"No FUNDS Left Behind":

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

Workshop F03: SGIM 32nd Annual National Meeting

Friday May 15, 2009

4:00 PM – 5:30 PM

Sponsored by the SGIM Clinical Practice Committee

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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 *critical care*, *prolonged service* codes and for *aggregating time*
6. Coding for E/M visits AND procedures on the same calendar day

Whirlwind review of E & M Guidelines

1995

1997

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)*

Complexity MDM (need 2 of 3)	Straightforward 1	Moderate 3	High 4
Diagnoses	Anything a consultant doesn't bill for	EC + EU -or- N	2 EU -or- EC + 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

Diagnoses points

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

(S)	Self limited, minor	1 (max 2 pts)
(EC)	Established – controlled	1
(EU)	Established – uncontrolled	2
(N)	New (-) w/u	3 (max 3 pts)
(NW)	New (+) w/u	4

Points *per* problem

Risk levels

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

Guidelines: History

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

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: History

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

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: History

< 10 ROS:
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
Physical(system/area)	5	8	8
Time (min)	30	50	70

Guidelines: History

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

Guidelines: Physical

Failure to document ≥ 8 organ systems limits your billing to a 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
Physical(system/area)	5	8	8
Time (min)	30	50	70

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 EC -or- EC + EU -or- N	4 EC -or- 2 EU -or- EC + 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:
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

< 4 modifiers of HPI:
Limits billing to levels 1 + 2

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 EC -or- 2 EU -or- EC + 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

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

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 EC -or- 2 EU -or- EC + 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

< 5 PE systems:

CV = 2

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

Complexity (need 2 of			
Diagnoses			High 4 4 EC -or- 2 EU -or- EC + 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 EC -or- 2 EU -or- EC + 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 4
Diagnoses			4 EC -or- 2 EU -or- EC + 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

< 5 PE systems:

Psych = 5

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

Complexity (need 2 of			High 4
Diagnoses			4 EC -or- 2 EU -or- EC + 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

Key concepts to keep in mind
for breakouts

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
- Wrong date

Observation vs. full admissions

- Observation, same day discharge (99234-6)
  - ✓ > 12 *(8)* hrs on the same *CALENDAR DATE*
  - ✓ Check with your hospital what is considered "admission time"

- Observation, next day discharge (99218-20)
  - ✓ Based on *CALENDAR DATE*, not # hours

- Full inpatient admission – based on *NEED* (99231-3)

Time based codes

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

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)	RVUs	$$
99238	≤ 30	[1.84]	$ 66.36
99239	> 30	[2.67]	$ 96.30

+ $ 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 “I spent > 30 min …”

Wrote *“30 min spent…”*

Prolonged services

99356 (30-74 min)	**[2.32]**	$ 83.67
99357 (each add'l 30 min)	**[2.34]**	$ 84.40

- 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 / Requirements

- ***Direct delivery by MD (full attn)***, critically ill pt
  - Treat $\geq$ 1 vital organ system(s) failure *-or-*
  - Prevent their further deterioration
- Medical necessity - High complexity MDM
  - Clinical – *high risk level*
  - Tx - 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, CHF exac
- HTN emergency, stroke

Critical Care

99291	(1st 31-74 min)	**[5.88]**	$ 212.07
99292	(each add'l 30 min)	**[2.94]**	$ 106.04
99233	*(level 3 subsequent)*	***[2.65]***	*$ 95.58*

+ $ 116.49

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) ie IV, blood draw, ABG

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~~

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

Pt admitted for altered mental status and fever. LP done same day.

99223 – 25 [780.97, 780.6]

62270 [780.97]

Modifier - 59

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

Left shoulder arthrocentesis done as well as right knee kenalog injection

20610 – LT [719.41]

20610 – 59 – RT [719.46]

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

36556 - 76

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

RVU's = Relative Value Units

By Yvette M Cua
Updated March 17, 2009

Weighted system -Assigns worth = "RVU's" to each CPT code
_3 components: Total RVU's = W + P + M

- Work "…Us…" (51%)
- Practice Expense "overhead" (45%)
- Malpractice "liability insurance" (4%)

Conversion Factor (CF) – dollar value of each RVU **$ 36.0666**/RVU

Payment = $[(RVU_W x GPCI_W)+(RVU_P x GPCI_P)+(RVU_M x GPCI_M)]$ x CF

= [Total RVU's] x CF

RVU's and medicare reimbursement

Based on $36.0666 per RVU
RVU's unadjusted by GPCIs
****Private insurers may reimburse higher*

Admissions	Observation status						Full inpatient admission		
	Same day discharge			Next day discharge					
	CPT	*RVU*	*reimb.*	*CPT*	*RVU*	*reimb.*	*CPT*	*RVU*	*reimb.*
Level 1	99234	3.53	$127.32	99218	1.74	$62.76	99221	2.49	$89.81
Level 2	99235	4.63	$166.99	99219	2.88	$103.87	99222	3.40	$122.63
Level 3	99236	5.75	$207.38	99220	4.04	$145.71	99223	5.00	$180.33
Discharge				99217	1.85	$ 66.72	99238	1.84	$66.36
							99239	2.67	$96.30
Subsequent visit									
	99231	1.03	$ 37.15						
	99232	1.85	$ 66.72						
	99233	2.65	$ 95.58						

Consultation

	Inpatient			*Outpatient (hospital base clinic)*		
Level 1	99251	1.35	$48.69	99241	0.92	$33.18
Level 2	99252	2.10	$75.74	99242	1.94	$69.97
Level 3	99253	3.18	$114.69	99243	2.70	$97.38
Level 4	99254	4.59	$165.55	99244	4.27	$154.00
Level 5	99255	5.60	$201.97	99245	5.33	$192.23

Outpatient visits (hospital based clinic)

	New			*Established*		
Level 1	99201	0.65	$23.44	99211	0.24	$8.66
Level 2	99202	1.25	$45.08	99212	0.64	$23.08
Level 3	99203	1.89	$68.17	99213	1.24	$44.72
Level 4	99204	3.16	$113.97	99214	1.92	$69.25
Level 5	99205	4.11	$148.23	99215	2.73	$98.46

Critical Care

1st 31 – 74 minutes	99291	5.88	$212.07
each additional 30 minutes	99292	2.94	$106.04

Prolonged services

1st 30 – 74 minutes	99356	2.32	$83.67
each additional 30 minutes	99357	2.34	$84.40

Common Procedures

	CPT	*RVU*	*reimb (hospital base)*
I/D abscess (single AND simple)	10060	2.35	$84.76
I/D abscess (≥2 OR complicated)	10061	4.18	$150.76
Drain subungal hematoma	11740	0.81	$29.21
Inject carpal tunnel (therapeutic)	20526	1.52	$54.82
Inject tendon sheath/ligament	20550	1.11	$40.03
Inject tendon origin/insertion	20551	1.13	$40.76
Inject trigger points (1 or 2)	20552	0.95	$34.26
Inject trigger points (≥3)	20553	1.05	$37.87
Drain or inject LG joint/bursa (knee hip shoulder)	20610	1.32	$47.61
Drain or inject MED joint/bursa (ankle wrist)	20605	1.10	$39.67
Drain or inject SM joint/bursa (toe, finger)	20600	1.06	$38.23
Thoracentesis (initial or subsequent)	32421	2.12	$76.46
Blood draw (require MD expertise)	36410	0.24	$8.66
Central line (non-tunneled) placement	36556	3.31	$119.38
Ultrasound guidance performed/interpreted by MD	76937	1.02	$36.79
Ultrasound only performed by MD	76937-TC	0.58	$20.92
Ultrasound only interpreted by MD	76937-26	0.44	$15.87
Central line – change over wire	36580	1.96	70.69
ABG	36600	0.42	$15.15
Art-line placement	36620	1.39	$50.13
NG tube / OG tube placement	43752	1.11	$40.30
Paracentesis (initial)	49080	1.94	$69.97
Paracentesis (subsequent)	49081	1.83	$66.00
Lumbar puncture (diagnostic)	62270	2.04	$73.58
Lumbar puncture (therapeutic drainage CSF)	62272	2.19	$78.99
Ventilator management (initial)	94002	2.43	$87.64
Ventilator management (subsequent days)	94003	1.76	$63.48
Pulse-oximetry (single)	94760	0.08	$2.89
Pulse-oximetry (multiple or continuous)	94761	0.16	$5.77

Time based codes

by Yvette M. Cua

CPT codes

Time (minutes)	Inpatient Admission	Subsequent visits	Consults		Outpatient visits	
			Inpatient	Outpatient	New	Established
5						99211
10					99201	99212
15		99231		99241		99213
20			99251		99202	
25		99232				99214
30	99221			99242	99203	
35		99233				
40			99252	99243		99215
45					99204	
50	99222					
55			99253			
60				99244	99205	
70	99223					
80			99254	99245		

	Discharge
0-30	99238
≥ 31	99239

	Critical Care
0-30	not reportable
31-74	99291
75-104	99291, 99292
105-134	99291, 99292 x 2
135-164	99291, 99292 x 3
165-194	99291, 99292 x 4

	Prolonged services	
min.	Inpatient	Outpatient
0-29	not reportable	
30-74	99356	99354
75-104	99356, 99357	99354, 99355
105-134	99356, 99357 x 2	99354, 99355 x 2
135-164	99356, 99357 x 3	99354, 99355 x 3
165-194	99356, 99357 x 4	99354, 99355 x 4

** stand alone codes, do not need modifier; MUST bill with E/M, not alone*

Inpatient modifiers

-21 Prolonged Evaluation and Management Service
you did more than the usual E/M service, but not enough to capture work thru time-based coding

-24 E/M visit during global period for unrelated problem or complication
you see pt. within global period of procedure but manage a problem unrelated to the procedure

-25 Significant, Separately Identifiable E/M Service by Same MD on Same Day of a Procedure or Other Service
do procedure same day as visit; modifier goes AFTER E/M code, not procedure code

-26 Professional Component
*you didn't do procedure, just interpreted test; ex: read EKG or PFT's (**This is ONLY if cards/pulm is NOT billing for reading.) This is NOT for your personal interpretation of EKG, CXR, etc. for data points.*

-52 Reduced Service
you did less than usual E/M service

-53 Discontinued Procedure
procedure is stopped due to risk to patient or extenuating circumstances

-59 Distinct Procedural Service
more than one procedure done same day, or same procedure done in 2 different locations
Ex: you aspirate a knee then inject a shoulder.

-76 Repeat Procedure by Same Physician
ex: you place central line and pt pulls it out. Have to do it again

-77 Repeat Procedure by Another Physician
ex: you do ABG in AM, then partner coveres in PM and does another ABG