UCLA Health System

Compliance Department

Overview of Non-Physician Practitioner Guidelines

11/2010

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

The Role of the Compliance Department

The Compliance Department assists physicians and other practitioners with complying with governmental regulations relating to medical record documentation and coding and billing for services.

- Professional Fee Billing and Documentation Policies and Procedures
- Routine audits, presenting results to division and department leadership and assisting with corrective action plans
- Proactively protecting our organization by providing educational sessions
- Responding to audit requests made by external oversight agencies
- Researching compliance-related issues with Medicare, Medi-Cal, and other governmental and non-governmental third-party payors

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Medicare & Medi-Cal Billing
Physician/Practitioner Interface

Medicare & Medi-Cal providers who employ or use the services of NPPs are required to develop a system of collaboration and physician supervision with each NPP. The Physician/practitioner Interface document establishes the means by which medical treatment services provided by physicians and NPPs are integrated and make consistent with accepted medical practice. This document must be kept on file at the provider's office, readily available for review by Centers for Medicare & Medicaid Services (CMS). *(Standard Practice of Care--Billing Protocols)*

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Medi-Cal Billing Physician Supervision

Primary care services rendered by a NPP must be performed under the general supervision of a physician. The supervising physician must be available to the NPP in person or through electronic means.

Nurse practitioners must practice in collaboration with a physician who has current practice or training in the field in which the nurse practitioner is practicing.

A physician's co-signature or countersignature is required for care provided by nurse practitioners.

Billing Medicare Independently

Dec. 31, 2000, NPs must be nationally certified or have a Medicare billing number.

After Jan. 1, 2001, NPs applying for a Medicare billing number for the first time must be nationally certified.

After Jan. 1, 2003, NPs applying for a Medicare billing number the first time must be nationally certified and have a master's degree in nursing.

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Billing Under Incident-To

SERVICES MUST BE:

1. An integral, although incidental, part of the physician's professional service;
2. Commonly rendered without charge or included in the physician's bill;
3. Of a type that are commonly furnished in physician's offices or clinics;
4. Furnished under the physician's direct personal supervision; and
5. Furnished by the physician or by an individual who qualifies as an employee of the physician.

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Billing Under Incident-To
(Continuation)

In other words:

1. The services are limited to services provided strictly as a follow-up to the physician's plan of care.
2. The visit cannot be with a new patient or with an established patient with a new problem.
3. The physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the non-physician practitioner is performing services.
4. Incident-to services cannot be performed in an inpatient or outpatient hospital setting.

Basics of Documentation

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Key elements to remember:

- The documentation is the only valid support for billing most professional services.
- Not documented = Not done
- Documentation must support the medical necessity of service provided.
- Notes must be complete and legible.

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Medical Record Documentation

- **INCLUDES:**
  - **Reason for the encounter (Chief Complaint) – always required**
  - **Relevant history**
  - **Physical exam findings and prior diagnostic test results**
  - **Assessment, clinical impression or diagnosis**
  - **Plan for care**
  - **Date and legible identity of performing provider (No stamped signatures)…electronic signatures are fine.**

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Evaluation and Management (E/M) Codes and Documentation

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

E/M Services Classifications

- Office or other outpatient
- Hospital Observation
- Hospital Inpatient
- Consultations
- Emergency Department
- Critical Care
- Neonatal Intensive Care
- Nursing Facility
- Domiciliary / Rest Home Care
- Home Services
- Prolonged Services
- Case Management
- Care Plan Oversight
- Preventive Medicine
- Newborn Care
- Special E/M Services
- Other E/M Services

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

E/M Services Subject to the Guidelines

- Office or other outpatient
- Hospital Observation
- Hospital Inpatient (including Initial)
- Consultations
- Emergency Department
- Nursing Facility
- Domiciliary / Rest Home Care

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

New or Established Patient

- New Patient
  - Has not received any professional E/M services from the physician or another physician of the same specialty who belongs to the same group practice within three years
- Established Patient
  - Has received E/M services from the group within three years

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Consultation Subcategories

- Office-Outpatient
- Hospital-Inpatient
  - There are no follow-up consult codes.

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Consultations

- E/M service provided by a physician whose opinion and advice is requested by another physician or appropriate requestor
- May initiate diagnostic and/or therapeutic services at the same visit
- A patient who is self-referred or “referred for management of a condition” is a NEW or ESTABLISHED patient, not a consult.
- If ongoing care of a particular condition is assumed, service is not a consult but a newest. patient visit.

Consult Documentation Requirements

3 R's

- REQUEST for a consultation must be documented by the attending physician (written or verbal). A resident may ask on behalf of the attending. However, the resident may not initiate the consult.

- The consultant must RENDER an opinion regarding the patient's management.

- A written REPORT of the consult is furnished to the requesting physician.

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Levels of Service

- History
  - History of Present Illness (HPI)
  - Review of Systems (ROS)
  - Past, Family and Social History (PFSH)
- Physical Examination
- Medical Decision Making
  - Time
  - Counseling
  - Coordination of Care
  - Nature of Presenting Problem

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Levels of Service
(Continuation)

- The First Time Encounter
  - New Patient, Hospital Admits, & Consultations
    - All three components required
      - History
      - Exam
      - Medical Decision-Making

- Follow-up Encounter
  - Established Visit and Subsequent Hospital Visit
    - The best two out of three components required
      - History and/or
      - Exam and/or
      - Medical Decision-Making

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Chief Complaint Should Normally be the First Thing in the Note

- Sign, Symptom or Condition - “pain, shortness of breath, fever.”
- Management or Follow-up visit – “management of diabetes & HTN,” “follow-up visit for dizziness.”
- Request for Service – “annual physical exam.”

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

History

- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past Medical History, Family History, and Social History (PMFSH)
- If unable to obtain, document why, and receive full credit for the history

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

History of Present Illness

- Location - Where is the pain/problem?
- Quality - Describe the pain/problem?
- Severity - How severe is the pain /problem?
- Duration - How long have you had this pain/problem?
  When did it start? How long does it last?
- Timing - Does this pain/problem occur at a specific time?
- Context - Where were you at the onset of this pain/problem?
  What were you doing?
- Modifying Factor - What makes the pain/problem worse or better?
  Have you had any previous episodes?
- Associated Signs/ Symptoms - What other associated problems are present?

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Two Levels of History of Present Illness

- Brief = 1-3 elements described
- Extended = 4+ elements described, or Status of at least 3 chronic or inactive conditions

✓Duration ✓Quality

“Mr. Doe has for two weeks felt a sharp pain in his left shoulder when he raises his arm.”

✓Location ✓Context

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Review of Systems (ROS)

An inventory of body systems obtained through questions seeking to identify signs and/or symptoms which the patient has or has had.

- Constitutional symptoms (e.g. fever, weight loss)
- Eyes
- Ears, Nose, Mouth, Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (including breasts)
- Neurological
- Psychiatric
- Endocrine
- Hematologic/Lymphatic
- Allergic/Immunologic

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Three Levels of ROS

- Problem Pertinent (1 system)
  - Directly related to the problem(s) identified in the HPI
- Extended (2-9 systems)
  - Directly related to the problem(s) identified in the HPI and a limited number of additional systems
- Complete (at least 10 systems)
  - Medi-Cal requires all 14 systems
- May be completed by patient, nurse or other staff
- Pertinent positives and negatives must be referred to in the note

Past Medical, Family, and Social History (PMFSH)

- **Past Medical**
  - Current medications
  - Prior illnesses/injuries
  - Dietary status
  - Operations/hospitalizations
  - Allergies
- **Family**
  - Health status or cause of death of siblings/parents
  - Hereditary/high risk diseases
  - Diseases related to the chief complaint, HPI, ROS
- **Social**
  - Living arrangements
  - Marital status
  - Drug or tobacco use
  - Occupational/educational history

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Two Levels of PFSH

- **Pertinent:** one of the three areas
- **Complete:** document specific item from all three areas
- **Complete - for established patients:** two of three areas is sufficient

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Patient Questionnaires

Patient questionnaires may be used for the ROS and the past medical, family, and social histories. However, the patient questionnaire must be referenced in the attending physician's or NPP's note and signed by the patient and provider.

Four Levels of History Minimum Requirements

- Problem focused (PF)
  - Brief HPI
    - 1 HPI
- Expanded problem focused
  - Brief HPI, Pertinent ROS, no PMFSH
    - 1 HPI & 1 ROS
- Detailed
  - Extended HPI and ROS, 1 PMFSH element
    - 4 HPI's, 2 ROS, & 1 Hx element
- Comprehensive
  - Extended HPI, Complete ROS and PMFSH
    - 4 HPI's, 10 ROS (14 MCal), & PMFSH

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Documenting the Physical Exam

- A general multi-system exam or any single organ system exam may be performed by any provider.
- The type and content are selected by the provider **depending upon medical necessity**.
- Note specific abnormal & relevant negative findings of the affected or symptomatic area(s)--“abnormal” is insufficient.
- Describe abnormal or unexpected findings of asymptomatic areas or systems.
- Noting “negative” or “normal” is sufficient to document normal findings in unaffected areas.

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Physical Exam Guidelines (1995)

- **Problem Focused**
  - A limited examination of the affected body area or organ system
- **Expanded Problem Focused**
  - A limited examination of the affected body area or organ system and other symptomatic or related organ system(s) 2-4 systems
- **Detailed**
  - An extended examination of the affected body area(s) and other symptomatic or related organ systems 5-7 systems
- **Comprehensive**
  - A general multi-system examination (8 or more of the 12 systems) or complete examination of a single organ system

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

General Multi-System Exam (1997)

- **Problem Focused**
  - Documentation of 1-5 elements
- **Expanded Problem Focused**
  - At least 6 elements
  - One or more organ/body system
- **Detailed**
  - at least 6 organ/body system covered
  - for each system/area, at least 2 elements noted

    OR
  - At least 12 elements total
  - 2 or more organ/body systems
- **Comprehensive**
  - At least nine organ systems/areas covered
  - For each, all elements should be performed
  - Document at least 2 elements in each system/area

See separate General Multi-System Exam slides for specific exam elements

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Single Organ System Examination

- Requirements for elements documented similar to 1997 multi-system
- Single organ system exams for the following:
  - Eyes
  - Ears, Nose, Mouth, and Throat
  - Cardiovascular
  - Respiratory
  - Genitourinary
  - Musculoskeletal
  - Skin
  - Neurological
  - Psychiatric
  - Hematologic/Lymphatic/Immunologic

See separate Single Organ System Exams for specific exam elements

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Medical Decision Making (MDM)

Complexity is Measured by:

- ✓ Number of Diagnostic and/or Management Options
- ✓ Amount and Complexity of Data
- ✓ Overall Risk
  - ✓ See Table of Risk
    - ✓ Presenting problem
    - ✓ Diagnostic procedures and orders
    - ✓ Management options selected

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Medical Decision Making Elements

- **Diagnostic and/or management options**
- Billing credit is based on a point system
  (Comprehensive = 4 “points”)
  - Self-limited, minor **(1 pt.)**
  - Established problem stable, improved **(1 pt.)**
  - Established problem worsening **(2 pts.)**
  - New problem, without workup planned **(3pts.)**
  - New problem, with workup planned **(4pt.)**

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Medical Decision Making Elements
(Continuation)

- Amount and/or Complexity of data
- Billing Credit is based on a point system
  (Comprehensive = 4 points)
  - Review/order of clinical lab, radiologic study, other non-invasive diagnostic study **(1 pt. per category of test)**
  - Discussion of diagnostic study w/interpreting phys. **(1 pt.)**
  - Independent review of diagnostic study **(2pts.)**
  - Decision to obtain old records or get data from source other than patient. **(1pt.)**
  - Review/summary old med records or gathering data from source other than patient **(2pts.)**

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Medical Decision Making Elements
(Continuation)

- Risk
  - Presenting problem
  - Diagnostic procedures
  - Management options

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Medical Decision Making Elements (Continuation)

Table of Risk (Billing credit is based on the highest level of one subcategory)

Level of Risk	Presenting Problem(s)	Diagnostic Procedures Ordered	Management Options Selected
Minimal	One self-limited or minor problem	Lab tests (blood, X-rays, EKG) Chest X-rays Urinalysis Ultrasound	Rest Superficial dressings Gargles
Low	Two of more self-limited problems One stable chronic illness (e.g., well-controlled hypertension or insulin dependent diabetes, cataract, BPH Acute uncomplicated illness or injury	Non-CV imaging studies with contrast e.g., barium enema Superficial needle biopsy Lab test requiring arterial puncture Skin biopsies Physiologic tests not under stress, e.g., PFTs	OTC drugs Minor surgery with no identified risk factors PT/OT IV fluids without additives
Moderate	1 chronic illness with mild exacerbation 2 or more stable chronic illness Undiagnosed new problem with uncertain prognosis Acute illness with systemic symptoms Acute complicated injury	Physiologic tests under stress Diagnostic endoscopies with no identified risk factors Deep needle or incisional biopsy Cardiovascular imaging studies with contrast and no identified risk fxs Obtain fluid from body cavity	Prescription drug management Minor surgery with risk factors Decision to perform elective major surgery with no identified risk fxs Therapeutic nuclear med. IV fluids with additives Closed treatment of fracture or dislocation without manipulation
High	1or more chronic illnesses with severe exacerbation Acute or chronic illness or injures that pose a threat to life or bodily function (e.g., multiple An abrupt change in neurological status	Cardiovascular imaging studies with contrast with identified risk factors Cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography	Elective major surgery with identified risk factors Decision to perform major emergency surgery Drug therapy requiring intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis

Level of Medical Decision-Making

Four levels:

- Straightforward
- Low complexity
- Moderate complexity
- High complexity

Two of the three areas:

dx options, amount of data, risk establish the MDM level

Dx/mgt options	**0-1pt**	**2pts**	**3pts**	**4pts**
Amount of data	**0-1pt**	**2pts**	**3pts**	**4pts**
Overall risk	**Minimal**	**Low**	**Moderate**	**High**
Level of MDM	***Strghtfwd***	***Low***	***Moderate***	***High***

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Note on Establishing MDM

Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services *unless* their presence significantly increases the complexity of the medical decision-making.

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

New Outpatient Visits/Consults
All 3 Components Are Required

Level	History	Exam 1997 MS	MDM
99201, 99241	Problem Focused (PF) 1 HPI	PF 1-5 Elements	Straightforward
99202, 99242	Exp Prob Focused (EPF) 1 HPI & 1 ROS	EPF 6-11 Elements	SF
99203, 99243	Detailed 4 HPIs, 2 ROS, & 1 Hx.	Detailed 12 Elements	Low
99204, 99244	Compr. 4 HPIs, 10 ROS, & PMFSH	Compr. 2 from 9 systems or areas	Moderate
99205, 99245	Compr. 4 HPIs, 10 ROS, & PMFSH	Compr. 2 from 9 systems or areas	High

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Established Outpatient Visits
2 Out Of The 3 Components Are Required

Level	History	Exam	MDM
99211	N/A	N/A	N/A
99212	PF	PF	SF
99213	EPF	EPF	Low
99214	Detailed	Detailed	Moderate
99215	Compr.	Compr.	High

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Initial Hospital/Observation
All 3 Components Are Required

Level	History	Exam	MDM
99221, 99218	Detailed	Detailed	SF/Low
99222, 99219	Compr.	Compr.	Moderate
99223, 99220	Compr.	Compr.	High

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Subsequent Hospital
2 Out of the 3 Components Are Required

Level	History	Exam	MDM
99231	PF	PF	SF/LOW
99232	EPF	EPF	Moderate
99233	Detailed	Detailed	High

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Documenting Time-based Coding

- If time spent counseling and/or coordinating care face-to-face is more than 50% of encounter, use time
- Face-to-face is defined:
  - Outpatient—patient must be in the same office/room with the TP
  - Inpatient—patient must be on the same unit or floor with the TP
- Documentation of the amount of time counseling, the total time spent on encounter, and what was discussed or coordination activities are required.
- Document only minimal history, exam OR medical decision making

Documenting Time-based Coding (Continued)

- Counseling as it relates to E/M coding is defined as 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;
  - Risk and benefits of management (treatment) options;
  - Instructions for management (treatment) and/or follow-up;
  - Importance of compliance with chosen management (treatment) options;
  - Risk factor reductions; and
  - Patient and family education.

Time as the Controlling Factor
Outpatient Services

Established Patient	New Patient	Consultation
99211 Nurse visit, 5 mins.	99201 – 10 minutes	99241 – 15 minutes
99212 -- 10 minutes	99202 – 20 minutes	99242 – 30 minutes
99213 – 15 minutes	99203 –30 minutes	99243 – 40 minutes
99214 – 25 minutes	99204 – 45 minutes	99244 – 60 minutes
99215 – 40 minutes	99205 – 60 minutes	99245 – 80 minutes

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Time as the Controlling Factor
Inpatient Services

Subsequent Hospital Visit	Admission	Consultation
99231 – 15 minutes	99221 – 30 minutes	99251 – 20 minutes
99232 – 25 minutes	99222 – 50 minutes	99252 – 40 minutes
99233 –35 minutes	99223 – 70 minutes	99253 – 55 minutes
		99254 – 80 minutes
		99255 – 110 minutes

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Examples of Time-based Codes

- Critical care
- Other E&M visits where >50% counseling
- Individual psychotherapy codes (non E&M)
- Prolonged services

TP presence or concurrent observation for entirety of time-based services is required.

Resident note may support level and type service, TP must personally document his/her involvement.

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

ICD-9CM Coding Diagnosis

- The CPT code or service is the driving force behind reimbursement. However, the ICD-9 diagnosis code must support the CPT code in order to be reimbursed.

- The system of diagnosis codes used is the International Classification of Diseases, 9the revision, Clinical Modification (ICD-9CM).

- The primary diagnosis must support or justify the physician's services. For instance, the inpatient consultant’s primary diagnosis would be the reason for the consult and not necessarily the admitting diagnosis.

ICD-9CM Coding Diagnosis
(Continuation)

- The highest level of specificity should be given when establishing a diagnosis. For instance, GI bleed has subclassifications, upper GI bleed and lower GI bleed. Sites of injuries, infections, and burns should also be provided. The claim should be as clean as possible. Therefore, try to avoid unspecified diagnoses and codes.

ICD-9CM Coding Diagnosis
(Continuation)

- The highest level of certainty should be given when establishing a diagnosis. “Suspected” or “Rule Out” diagnoses cannot be coded. If the physician is working only with phenomena and has not yet formed a diagnosis, then the sign, symptom, or laboratory abnormality should be selected.

- Document all conditions that co-exist at the time of the visit that require or affect patient care, treatment or management. Conditions that were previously treated and no longer exist should not be coded.

Modifier 25

- Append a modifier 25 to an E&M code if a significant, separately identifiable E&M service is performed by the same physician on the same day of a procedure or other service.
- The patient's condition must require E&M services above and beyond what would normally be performed in the provision of the procedure.
- The necessity for the E&M service may be prompted by the same diagnosis as the procedure.
- A new patient E&M service is considered separate from the same day surgery or procedure—no 25 modifier needed.

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Modifier 25
(Continuation)

- For an established patient, if the E&M service resulted in the initial decision to perform a minor procedure (0-10 days global period) on the same day and medical necessity indicates an E&M service beyond what is considered normal protocol for the procedure, the 25 modifier is appropriate.
- To determine the correct level of E&M service to submit, identify services unrelated to the procedure and use as E&M elements.
- Clearly mark the encounter form to indicate that a 25 modifier should be attached to the E&M.

Some Common Scenarios

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Other procedures

- Time-based procedures billed on time only
  - Critical care
  - Hospital discharge day management
  - Prolonged services
  - Care plan oversight
  - E&M counseling/coordination of care

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Clinical Examples
(Continuation)

New patient 99204

- Initial office visit for a 17-yr-old female with depression
- Initial office visit for initial evaluation of a 63-yr-old male with chest pain on exertion
- Initial office visit for evaluation of 70-yr-old patient with recent onset of episodic confusion.

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Clinical Examples
(Continuation)

Established patient 99213

- Office visit for a 62-yr-old female, established patient, for follow-up for stable cirrhosis of the liver.
- Office visit for a 60-yr-old, established patient, with chronic essential hypertension on multiple drug regimen, for blood pressure check.
- Office visit for a 50-yr-old female, established patient, with insulin-dependent diabetes mellitus and stable coronary artery disease, for monitoring.

Clinical Examples
(Continuation)

Established Patient 99214

- Office visit for a 28-yr-old male, established patient, with regional enteritis, diarrhea, and low-grade fever.

- Office visit for a 28-yr-old female, established patient, with right lower quadrant abdominal pain, fever, and anorexia.

- Office visit with 50-yr-old female, established patient, diabetic, blood sugar controlled by diet; complains of frequency of urination and weight loss, blood sugar of 320 and negative ketones of dipstick.

Clinical Examples
(Continuation)

Established Patient 99215

- Office visit with 30-yr-old, est. patient, for 3- month history of fatigue, weight loss, intermittent fever, and presenting with diffuse adenopathy and splenomegaly.

- Office visit for evaluation of recent onset syncopal attacks in a 70-yr-old woman, est. patient.

- Office visit for a 70-yr-old female, est. patient, with diabetes mellitus and hypertension, presenting with a two-month history of increasing confusion, agitation and short-term memory loss.

Coding Checklist for E/M Services

Is the type of visit:

- New?
- Established?
- Consult?

Is the level of visit:

- Medically necessary?
- Performed?
- Documented?

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Coding Checklist for E&M Services
(Continuation)

- ✓ If the level of visit is to be based on time, is the time spent in counseling and/or discussion of the treatment plan greater than 50% of the total visit?

- ✓ Are the total visit time, counseling time, and what was discussed documented?

- ✓ Is there a summarizing, patient-specific note by the TP documenting involvement in each of the key portions of the visit?

Coding Checklist for E&M Services
(Continuation)

- ✓ Is the providing physician, the documenting physician and the billing physician the same person? Is the encounter form clearly marked as to provider?
- ✓ If there was a procedure, ***and*** there was a separately identifiable evaluation and management service on the same day, an E&M code may be billed by checking the “25 modifier” box on the encounter form.

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY

Resources

- UCLA Compliance Office
  - Marti Arvin, Chief Compliance Officer (310) 794-6763

- Confidential Hotline **1-800 296-7188**

- UCLA Compliance Website http://www.mednet.ucla.edu/compliance/.

TRUST
OPENNESS
RESPONSIBILITY
CONFIDENTIALITY
HONESTY