Dr. Manaker serves as a consultant for Apnicure, Aetna, Pfizer, Novartis, Johnson and Johnson and participates as a Grand Rounds speaker and lecturer, but these do not create a conflict related to the following presentation.
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Associate Professor of Medicine and Pharmacology
Pulmonary and Critical Care Division
University of Pennsylvania Health System

Vice Chair for Regulatory Affairs, Department of Medicine, UPHS
Medical Director, Information Services, UPHS

Novitas (J-12: PA, NJ, MD, DE, DC) Medicare, Contractor Advisory Committee (CAC)
CMS Hospital Outpatient Payment (HOP) Advisory Panel

American College of Chest Physicians (ACCP)/American Thoracic Society (ATS)
CHEST Regulations & Reimbursement (ACCP) / Clinical Practice (ATS) Committees

American College of Physicians (ACP)
Coding & Payment Policy Subcommittee

American Medical Association (AMA)
AMA Relative Value Update Committee (RUC)
Chair, Practice Expense Subcommittee
Office of Clinical Documentation
Department of Medicine

Scott Manaker, M.D., Ph.D.  
Mary Mulholland, R.N., C.P.C., M.H.A.  
Carol Pohlig, R.N., C.P.C., A.C.S.  
Ann Marie Holmes, R.N., C.P.C.  
Tonja Mitchell

- Provide annual and *ad hoc* supplement education sessions
- Respond to record requests and internal/external audits
- Participate in revenue cycle processes
- Advocate for the faculty and the DOM
Disclaimers

Opinions - my own

Consultant – see disclosure* in program

No representation, guarantee or warranty of fitness

Critical Care:
Missing “Time” = Subsequent hospital visit

Critical care time
>30 >74 >104 >134 min [ ] No Overlap
[ ] Initial Visit 9922 __________ (1-3)
[ ] Consultation 9925 __________ (1-5)
[ ] Vent Management 94002-3

[ ] Discharge Day Mgmt
[ ]-25. see separate procedure note [ ] >30 min

NO time documented
Critical Care:
No Signature = Non Billable
Missed Billing Opportunity: 
CPR CPT 92950

<table>
<thead>
<tr>
<th>Time</th>
<th>Procedure</th>
<th>MD Signature</th>
<th>commenting</th>
<th>Vital Signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>3:00</td>
<td>CPR</td>
<td></td>
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<td>CPR</td>
<td></td>
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<tr>
<td>3:10</td>
<td>CPR</td>
<td></td>
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<tr>
<td>3:15</td>
<td>CPR</td>
<td></td>
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<tr>
<td>3:20</td>
<td>CPR</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:
- Interventions and Responses to Intervention
- Bicarb
- N/15
- Vasopressin
- Propranolol by MD.
I think it's time we upgraded to electronic medical records.

I agree... your chiseling is getting more and more illegible!
Missing/Incomplete Documentation
What to do?

NEVER BACKDATE!
• How many copies are out there?!

Date and time a current addendum
• Current date/time of addendum
• Explain need for addendum (pt off floor, chart not available, previous note lost, you were distracted, etc…)

Implications
• Malpractice liability
• Billing Fraud
• Credibility/professional reputation (especially w/ long delay!)
Addendums

Date/time the Addendum

• Different date/time from the procedure/service date!

Indicate need for addendum

• “Correction required due to…”, e.g., “…misread CBC results.”
• “Chart not available because…”, e.g., “…pt @ CT scan.”
• “Information inadvertently left out …”, e.g., “I forgot.” or “I was distracted.”

Separate signature

• Must be legible!

• Must be legal electronic signature!
COUNSELING/COORDINATION OF CARE DOCUMENTATION (>50% time) Greater than 50% of the visit was spent discussing the following topics; {BILLING BY TIME SPENT: 502045: "results", "management", "risks/benefits", "compliance", "risk reduction"}. The total visit time was {NUMBERS BY 5'S: 501220} minutes.
32 min critical care:

- Critically ill with?
- No hypotension; NE weaned yesterday and no mention of residual vasopressin drip
- No resp insuff - wean O₂ (4LNC) and extubated 11PM previous night!

**Hematologic:**

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>WBC</th>
<th>HCT</th>
<th>HGB</th>
<th>PLT</th>
<th>Coagulation</th>
<th>PT</th>
<th>PT(INR)</th>
<th>PTT</th>
<th>Date/Time</th>
<th>PF4</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/14/2010 11:25</td>
<td>18.33</td>
<td>31.7</td>
<td>10.6</td>
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<td></td>
<td>16.9</td>
<td>1.4</td>
<td>55.1</td>
<td>08/11/2010 19:00</td>
<td>NEG</td>
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<td>08/14/2010 04:39</td>
<td>19.19</td>
<td>32.8</td>
<td>10.6</td>
<td>143</td>
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<td>08/14/2010 03:57</td>
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<td>32.9</td>
<td>10.8</td>
<td>157</td>
<td></td>
<td>17.8</td>
<td>1.5</td>
<td>42.5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Anticoagulation: Aspirin/ Goal: INR PTT DVT Prophylaxis:

**Infectious Disease:** Current antibiotics: Tmax: 101.1°F

**Tubes, Lines, and Drains:** left femoral arterial line D/Ced right radial arterial line day 2/ right internal jugular central venous line day 2/ right femoral pulmonary artery line D/Ced pericardial chest tube day 3/ L pleural chest tube day 3/ ventricular wire day 3/ ? d/c CT later

*** Assessment and Plan by System ***

**Neurological:** Plan: Adequate pain management with dilaudid, RTC APAP.

**Cardiovascular:** hypotension/ chronic ischemic heart disease/
Plan: Will need beta blocker, statin, ASA; Enzymes down, ECG reassuring. Weaning off pressors as tolerated

**Respiratory:** postoperative respiratory insufficiency/
Plan: wean O₂, chest PT, oob, deep breath, cough

**Gastrointestinal:** Plan: ADAT gently.

**Renal:** chronic renal insufficiency/ volume depletion/
Plan: Even Fluid Balance/ albumin 250cc x 1 now, likely will run approx even today.

**Endocrine:** Plan: Continue intravenous insulin therapy/portland protocol

**Hematologic:** Plan: Resume aspirin; relatively elevated HCT c/w low volume status.

**Infectious Disease:** Plan: Perioperative ABX only.

**Tubes, Lines, and Drains:** Plan to D/C today: pericardial chest tube/ L pleural chest tube/

**Disposition:** Will remain in unit/

*** Entered by __________ M.D. on 8/14/_________ ***

*** Signed by __________ M.D. on 8/14/_________ ***

*** ICU Attending Progress Note Addendum ***

This patient developed hypotension/ postoperative respiratory insufficiency/ volume depletion/. I spent 32 minutes providing critical care services to the patient. These services included: hemodynamic management/ fluid management/ physical examination/ reviewing imaging studies/ reviewing laboratory studies/ reviewing patient's condition with consultants/. I reviewed Dr. _______ documentation, and I agree with the physical examination, assessment and plan of care. Time involved in separately billable procedures was not included in my critical care time.

*** Signed by __________ M.D. ID# __________ ***
As a member of our hospital rapid response team (RRT; also medical emergency team, MET) called to a cardiac arrest, I lead a successful resuscitation lasting 8 minutes. I then provide 70 minutes critical care, stabilizing the patient and transporting them to the ICU where other physicians assume the care.

Report which CPT code(s)?

a) only 99291
b) 99291 and 99292
c) only 92950
d) 99291 and 92950
e) 99233 and 99356
As a member of our hospital rapid response team (RRT; also medical emergency team, MET) called to a cardiac arrest, I lead a successful resuscitation lasting 8 minutes. I then provide 70 minutes critical care, stabilizing the patient and transporting them to the ICU where other physicians assume the care. Report which CPT code(s)

a. only 99291
b. 99291 and 99292
c. only 92950
d. 99291 and 92950
e. 99233 and 99356

Correct answer: d. 99291 and 92950
Cardiopulmonary Resuscitation

- CPT 92950
- NOT bundled into 99291 Critical Care
- Physician supervision of resuscitation service
  - Do NOT need to be AHA certified (either CPR or ACLS)
- 000 Global Period procedure
  - Separate procedure note (dated & signed; code form acceptable) from E/M
  - append modifier 25 to E/M
  - No time minimum or maximum
Bill critical care 99291-25:
  - document all history, exam, decision making for good patient care
  - document the critical care diagnosis, service and time
  - your transport time counts
  - affirmatively exclude the code time!

DO NOT bill any 99292:
  - not met the 75 minute minimum threshold
  - must delete any separately reportable procedure time

Bill cardiopulmonary resuscitation 92950:
  - Sign the code sheet or write a procedure note summarizing the code

Contracting and reimbursement issues
  - Often paid shift work – who keeps reimbursements?
Question #2

As the ICU physician receiving this patient, I provide 25 minutes of critical care when the patient has another cardiac arrest. The unsuccessful resuscitation lasts 28 minutes. While still in the ICU, I then call the family and local OPO, complete the death certificate, and dictate the discharge summary.

Report which CPT code(s)?

a) 99233-25 and 92950
b) 99238-25 and 92950
c) 99239-25 and 92950
d) 99291 alone
e) 99291-25 and 92950
As the ICU physician receiving this patient, I provide 25 minutes of critical care when the patient has another cardiac arrest. The unsuccessful resuscitation lasts 28 minutes. While still in the ICU, I then call the family and local OPO, complete the death certificate, and dictate the discharge summary. Report which CPT code(s)?

- 99233-25 and 92950
- 99238-25 and 92950
- 99239-25 and 92950
- 99291 alone
- 99291-25 and 92950

Correct answer: e. 99291-25 and 92950
DISCHARGE DAY - Calendar Day (MN → MN)
Is it 99238 or 99239?

- Cumulative time or start/stop time
- No over-lap/carry-over time
- No time from other procedures
- Must be clearly documented in the chart!
  - 9-9:35 AM; or 40 minutes discharge day time
  - no time documented = only 99238 can be billed!

- 99238 (1.28 RVU; $73*) vs 99239 (1.90 RVU; $107*)
  - 99232 (1.39 RVU; $72*) vs 99233 (2.00 RVU; $104*)

2014 Medicare $
Assuming the calls, forms, etc, take more than 5 min, bill critical care 99291-25:
- document all history, exam, decision making for good patient care
- document all history, exam, decision making for malpractice considerations
- document the critical care diagnosis, service and time
- affirmatively exclude the resuscitation time!

DO NOT bill any 99292:
- not met the 75 minute minimum threshold
- must delete any separately reportable procedure (resuscitation) time

Bill cardiopulmonary resuscitation 92950:
- sign the code sheet or write a procedure note summarizing the code

Discharge Day Management
- becomes part of the critical care service, just like a note on surviving patient
Critical Care Documentation Checklist
5 steps to a great note

• Pt is/remains critically ill, with…
  – List ≥ 1 critical care dx

• Relevant Hx, PE (12 organ systems) and Data
  – Good pt care, reduce malpractice and compliance liability

• I did…
  – What critical care service did you provide?
  – E.g., keep vent the same, continue to titrate drips, etc

• No overlap…
  – …with other providers; or …with separately billable services

• My time
  – Start/stop time(s) or total times
Smoking Cessation Counseling

99406: Smoking and tobacco cessation counseling; intermediate, >3-10 min

99407: Smoking and tobacco cessation counseling; intensive, >10 min

- Up to 2 “attempts”/yr; 4 sessions per “attempt”
- **Must** be the billing provider (physician or NPP), *not* clinical staff
- Document time (total or start/stop), and **co-morbidities/medical necessity**
  ICD-9 diagnosis code provides medical necessity
- Bill in addition to appropriate E&M service; append -25 modifier
- Standardized handout/information often recommended by contractors, not mandated by CMS (or Novitas Solutions in PA)

Pohlig C. Smoking cessation counseling. CHEST 130:1231-3, 2006
Tobacco Cessation Counseling
Medicare Claims

Only 1.75% Inpatient Hospital!
Pulmonary: 9% (4th, after IM, FP, Card)
Smoking Cessation Counseling

- Document time (total or start/stop), and co-morbidities in clinical note
- Bill in addition to appropriate E&M service; append -25 modifier
- Use ICD-9 305.1 (Tobacco use disorder) and co-morbidity w/99406-7
  - eg., DM (250.XX), COPD (496), etc, no longer required

<table>
<thead>
<tr>
<th></th>
<th>CPT</th>
<th>Physician wRVUs</th>
<th>2014 Medicare $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate, &gt;3-10 mins</td>
<td>99406</td>
<td>0.24</td>
<td>$12</td>
</tr>
<tr>
<td>Intensive, &gt;10 mins</td>
<td>99407</td>
<td>0.50</td>
<td>$26</td>
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</table>

Pohlig C. Smoking cessation counseling. CHEST 130:1231-3, 2006
Smoking Cessation Counseling
Smoking Cessation Counseling
Jencks et al. Rehospitalizations among Medicare FFS Pts
NEJM 360: 1418-1428, 2009
Jencks et al. Rehospitalizations among Medicare FFS Pts
NEJM 360: 1418-1428, 2009
Pham et al. PCP Links to Other Physicians

PCP ↔ 229 physicians in 117 practices

Physician A

Patient 1
(primary patient of physician A)

Physician B

Patient 2
(primary patient of physician C)

Physician C

Patient
(primary patient of physician D)

Physician D

Primary pt = physician with plurality of E/M services
Transitional Care Management Services

**CPT 99495 and 99496**

Designed for primary care (esp. PCMH – pt centered medical homes) with goal of reducing readmissions

Report TCM of pt transitioning from facility (inpt hospital, obs status, nursing/SNF) to a home (home, domiciliary, rest home or assisted living)

- d/c to nursing/SNF facilities **not eligible**

Report *once*, by *one* provider, *30 days after* the original d/c date

- need to capture charges (call and visit) yet **delay claim production**

Must have *face-to-face* service by a *provider* (NP, PA, CNS, CNM)

Must have *non-face-to-face* service performed by *clinical practice staff*

Bindman AB, Blum JD, Kronick R. *NEJM* 368: 692-694, 2012
Medicare’s transitional care payment – a step toward the medical home.
Transitional Care Management Services

**CPT 99495 and 99496: Documentation**

**CPT 99495 – Moderate Complexity MDM**

- Communication (direct, telephone, electronic) w/pt and/or caregivers w/in 2 **business** days post-d/c
- MDM of **moderate** complexity during the service period
- Face – to – face visit w/in 14 **calendar** days post-discharge, w/med reconciliation

**CPT 99496 – High Complexity MDM**

- Communication (direct, telephone, electronic) w/pt and/or caregivers w/in 2 **business** days post-d/c
- MDM of **high** complexity during the service period
- Face – to – face visit w/in 7 **calendar** days post-discharge, w/med reconciliation

cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf
Question #3

Which is true regarding Transitional Care Management (TCM)?

a) Intensivists should not report TCM
b) Only the first submitted claim for TCM gets paid
c) Hospital readmission precludes reporting TCM
d) TCM cannot be reported after a readmission
e) Nonphysician providers cannot report TCM
Which is true regarding Transitional Care Management (TCM)?

a. Intensivists should not report TCM
b. Only the first submitted claim for TCM gets paid
c. Hospital readmission precludes reporting TCM
d. TCM cannot be reported after a readmission
e. Nonphysician providers cannot report TCM

- b. Only the first submitted claim for TCM gets paid
Services from clinical practice staff:

- Identification, communication, facilitating access, coordination of home health or other community services

- Pt/family caregiver education for self-management, treatment adherence, medication management

- Can still report after 2 unsuccessful attempts to reach patient if other TCM criteria met
Transitional Care Management Services

CPT 99495 and 99496

Services from provider:

• Review of d/c info, review & f/up on dx tests and therapies
• Interacting w/other providers (specialists) assuming/resuming care of “system specific problems”
• Education of pt/caregiver
• Referrals, arrangements, scheduling, f/up assistance w/providers or community services

Does not prevent providing d/c day services (99238, 99239)
## TCM Code Reimbursement

<table>
<thead>
<tr>
<th>TCM Code Description</th>
<th>CPT</th>
<th>wRVUs</th>
<th>2014 Medicare* $</th>
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</thead>
<tbody>
<tr>
<td>TCM – Moderate Complexity</td>
<td>99495</td>
<td>2.11</td>
<td>$111</td>
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<tr>
<td>Established outpt, mod complexity MDM</td>
<td>99214</td>
<td>1.50</td>
<td>$ 79</td>
</tr>
<tr>
<td>TCM – High Complexity</td>
<td>99496</td>
<td>3.05</td>
<td>$161</td>
</tr>
<tr>
<td>Established outpt, high complexity MDM</td>
<td>99215</td>
<td>2.11</td>
<td>$111</td>
</tr>
</tbody>
</table>

*Non-Medicare coverage varies, often bundled into PCMH demonstrations/pilots
Bundled Services for TCM Services

- Care plan oversight service (99339, 99340, 99374-99380, G0181, G0182)
- Prolonged service w/out direct patient contact (99358-99359)
- Anticoagulant management (99363, 99364)
- Medical team conferences (99366-99368)
- Education and training (98960-98962, 99071, 99078)
- Telephone services (98966-98968, 99441-99443)
- End-stage renal disease services (90951-90970)
Selecting TCM in EPIC...  
...sends charges for claim delay
Two Midnights
OBSERVATION DAYS
Coding Anatomy of A Hospitalization
#1- Same Day Discharge

1. Admit to Observation; *distinct from procedural services!*
2. Discharge (>8 hrs after admit)

Code/Bill Observation Care (99234, 99235, 99236)
- includes admission (1st visit and 1st note)
- includes discharge (2nd visit and 2nd note)
- includes all work in other settings (office, ER, NH, etc) by same physician (provider group)
- requires comprehensive Hx/Exam & separate documentation of discharge (99235, 99236)
OBSERVATION DAYS
Coding Anatomy of A Hospitalization
#2 - Next Day Discharge

MN

MN

MN

OBSERVATION
STATUS

① Admit to observation
  – code/bill Initial Observation (99218, 99219, 99220)
  – requires comprehensive Hx/Exam (99219, 99220)
  – includes all work in other settings (offices, ER, NH, etc) by same physician

② Discharge
  – code/bill Observation Discharge (99217)
  – typically occurs < 24 hours of ① for Hospital Billing
    (may affect provider/professional billing)
INPATIENT STAYS
Coding Anatomy of A Hospitalization
“Two Midnight Rule”

<table>
<thead>
<tr>
<th>MN</th>
<th>MN</th>
<th>MN</th>
<th>Many</th>
<th>MN</th>
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<tbody>
<tr>
<td></td>
<td>Admit for inpatient services</td>
<td>Subsequent Day</td>
<td>Discharge (or Subsequent) Day</td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td>Tuesday</td>
<td>Wednesday</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Monday - Code/Bill Initial Hospital (99221, 99222, 99223)
  - written expectation of inpt services required lasting 2 midnights
Tuesday - Code/Bill Subsequent Hospital (99231, 99232, 99233)
Wednesday - Code/Bill Discharge Day (99238, 99239) or Subsequent Hospital (99231, 99232, 99233)
Goals

- Avoid prolonged observation stays
- Reduce CERT error rates and RAC reviews, confirmed by OIG and DOJ
  - Cardiology services always prominent!

Privileged admitting provider must order admission for inpt services

- Previously, an expectation not present in statute or regulation
- Expect 2 MN required; clock starts with hospital services (including ED and obs care)
- Exception: inpatient-only procedures, transfer, death, leave AMA, invasive ventilation
- Can be resident or NP/PA; must have attending attestation prior to discharge

Effective 10/1/13; enforced after 4/1/14

Upon retrospective review, expected inpt stays can be re-billed as outpt services
(use Condition Code 44 if pre-d/c)


### OBSERVATION DAYS
Coding Anatomy of A Hospitalization

**#5 – Three Day OBS Stay**

<table>
<thead>
<tr>
<th>Observation Status</th>
<th>Subsequent OBS Day</th>
<th>Discharge to Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>Tuesday</td>
<td>Wednesday</td>
</tr>
</tbody>
</table>

Monday - Code/Bill Initial Observation (99218, 99219, 99220)

Tuesday - Code/Bill Subsequent Observation (99224, 99225, 99226)

Wednesday - Code/Bill Observation Discharge (99217)

Thursday – Retro Mon/Tues/Wed to 99221-3/99231-3/99238 after order attesting to need for inpt services!
INPATIENT STAYS

Generated for all ordering providers

Generated only for non-attending admit orders
OBSERVATION DAYS
Coding Anatomy of A Hospitalization
#4 - Next Day Conversion To Admission

<table>
<thead>
<tr>
<th>MN</th>
<th>Admit to Observation Monday</th>
<th>Convert to Hospital Admission Tuesday</th>
<th>Subsequent Days Wednesday</th>
</tr>
</thead>
</table>

Monday - Code/Bill Initial Observation (99218, 99219, 99220)
Tuesday* - Code/Bill Initial Hospital (99221, 99222, 99223)
Wednesday - Code/Bill Subsequent Hospital (99231, 99232, 99233)

* Hospital can begin admission on Monday! Convert Monday/Tuesday to Initial and Subsequent Hospital visits?
Question #4

You are asked to evaluate a young man in the ED. Found down, he arrived comatose, and was intubated for airway protection. He has normal lactate, electrolytes, and noncontrast head. Tox screen is still pending, but he is now making purposeful movements and communicative after 6 hrs in the ED.

Which is the best management?

a) Observe him in the ED another two hours hoping to extubate
b) Extubate and admit him for observation services
c) Admit him for inpatient care in the MICU
d) Decline to evaluate the patient as not critically ill
e) Sedate pending the tox screen results
You are asked to evaluate a young man in the ED. Found down, he arrived comatose, and was intubated for airway protection. He has normal lactate, electrolytes, and noncontrast head. Tox screen is still pending, but he is now making purposeful movements and communicative after 6 hrs in the ED. Which is the best management?

A. Observe him in the ED another two hours hoping to extubate
B. Extubate and admit him for observation services
C. Admit him for inpatient care in the MICU
D. Decline to evaluate the patient as not critically ill
E. Sedate pending the tox screen results
“We’d now like to open the floor to shorter speeches disguised as questions”