct separate procedure performed on same day calendar day. *The procedure must not be a component of another procedure.*

- When to use modifier 59:
  - ✓ Different session
  - ✓ Different procedures
  - ✓ Different site
  - ✓ Different lesion or entry site

Modifier - 59

Example 1: Left shoulder arthrocentesis done as well as right knee kenalog injection

20610-LT

20610-59-RT

Example 2: Large abscess drained and packed in right knee plus small abscess I&D on left arm without packing

10061-RT

10060-59-LT

Modifier –76 and -77

Procedure done twice on same calendar day

- -76 Repeated by same MD
- -77 Repeated by different MD’s

Central line placement. Pt. pulled it out and new one placed later that day.

36556-76

List of modifiers used on inpatient medicine service

-21 Prolonged Evaluation and Management Service

-22 Unusual Procedural Service

-24 Unrelated Evaluation and Management Service by the Same Physician During a Post-operative Period

-25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service

-26 Professional Component

-32 Mandated Service

-50 Bilateral Procedure

-51 Multiple Procedures

-52 Reduced Service

-53 Discontinued Procedure

-59 Distinct Procedural Service

-76 Repeat Procedure by Same Physician

-77 Repeat Procedure by Another Physician

-90 Reference (Outside) Laboratory

-91 Repeat Clinical Laboratory Diagnostic Test

-99 Multiple Modifiers

-QR Item or service provided in a Medicare qualifying clinical trial

Maximizing reimbursement

What can I do while trying to learn this junk?

- ✓ Submit bills promptly
- ✓ Monitor and learn from your denials
- ✓ Get to know your coders, compliance office
- ✓ Coordinate billing with consultants
- ✓ Learn differences among payors