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Non-Physician Providers
EVALUATION AND MANAGEMENT SERVICES

DEFINITIONS OF THE HISTORY OF PRESENT ILLNESS ELEMENTS:
Taken from Physician Practice Coder, March 1998

**Location:** Most complaints refer to a specific area of the body for example: abdominal pain, sore throat, knee swelling, etc. **Not every history will always state a location.**

**Quality:** You can describe the pain as dull, stabbing, sharp, radiating, throbbing. Describe a laceration as jagged or straight, or describe a sore throat as scratchy.

**Severity:** Measure pain on a scale of 1-10, with 10 as the highest. You will note from the definition, that severity itself is considered a “quality.” Ask questions like “just how bad is that scratchy throat,” or you might read statements such as “he had so much trouble (with coughing and choking) that he got very frightened.” On the opposite side, you may see “the patient feels really well.”

**Duration:** Typically, statements are made such as “Onset three days ago”, “Since last Monday,” since (date), “for about two months”, “yesterday”, “in the last two weeks”, “approximately one year ago.”

**Timing:** You can use statements such as “recurrent” or “the pain comes and goes”, “continuous”, or “the pain never really seems to go away.” You can use other statements such as “seldom” or “frequently” to describe the regularity of the recurrence may be counted toward timing.

**Context:** It’s the one descriptor that has given auditors the most trouble. Look for statements that describe how a complaint occurred such as: “Injuries incurred in a motor vehicle accident”, “running down the steps”, sitting in a chair”, “playing sports”, etc.

**Modifying Factors:** In many cases this may be the steps your patient has taken to alleviate his/her symptoms. Details may include such examples as “wheezing clears with coughing,” “patient uses ace wrap for support.”

**Associated Signs and Symptoms:** Patients who describe the scratchy throat with nasal congestion and low grade fevers, are describing not only the chief complaint, but also the associated signs and symptoms. Usually these signs and symptoms are volunteered by the patient. Some of the examples could be counted in more than one area. **Keep in mind, however, that you should only count a statement once, regardless upon which descriptor you decide it relates to.**

*Updated July 20, 2000*
Chief Complaint: The Chief Complaint (CC) is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient’s words. (American Medical Association and Health Care Financing Administration, November 1997)

History of Present Illness
(Excerpts taken from CPT Assistant Volume 6, Issue 4, April 1996)

Location: Is the pain diffuse or localized? Is the problem unilateral or bilateral? Is the problem fixed or migratory?

Includes: “left”; “all over”; “right here” (with explanation of the place the patient indicated); a drawing with the location indicated; “renal.”
Excludes: chief complaint without a specific location in the body (e.g., diabetes, hypertension, fatigue)
Hint: The location is often confused with the chief complaint because it is often found in the chief complaint. However, complaints without a specific location that also do not have a manifestation than can be localized are not eligible to use this element of HPI.

Quality: Is the problem sharp, dull, throbbing, stabbing, constant, intermittent, acute, chronic, stable, improving or worsening? How does the problem look, feel, behave?

Includes: “off and on”; “sleeping”; “raised”; “crusty”; “healing”; “non-healing”; “diffuse”
Excludes: “rash is spread 3 inches across abdomen” (may be Severity)
Hint: The “quality” of the presenting problem are the words that describe the problem and vary depending on the type of problem the patient has.

Severity: Have the patient describe the severity of the pain by employing a crude self-assessment scale to measure subjective levels (e.g, 1 to 10, with 1 being no pain and 10 being the worst pain they’ve ever experienced).

Includes: “so much trouble, he felt he could not breathe”; “severe”; “slightly”; “worst I’ve ever had”; “piercing”
Excludes: 
Hint: Look for words that convey just how bad a condition is.

Updated July 20, 2000
**Duration:** How long has the problem been present? When did the symptoms begin?

*Includes:* “1 hour”; “since 10:00”; “happening now”; “started last year”; “all of her life”; “always.”

*Excludes:* “recent”; “off and on” (may be **Quality**)

*Hint:* Look for words that convey a sense of a specific timeframe.

**Timing:** Is the symptom primarily nocturnal, diurnal, or continuous? Has there been a repetitive pattern for the symptom?

*Includes:* “continuous”; “seldom”; “frequently”; “at night”; “after meals”; “before meals” comes and goes”; “after I take medicine”; “after or during exercise”

*Excludes:* words that describe how a complaint occurred (“injuries incurred in a MVA – this would be **Context**).

*Hint:* Look for words that describe where the patient is when the pain/symptom occurs.

**Context:** Are you at rest or involved in an activity when the symptom occurs? Is the symptom aggravated or relieved, or does it recur with a specific activity?

*Includes:* “found on chest x-ray”; “running down steps”; “fell off ladder”; “injuries incurred in a motor vehicle accident”; “sitting in a chair”; “playing sports”; “dairy products”; “big meals”

*Excludes:

*Hint:* Look for situations associated with the pain/symptom, e.g., how the complaint occurred.

**Modifying Factors:** Does eating relieve or exacerbate an abdominal discomfort? Does coughing irritate the pain? Have over-the-counter or prescribed medications been attempted? What were the results?

*Includes:* “wheezing clears with coughing”; “if I eat spicy food, I get heartburn; but if I drink milk afterwards, it isn’t as bad”; “I have migraines, but if I lie down in a quiet room with an ice pack on my head, it helps the pain.”; “I had a trigger point injection 6 weeks ago and that seemed to alleviate the pain.”; “Advil relieves my backache.”

*Excludes:

*Hint:* Things done to make the symptom/pain worse or better.

**Associated Signs and Symptoms:** What are some additional sensations or feelings you’re experiencing with your compliant?

*Includes:* “chest pain leads to shortness of breath”; “headache leads to vision constriction”;

“patient with (scratchy sore throat) has nasal congestion and low grade fever”

*Excludes:

*Hint:* Look for other things that happen when the symptom/pain occurs.

*Updated July 20, 2000*
A Review of Systems (ROS) is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the patient may be experiencing or has experienced.

A problem pertinent ROS inquires about the system directly related to the problem(s) identified in the HPI.

- **DG:** The patient’s positive responses and pertinent negatives for the system related to the problem should be documented.

An extended ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

- **DG:** The patient’s positive responses and pertinent negatives for two to nine systems should be documented.

A complete ROS inquires about the system(s) directly related to the problem(s) identified in the HPI plus all additional body systems.

- **DG:** At least ten organ systems must be reviewed. Those systems with positive or pertinent negative responses must be individually documented. For the remaining systems, a notation indicating all other systems are negative is permissible. In the absence of such a notation, at least ten systems must be individually documented.

When you audit a review of systems (ROS), you should look for statements such as additional signs and symptoms to determine the extent and complexity of the patient’s problems. The second component piece of the history can be difficult to distinguish.

Here’s a list of the typical questions you should check to see if the physician asked during the review of questions.

**Hint:** Look for statements such as “patient denies”; “patient complains of…” This is information that the patient is offering the physician. The physician is not finding this information on his/her exam.

**Constitutional:** Asking the patient about any unusual symptoms or problems they’ve experienced, such as excessive fatigue exercise intolerance, fever, weakness, night sweats, weight loss, etc.

**Eyes:** Finding out the date of the patients last eye examination; when they were last checked for glaucoma (patient over 50); the history of any eye infections or injury. Have they used corrective lenses; is there any eye discharge, itching, excessive tearing or pain, any spots or floaters. Is there any history of glaucoma or cataracts?

*Updated July 20, 2000*
**Ear, Nose, Throat and Mouth:** Includes questions regarding the date and results of the last hearing test, sensitivity to noise, ear pain, ringing in the ear, history of ear infections, any vertigo, etc. Having the patient describe any history of nose bleeds, post nasal drip, frequent sneezing, frequent nasal drainage (note amount and color), impaired ability to smell, etc. Does the patient complain of any history of sore throats, a current or past lesion in the mouth, history of oral herpes infections, update of last dental exam, a overall description of dental health, etc.

**Cardiovascular:** Is the patient having any chest pains, palpitations, heart murmurs, irregular pulse, or hypertension? Does the patient need to sit in a particular position to breathe, any coldness or numbness in extremities, color changes in fingers or toes, edema, leg pain when walking or any hair loss on legs?

**Respiratory:** Asking the patient about history of asthma or other breathing problems, a chronic cough, hemoptysis, breathing problems after exercise, sputum production (note color and amount), wheezy or noisy respiration’s, and any history of bronchitis or pneumonia.

**Gastrointestinal:** Asking the patient about indigestion or pain associated with eating, history of hematemesis, any burning sensation in the esophagus, frequent nausea and/or vomiting, history of liver disease or Jaundice, history of gallbladder disease, abdominal swelling or ascites, changes in bowel habits, stool characteristics, history of diarrhea or constipation, a history of hemorrhoids, use of digestive aids or laxatives, date and result of last hemoccult exam (for patients over 50).

**Genitourinary:** Does the patient have painful urination, urine characteristics, patterns in urination, a hesitancy starting stream, changes in urine stream, history of any renal calculi or flank pain, hematuria, history of decreased or increased urine output, dribbling, incontinence, frequent urination at night, for children: toilet training or bed wetting.

**Musculoskeletal:** Does the patient have a history of fractures: muscle cramping, twitching or pain, weakness, limitations on walking, running or participation in sports. Any joint swelling redness or pain, a joint deformity, a joint stiffness, noise with joint movement, a spinal deformity, chronic back pain, interference with activities of daily living.

**Integumentary:** Does the patient have any known skin diseases? Any itching, skin reactions to hot/cold, the presence of scars, moles, sores, color changes of lesions, changes in nail color or texture. The date and result of last mammogram and/or breast exam, pattern of self examination, any breast pain, tenderness or swelling, any nipple discharge or changes, or history of breast feeding.

**Neurological:** Does the patient have a history of fainting or unconsciousness, history of seizures or anticonvulsant therapy, a history of memory loss, hallucinations, disorientation, speech or language dysfunction, inability to concentrate, history of sensory disturbances history of motor disturbances, any interference of daily living?

*Updated July 20, 2000*
**Psychiatric:** Does the patient have any history of psychiatric conditions or treatment?

**Endocrine:** Does the patient have a history of endocrine disease such as thyroid disease, adrenal problems or diabetes, unexplained changes in height and/or weight, increased appetite, thirst or urinary output, heat or cold intolerance? A history of goiter, unexplained weakness, previous or current hormone therapy, changes in hair distribution or skin pigmentation?

**Hematologic/Lymphatic:** Does the patient have any history of anemia, bleeding tendencies, easy bruising or fatigue, low platelet count, a history of blood transfusion, unexplained granular swelling, a history of systemic infections.

*Updated July 20, 2000*
**Past, Family and/or Social History (PFSH)**

The PFSH consists of a review of three areas:

- **Past history** (the patient’s past experiences with illnesses, operations, injuries and treatments);

- **Family history** (a review of medical events in the patient’s family, including diseases which may be hereditary or place the patient at risk); and

- **Social history** (an age appropriate review of past and current activities).

For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care.

A **pertinent** PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

- **DG:** At least one specific item from any of the three history areas must be documented for a pertinent PFSH.

A **complete** PFSH is a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

- **DG:** At least one specific item from two of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; domiciliary care, established patient; and home care, established patient.

- **DG:** At least one specific item from each of the three history areas must be documented for a complete PFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care - new patient; and home care - new patient.

*Updated July 20, 2000*
**MISCELLANEOUS QUESTIONS AND ANSWERS**

Q. **Associated Signs & Symptoms:** Can you count a pertinent positive/negative related to the patient’s problem in Review of System?
A. Yes.

Q. **When can you caveat the entire history?**
A. You can give a comprehensive history when the patient is intubated, unconscious, or unable to give the physician a history. If there is documentation that a family member is present, then look for a notation that they are unable to provide further historical information. (The physician must indicate in the documentation the reason the patient is unable to give a history.)

Q. **Can a ROS and/or PFSH be used from a previous encounter?**
A. Yes. A ROS and/or PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information (“incorporating by reference”). This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:
- Describing any new ROS and/or PFSH information or noting there has been no change in the information.
- Noting the date and location of the earlier ROS and/or PFSH with a provider signature.

Q. **Can someone record the patient’s history other than the physician?**
A. The ROS and/or PFSH may be recorded by ancillary staff/resident/student or on a form completed by the patient. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others from the physician.

Q. **What can you count in the Social History?**
A. Anything pertaining to the patient’s social life (i.e. marriage information, pets, home, occupation, children, etc)

Q. **Can we count the “Allergies” sticker on the front of the chart?**
A. If the physician properly documents to “see front of chart for allergies”
Physical Examination
1995 Rules

The Body Areas OR the Organ Systems are to be used for the examination but auditor may NOT cross over between the two categories.

- Seven Body Areas
  - Head, including face
  - Neck or thyroid
  - Chest, including breasts and axillae
  - Abdomen
  - Genitalia, groin, buttocks
  - Back, including spine
  - Each extremity

- Twelve Organ Systems
  - Constitutional
  - Eyes
  - Ears, nose, mouth, throat or thyroid
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Genitourinary
  - Musculoskeletal
  - Skin
  - Neurologic
  - Psychiatric
  - Hematologic/lymphatic/

Content and Documentation Requirements

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<th>Level</th>
<th>Description</th>
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<td>Expanded Problem Focused</td>
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<td>Detailed</td>
<td>5 – 7 body areas or systems including affected area</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>8 or more systems</td>
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*Updated November 1, 2000*
General Multi-System Examination

1997 Rules
System/Body Area
Elements of Examination

• Constitutional
  Measurement of any three of the following seven vital Signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)

  General appearance of patient (eg, development, nutrition, body habits, deformities, attention to grooming, in no acute distress)

• Eyes
  Inspection of conjunctivae and lids

  Examination of pupils and irises (eg, reaction to light and accommodation, size and symmetry)

  Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)

• Ears, Nose, Mouth & Throat
  External inspection of ears and nose (eg, overall appearance, scars, lesions, masses)

  Otoscopic examination of external auditory canals and tympanic membranes

  Assessment of hearing (eg, whispered voice, finger rub, tuning fork)

  Inspection of nasal mucosa, septum and turbinates

  Inspection of lips, teeth and gums

  Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx

Updated July 20, 2000
• **Neck**
  Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)
  Examination of thyroid (eg, enlargement, tenderness, mass)
• **Respiratory**
  Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)
  Percussion of chest (eg, dullness, flatness, hyperresonance)
  Palpation of chest (eg, tactile fremitus)
  Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
• **Cardiovascular**
  Palpation of heart (eg, location, size, thrills)
  Auscultation of heart with notation of abnormal sounds and murmurs
  Examination of:
  - Carotid arteries (eg, pulse amplitude, bruits)
  - Abdominal aorta (eg, size, bruits)
  - Femoral arteries (eg, pulse amplitude, bruits)
  - Pedal pulses (eg, pulse amplitude)
  - Extremities for edema and/or varicosities
• **Chest (Breasts)**
  Inspection of breasts (eg, symmetry, nipple discharge)
  Palpation of breasts and axillae (eg, masses or lumps, tenderness)

*Updated July 20, 2000*
• **Gastrointestinal**  
  *(Abdomen)*  
  Examination of abdomen with notation of presence of masses or tenderness  
  Examination of liver and spleen  
  Examination for presence or absence of hernia  
  Examination of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses  
  Obtain stool sample for occult blood test when indicated

• **Genitourinary**  
  **MALE:**  
  Examination of the scrotal contents (eg, hydrocele, spermatocele, tenderness of cord, testicular mass)  
  Examination of penis  
  Digital rectal examination of prostate gland (eg, size, symmetry, nodularity, tenderness)

**FEMALE:**  
Pelvic examination (with or without specimen collection for smears and cultures), including  
  ✓ Examination of external genitalia (eg, general appearance, hair distribution, lesions) and vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)  
  ✓ Examination of urethra (eg, masses, tenderness, scarring)  
  ✓ Examination of bladder (eg, fullness, masses, tenderness)  
  ✓ Cervix (eg, general appearance, lesions, discharge)  
  ✓ Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support)  
  ✓ Adenxa/parametria (eg, masses, tenderness, organomegaly, nodularity)
• **Lymphatic**

Palpation of lymph nodes in **two or more** areas:

- Neck
- Axillae
- Groin
- Other

• **Musculoskeletal**

Examination of gait and station

Inspection and/or palpation of digits and nails (eg, clubbing, cyanosis, inflammatory conditions, petechiae, infections, nodes)

Examination of joints, bones, muscles of **one or more of the following six** areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes:

- Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions

- Assessment of range of motion of any pain, crepitation or contracture

- Assessment of stability with notation of any dislocation (luxation), subluxation or laxity

- Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements

*Updated July 20, 2000*
• **Skin**
  Inspection of skin and subcutaneous tissue (eg, rashes, Lesions, ulcers)
  Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening)

• **Neurologic**
  Test cranial nerves with notation of any deficits
  Examination of deep tendon reflexes with notation of pathological reflexes (eg, Babinski)
  Examination of sensation (eg, by touch, pin, vibration, proprioception)

• **Psychiatric**
  Description of patient’s judgment and insight
  Brief assessment of mental status including:
  ✓ Orientation to time, place and person
  ✓ Recent and remote memory
  ✓ Mood and affect (eg, depression, anxiety, agitation)

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**Content and Documentation Requirements**

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<tr>
<th><strong>Level of exam</strong></th>
<th><strong>Perform and Document</strong></th>
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<td><strong>One to five</strong> elements identified by a bullet</td>
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<tr>
<td>Expanded Problem Focused</td>
<td><strong>At least six</strong> elements identified by a bullet</td>
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<tr>
<td>Detailed</td>
<td><strong>At least two</strong> elements identified by a bullet from each of six areas/systems OR at least twelve elements identified by a bullet in two or more areas/systems.</td>
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<tr>
<td>Comprehensive</td>
<td>Perform all elements identified by a bullet in at least nine organ systems or body areas and document at least two elements identified by a bullet from each of nine areas/systems.</td>
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</tbody>
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*Updated July 20, 2000*
**Single-Specialty Examinations**

**Cardiovascular Examination**

**Constitutional:**
- Measurement of *any three of the following seven* vitals signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)
- General appearance of the patient (eg, development, nutrition, body habitus, deformities, attention to grooming, *in no acute distress*)

**Eyes:**
- Inspection of conjunctivae and lids (eg, xanthelasma)

**Ears, Nose, Mouth and Throat:**
- Inspection of teeth, gums and palate
- Inspection of oral mucosa with notation of presence of pallor or cyanosis

**Neck:**
- Examination of jugular veins (eg, distension; a, v or cannon a waves)
- Examination of thyroid (eg, enlargement, tenderness, mass)

**Respiratory:**
- Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)

**Cardiovascular:**
- Palpation of heart (eg, location, size and forcefulness of the point of maximal impact; thrills; lifts; palpable S3 or S4)
- Auscultation of heart including sounds, abnormal sounds and murmurs
- Measurement of blood pressure in two or more extremities when indicated (eg, aortic dissection, coarctation)

Examination of:
- Carotid arteries (eg, waveform, pulse amplitude, bruits, apical-carotid delay)
- Abdominal aorta (eg, size, bruits)
- Femoral arteries (eg, pulse amplitude, bruits)
- Pedal pulses (eg, pulse amplitude)
- Extremities for peripheral edema and/or varicosities

**Gastrointestinal (Abdomen):**
- Examination of abdomen with notation of presence of masses or tenderness
- Examination of liver and spleen
- Obtain stool sample for occult blood from patients who are being considered for thrombolytic or anticoagulant therapy

*Updated July 20, 2000*
Cardiovascular Examination – cont -

Musculoskeletal:
- Examination of the back with notation of kyphosis or scoliosis
- Examination of gait with notation of ability to undergo exercise testing and/or participation in exercise programs
- Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements

Extremities:
- Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, Osler’s nodes)

Skin:
- Inspection and/or palpation of skin and subcutaneous tissue (eg, stasis dermatitis, ulcers, scars, xanthomas)

Neurological/Psychiatric:
Brief assessment of mental status including:
- Orientation to time, place and person
- Mood and affect (eg, depression, anxiety, agitation)

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<td><strong>Perform</strong> all elements identified by a bullet; document <strong>every element in the shaded border</strong>, and at least one element in an unshaded border</td>
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Updated July 20, 2000
Ears, Nose and Throat Examination

Constitutional:
- Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured by ancillary staff)
- General appearance of patient (in no acute distress)
- Assessment of ability to communicate (eg, use of sign language or other

Head and Face:
- Inspection of head and face (eg, overall appearance, scars, lesions and masses)
- Palpation and/or percussion of face with notation of presence or absence of sinus tenderness
- Examination of salivary glands
- Assessment of facial strength

Eyes:
- Test ocular motility including primary gaze alignment

Ears, Nose, Mouth and Throat:
- Otoscopic examination of external auditory canals and tympanic membranes including pneumo-otoscopy with notation of mobility of membranes
- Assessment of hearing with tuning forks and clinical speech reception thresholds (eg, whispered voice, finger rub)
- External inspection of ears and nose (eg, overall appearance, scars, lesions and masses)
- Inspection of nasal mucosa, septum and turbinates
- Inspection of lips, teeth and gums
- Examination of oropharynx: oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx (eg, asymmetry, lesions, hydration of mucosal surfaces)
- Inspection of pharyngeal walls and pyriform sinuses (eg, pooling of saliva, asymmetry, lesions)
- Examination by mirror of larynx including the condition of the epiglottis, false vocal cords, true vocal cords and mobility of larynx (Use of mirror not required in children)
- Examination by mirror of nasopharynx including appearance of the mucosa, adenoids, posterior choanae and eustachian tubes (Use of mirror not required in children)

Neck:
- Examination of the neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)
- Examination of thyroid (eg, enlargement, tenderness, mass)
**Respiratory:**
- Inspection of chest including symmetry, expansion and/or assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement).
- Auscultation of lungs (e.g., breath sounds, adventitious sounds, rubs)

**Cardiovascular:**
- Auscultation of heart with notation of abnormal sounds and murmurs
- Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness)

**Lymphatic:**
- Palpation of lymph nodes in neck, axillae, groin and/or other location

**Neurological/Psychiatric**
- Test cranial nerves with notation of any deficits
- Brief assessment of mental status including
  - Orientation to time, place and person,
  - Mood and affect (e.g., depression, anxiety, agitation)

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*Updated July 20, 2000*
Eye Specialty Examination

Eyes:
- Test visual acuity (does not include determination of refractive error)
- Gross visual field testing by confrontation
- Test ocular motility including primary gaze alignment
- Inspection of bulbar and palpebral conjunctivae
- Examination of ocular adnexae including lids (eg, ptosis or lagophthalmos), lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes
- Examination of pupil and irises including shape, direct and consensual reaction (afferent pupil), size (eg, anisocoria) and morphology
- Slit lamp examination of the corneas including epithelium, stroma, endothelium, and tear film
- Slit lamp examination of the anterior chambers including depth, cells and flare
- Slit lamp examination of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus
- Measurement of intraocular pressures (except in children and patients with trauma or infectious disease)

Ophthalmoscopic examination through dilated pupils (unless contraindicated) of
- Optic discs including size, C/D ratio, appearance (eg, atrophy, cupping, tumor elevation) and nerve fiber layer
- Posterior segments including retina and vessels (eg, exudates and hemorrhages)

Neurological/Psychiatric:
Brief assessment of mental status including
- Orientation to time, place and person
- Mood and affect (eg, depression, anxiety, agitation)

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Updated July 20, 2000
Genitourinary Examination

**Constitutional:**
- Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)
- General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming, *no acute distress*)

**Neck:**
- Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)
- Examination of thyroid (eg, enlargement, tenderness, mass)

**Respiratory:**
- Assessment of respiratory effort (eg, intercostal re retractions, use of accessory muscles, diaphragmatic movement)
- Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)

**Cardiovascular:**
- Auscultation of heart with notation of abnormal sounds and murmurs
- Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)

**Chest (Breasts):**
[See genitourinary (female)]

**Gastrointestinal (Abdomen):**
- Examination of abdomen with notation of presence of masses or tenderness
- Examination for presence or absence of hernia
- Examination of liver and spleen
- Obtain stool sample for occult blood test when indicated

**Genitourinary:**

**MALE:**
- Inspection of anus and perineum
- Examination (with or without specimen collection for smears and cultures) of genitalia including:
  - Scrotum (eg, lesions, cysts, rashes)
  - Epididymides (eg, size, symmetry, masses)
  - Testes (eg, size, symmetry, masses)
  - Urethral meatus (eg, size, location, lesions, discharge)
  - Penis (eg, lesions, presence or absence of foreskin, foreskin retractability, plaque, masses, scarring, deformities)
Genitourinary Examination – cont -

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<td>- Prostate gland (eg, size, symmetry, nodularity, tenderness)</td>
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<td>- Seminal vesicles (eg, symmetry, tenderness, masses, enlargement)</td>
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<td>- Sphincter tone, presence of hemorrhoids, rectal masses</td>
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**FEMALE:**
Includes at least seven of the following eleven elements identified by bullets:

- Inspection and palpation of breasts (eg, masses or lumps, tenderness, symmetry, nipple discharge)
- Digital rectal examination including sphincter tone, presence of hemorrhoids, rectal masses
- Pelvic examination (with or without specimen collection for smears and cultures) including:
  - External genitalia (eg, general appearance, hair distribution, lesions)
  - Urethral meatus (eg, size, location, lesions, prolapse)
  - Urethra (eg, masses, tenderness, scarring)
  - Bladder (eg, fullness, masses, tenderness)
  - Vagina (eg, general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)
  - Cervix (eg, general appearance, lesions, discharge)
  - Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support)
  - Adenexa/parametria (eg, masses, tenderness, organomegaly, nodularity)
  - Anus and perineum

**Lymphatic:**
- Palpation of lymph nodes in neck, axillae, groin and/or other location

**Skin:**
- Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)

**Neurological/Psychiatric:**
Brief assessment of mental status including:
- Orientation (eg, time, place and person) and
- Mood and affect (eg, depression, anxiety, agitation)

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*Updated July 20, 2000*
**Hematologic/Lymphatic/Immunologic Examination**

**Constitutional:**
- Measurement of *any three of the following seven* vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)
- General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)

**Head and Face:**
- Palpation and/or percussion of face with notation of presence or absence of sinus tenderness

**Eyes:**
- Inspection of conjunctivae and lids

**Ears, Nose, Mouth and Throat:**
- Otoscopic examination of external auditory canals and tympanic membranes
- Inspection of nasal mucosa, septum and turbinates
- Inspection of teeth and gums
- Examination of oropharynx (eg, oral mucosa, hard and soft palate, tongue, tonsils, posterior pharynx)

**Neck:**
- Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)
- Examination of thyroid (eg, enlargement, tenderness, mass)

**Respiratory:**
- Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)

**Cardiovascular:**
- Auscultation of heart with notation of abnormal sounds and murmurs
- Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)

**Gastrointestinal (Abdomen):**
- Examination of abdomen with notation of presence of masses or tenderness
- Examination of liver and spleen

**Lymphatic:**
- Palpation of lymph nodes in neck, axillae, groin, and/or other location

*Updated July 20, 2000*
Hematologic/Lymphatic/Immunologic Examination –cont. –

Extremities:
- Inspection and palpation of digits and nails (e.g. clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)

Skin:
- Inspection and/or palpation of skin and subcutaneous tissue (e.g. rashes, lesions, ulcers, ecchymoses, bruises)

Neurological/Psychiatric:
Brief assessment of mental status including
- Orientation to time, place and person
- Mood and affect (e.g. depression, anxiety, agitation)

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Updated July 20, 2000
## Musculoskeletal Examination

### Constitutional:
- Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)
- General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming, *in no acute distress*)

### Cardiovascular:
- Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)

### Lymphatic:
- Palpation of lymph nodes in neck, axillae, groin and/or other location

### Musculoskeletal:
- Examination of gait and station
- Examination of joint(s), bone(s) and muscle(s)/tendon(s) of **four of the following six** areas: 1) head and neck, 2) spine, ribs and pelvis, 3) right upper extremity, 4) left upper extremity, 5) right lower extremity, 6) left lower extremity. The examination of a given area includes:
  - Inspection, percussion and/or palpation with notation of any misalignment, asymmetry, crepitation, defects, tenderness, masses or effusions
  - Assessment of range of motion with notation of any pain (eg, straight leg raising), crepitation or contracture
  - Assessment of stability with notation of any dislocation (luxation), subluxation or laxity
  - Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements

**NOTE:** For the comprehensive level of examination, all four of the elements identified by a bullet must be performed and documented for each of four anatomic areas. For the three lower levels of examination, each element is counted separately for each body area. For example, assessing range of motion in two extremities constitutes two elements.

### Extremities:
- [See Musculoskeletal and skin]

### Skin:
- Inspection and/or palpation of skin and subcutaneous tissue (eg, scars, rashes, lesions, café-au-lait spots, ulcers) in **four of the following six** areas: 1) head and neck, 2) trunk, 3) right upper extremity, 4) left upper extremity, 5) right lower extremity, 6) left lower extremity.

*Updated December 7, 2000*
NOTE: For the comprehensive level, the examination of all four anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of two extremities constitute two elements.

Neurological/Psychiatric:
- Test coordination (e.g., finger/nose, heel/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)
- Examination of deep tendon reflexes and/or nerve stretch test with notation of pathological reflexes (e.g., Babinski)
- Examination of sensation (e.g., by touch, pin, vibration, proprioception)

Brief assessment of mental status including
- Orientation to time, place and person
- Mood and affect (e.g., depression, anxiety, agitation)

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*Updated July 20, 2000*
## Neurologic Examination

### Constitutional:
- Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)
- General appearance of the patient (eg, development, nutrition, body habitus, deformities, attention to grooming, *no acute distress*)

### Eyes:
- Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages)

### Cardiovascular:
- Examination of carotid arteries (eg, pulse amplitude, bruits)
- Auscultation of heart with notation of abnormal sounds and murmurs
- Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)

### Musculoskeletal:
- Examination of gait and station
- Assessment of motor function including:
  - Muscle strength in upper and lower extremities
  - Muscle tone in upper and lower extremities, (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (eg, fasciculation, tardive dyskinesia)

### Extremities:
[See Musculoskeletal]

### Neurological:
- Evaluation of higher integrative functions including:
  - Orientation to time, place and person
  - Recent and remote memory
  - Attention span and concentration
  - Language (eg, naming objects, repeating phrases, spontaneous speech)
  - Fund of knowledge (eg, awareness of current events, past history, vocabulary)

Test the following cranial nerves:
- 2\textsuperscript{nd} cranial nerve (eg, visual acuity, visual fields, fundi)
- 3\textsuperscript{rd}, 4\textsuperscript{th} and 6\textsuperscript{th} cranial nerves (eg, pupils, eye movements)
- 5\textsuperscript{th} cranial nerve (eg, facial sensation, corneal reflexes)
- 7\textsuperscript{th} cranial nerve (eg, facial symmetry, strength)
- 8\textsuperscript{th} cranial nerve (eg, hearing with tuning fork, whispered voice and/or finger rub)

*Updated July 20, 2000*
Neurological Examination –cont-

- 9th cranial nerve (eg, spontaneous or reflex palate movement)
- 11th cranial nerve (eg, shoulder shrug strength)
- 12th cranial nerve (eg, tongue protrusion)
- Examination of sensation 9eg, by touch, pin, vibration, proprioception)
- Examination of deep tendon reflexes in upper and lower extremities with notation of pathological reflexes (eg, Babinski)
- Test coordination (eg, finger/nose, heal/knee/shin, rapid alternating movements in the upper and lower extremities, evaluation of fine motor coordination in young children)

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Updated July 20, 2000
Psychiatric Examination

**Constitutional:**
- Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)
- General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming, no acute distress)

**Musculoskeletal:**
- Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
- Examination of gait and station

**Psychiatric:**
- Description of speech including: rate, volume, articulation, coherence, and spontaneity with notation of abnormalities (eg, perseveration, paucity of language)
- Description of thought processes including: rate of thoughts, content of thoughts (eg, logical vs. illogical, tangential), abstract reasoning, and computation
- Description of association (eg, loose, tangential, circumstantial, intact)
- Description of abnormal or psychotic thoughts including: hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, and obsessions)
- Description of the patient’s judgment (eg, concerning everyday activities and social situations) and insight (eg, concerning psychiatric condition)

Complete mental status examination including:
- Orientation to time, place and person
- Recent and remote memory
- Attention span and concentration
- Language (eg, naming objects, repeating phrases)
- Fund of knowledge (eg, awareness of current events, past history, vocabulary)
- Mood and affect (eg, depression, anxiety, agitation, hypomania, lability)

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*Updated July 20, 2000*
### Respiratory Examination

**Constitutional:**
- Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)
- General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming, *no acute distress*)

**Ears, Nose, Mouth and Throat:**
- Inspection of nasal mucosa, septum and turbinates
- Inspection of the teeth and gums
- Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx)

**Neck:**
- Examination of the neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)
- Examination of the thyroid (eg, enlargement, tenderness, mass)
- Examination of jugular veins (eg, distension; a, v or cannon a waves)

**Respiratory:**
- Inspection of chest with notation of symmetry and expansion
- Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Percussion of chest (eg, dullness, flatness, hyperresonance)
- Palpation of chest (eg, tactile fremitus)
- Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)

**Cardiovascular:**
- Auscultation of heart including sounds, abnormal sounds and murmurs
- Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)

**Gastrointestinal (Abdomen):**
- Examination of abdomen with notation of presence of masses or tenderness
- Examination of liver and spleen

**Lymphatic:**
- Palpation of lymph nodes in neck, axillae, groin and/or other location

**Musculoskeletal:**
- Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy and abnormal movements
- Examination of gait and station

*Updated July 20, 2000*
Respiratory Examination –cont. -

**Extremities:**
- Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)

**Skin:**
- Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)

**Neurological/Psychiatric:**
Brief assessment of mental status including
- Orientation to time, place and person
- Mood and affect (e.g., depression, anxiety, agitation)

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*Updated July 20, 2000*
Skin Examination

**Constitutional:**
- Measurement of **any three of the following seven** vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff)
- General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming, *no acute distress*)

**Eyes:**
- Inspection of conjunctivae and lids

**Ears, Nose, Mouth and Throat:**
- Inspection of lips, teeth and gums
- Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx)

**Neck:**
- Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (eg, pulses, temperature, edema, tenderness)

**Gastrointestinal (Abdomen):**
- Examination of liver and spleen
- Examination of anus for condyloma and other lesions

**Lymphatic:**
- Palpation of lymph nodes in neck, axillae, groin and/or other location

**Extremities:**
- Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)

**Skin:**
- Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated) and extremities
- Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers, susceptibility to and presence of photo damage) in **eight of the following ten** areas:
  - Head, including face
  - Neck
  - Chest, including breasts and axillae
  - Abdomen
  - Genitalia, groin, buttocks
  - Back

*Updated July 20, 2000*
Skin examination –cont.-

- Right upper extremity
- Left upper extremity
- Right lower extremity
- Left lower extremity

**NOTE:** For the comprehensive level, the examination of at least eight anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of the right upper extremity and the left upper extremity constitute two elements.

- Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidroses or bromhidrosis

**Neurological/Psychiatric:**
Brief assessment of mental status including:
- Orientation to time, place and person
- Mood and affect (eg, depression, anxiety, agitation)

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*Updated July 20, 2000*
Examination Questions and Answers

1. Can you count nurse vitals located on the same page if MD does not reference? What if they are on a different page with no reference?

   Yes, if they are on the same page and you can clearly tell it’s the correct date of service. If they are on different pages, the doctor MUST reference them for them to be counted.

2. If MD documents extremities (pleural) normal is a bullet given?

   One bullet is given. (Can count in either Musculoskeletal or Cardiovascular)

3. If the provider documents “Alert & Oriented” do I give a Psych bullet?

   In order to receive the psych bullet, orientation to time, place and person must all be documented. (E.g., Oriented x 3)

4. Where would I give credit for the provider stating “Patient is in no acute distress”?

   That statement would qualify under General Appearance/Constitutional.

5. Where is the thyroid examination given in the 1995 exam?

   Medicare Reviewers will put it under Neck (body area) for 1995, but may also use it in the ENMT for 1995 (organ system). They WILL NOT however, put it in Hematologic/Lymphatic.

6. Where do I put “Jugular Venous Distension” under the 1995 guidelines?

   Under 1995 the bullet would count under Neck (body area) or Cardiovascular (organ system).

7. How should the provider document that the patient actually refused to have that part of the exam performed?

   The proper terminology that should be used is “DECLINED”. If the patient ‘declines examination’ of a certain area, the provider is allowed a bullet for that area because they would have examined that area had it not been for the patient’s refusal. If the documentation states that the GU system was deferred, then the provider does NOT receive a bullet. DECLINED mean refused, DEFERRED mean physician chose not to perform.

8. Where would ‘head atraumatic, normocephalic’ be counted under examination?

   You may count it as a musculoskeletal examination bullet.

9. If the statement ‘Resp: Right to Left Normal’ appears in the medical record would it constitute an examine bullet as Respiratory Effort under 1997 guidelines?

   Yes. This sufficiently describes that the provider is looking to see how much effort is involved in the patient’s breathing.

10. Can I give credit for “No signs of Meningitis”?

    Because meningitis is a problem of the neurological system, the bullet could be counted as a Neurological examination bullet.

*Updated July 30, 2001*
Documentation of the Complexity of Medical Decision Making

The levels of E/M services recognize four types of medical decision making (straightforward, low complexity, moderate complexity and high complexity). Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered;
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed and analyzed; and
- The risk of significant complications, morbidity and/or mortality, as well as comorbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s) and/or the possible management options.

The chart below shows the progression of the elements required for each level of medical decision making. To qualify for a given type of decision making, **two of the three elements in the table must be either met or exceeded.**

<table>
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<th>Amount and/or complexity of data to be reviewed</th>
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<tr>
<td>Minimal</td>
<td>Minimal or None</td>
<td>Minimal</td>
<td><strong>Straightforward</strong></td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Low</td>
<td><strong>Low Complexity</strong></td>
</tr>
<tr>
<td>Multiple</td>
<td>Moderate</td>
<td>Moderate</td>
<td><strong>Moderate Complexity</strong></td>
</tr>
<tr>
<td>Extensive</td>
<td>Extensive</td>
<td>High</td>
<td><strong>High Complexity</strong></td>
</tr>
</tbody>
</table>

Each of the elements of medical decision making is described below:

*Updated July 20, 2000*
 NUMBER OF DIAGNOSES OR MANAGEMENT OPTIONS

The number of possible diagnoses and/or the number of management options that must be considered is based on the number and types of problems addressed during the encounter, the complexity of establishing a diagnosis and the management decisions that are made by the physician.

Generally, decision making with respect to a diagnosed problem is easier than that for an identified but undiagnosed problem. The number and type of diagnostic tests employed may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those that are worsening or failing to change as expected. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

➢ DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

• For a presenting problem with an established diagnosis the record should reflect whether the problem is: a) improved, well controlled, resolving or resolved; or, b) inadequately controlled, worsening, or failing to change as expected.

• For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of differential diagnoses or as a “possible”, “probable”, or “rule out” (R/O) diagnosis.

➢ DG: The initiation of, or changes in, treatment should be documented. Treatment includes a wide range of management options including patient instruction, nursing instruction, therapies, and medications.

➢ DG: If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral or consultation is made or from whom the advice is requested.

Updated July 20, 2000
AMOUNT AND/OR COMPLEXITY OF DATA TO BE REVIEWED

The amount and complexity of data to be reviewed is based on the types of diagnostic testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount and complexity of data to be reviewed.

Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion, the physician who ordered a test may personally review the image, tracing or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

- **DG:** If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, e.g., lab or x-ray, should be documented.

- **DG:** The review of lab, radiology and/or other diagnostic tests should be documented. A simple notation such as “WBC elevated” or “chest x-ray unremarkable” is acceptable. Alternatively, the review may be documented by initialing and dating the report containing the test results.

- **DG:** A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented.

- **DG:** Relevant findings from the review of old records, and/or the receipt of additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of “Old records reviewed” or “additional history obtained from family” without elaboration is insufficient.

- **DG:** The results of discussion of laboratory, radiology or other diagnostic tests with the physician who performed or interpreted the study should be documented.

- **DG:** The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.
RISK OF SIGNIFICANT COMPLICATIONS, MORBIDITY, AND/OR MORTALITY

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

- **DG:** Comorbidities/underlying diseases or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.

- **DG:** If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure, e.g., laparoscopy, should be documented.

- **DG:** If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented.

- **DG:** The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

The following table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is minimal, low, moderate, or high. Because the determination of risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. The assessment of risk of the presenting problem(s) is based on the risk related to the disease process anticipated between the present encounter and the next one. The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment. The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines the overall risk.

*Updated July 20, 2000*
# Table of Risk

<table>
<thead>
<tr>
<th>Level Of Risk</th>
<th>Presenting Problems</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| MINIMAL       | • One self-limited or minor problem, e.g. cold, insect bite tinea corporis | • Laboratory 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 problem  
• 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. PFT’s  
• Non-Cardiovascular imaging studies with contrast, e.g. barium enema  
• Superficial needle biopsies  
• Clinical laboratory tests requiring arterial puncture  
• Skin biopsies | • Over-the-counter drugs  
• Minor surgery with no identified risk factors  
• Physical Therapy  
• Occupational Therapy  
• IV fluids with additives  
• Closed treatment of fracture or dislocation without manipulation |
| MODERATE      | • One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment  
• Two or more stable chronic illnesses  
• Undiagnosed new problem with uncertain prognosis, e.g. lump in breast  
• Acute illness with systemic symptoms, e.g. pyelonephritis, pneumonitis, colitis  
• Acute Complicated injury, e.g. head injury with 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 w/ 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 illness with severe exacerbation, progression or side effect of TX  
• Acute or chronic illness or injury that may pose a threat to life or bodily function, e.g. multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure  
• An abrupt change in neurologic status, e.g. seizure, TIA, weakness, or sensory loss | • Cardiovascular imaging studies with contrasts with identified risk factors  
• Cardiac Electrophysiological 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 |
Complexity Section Questions & Answers

Q. If DNR is listed on the patient record that is in the hospital for an extended time, would the level of risk in the MDM section be considered high throughout the hospitalization or would it only be counted if it’s specifically mentioned on that encounter?

A. You would only count the “High Risk” part of the MDM on the day that they initially reviewed the DNR order. For the remainder of the stay, either the circumstance must be evaluated to determine high risk or the MD needs to review the DNR status again.

Q. What is the difference between Independent Visualization of Image, Tracing or Specimen Itself and Review and/or Order of Tests in the Radiology Section of CPT in Complexity Table B?

A. In order to get credit for the visualization the provider MUST document that he/she viewed the CT, X-Ray, or MRI film. It must NOT be assumed that the film was viewed, it must be clearly stated within the documentation.

Q. Could a MRI be accounted for in the Medicine Section of Table B for Complexity if a CT or an X-ray has already been counted in the radiology section?

A. No, only the CT codes in the Medicine section (90281-99199) may be counted for this bullet.

Q. If the patient presents with a new problem to the examiner, but the problem is not new to the patient and has been evaluated by a colleague in the same specialty, can we give credit for a New Problem on Table A for Complexity?

A. According to Dr. Price, the Medical Director for our Medicare Fiscal Intermediary, if the problem is new to the provider BUT is established to the patient and the provider’s colleague, it is NOT considered a new problem for Table A.
DOCUMENTATION OF AN ENCOUNTER DOMINATED BY TIME SPENT COUNSELING OR COORDINATION OF CARE

In the case where counseling and/or coordination of care dominates (more than 50%) the physician/patient and/or family encounter (face-to-face time in the office or other or outpatient setting, floor/unit time in the hospital or nursing facility), time is considered the key or controlling factor to qualify for a particular level of E/M services.

DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter (face-to-face or floor time, as appropriate) should be documented and the record should describe the counseling and/or activities to coordinate care.

As of November, 1999, Medicare has mandated that services billed on the basis of time factors (as identified in CPT) also reflect start/stop times in the encounter record. For example: ‘More than half of the patient visit was spent counseling. I counseled for 25 minutes, from 12:35 p.m. to 1:00 p.m.’ (Initials are to be written near this statement in the document and done only by the physician.)

Some Frequently Asked Questions Regarding Billed Based on Time

Q: We have a patient who spent an hour in the examination room waiting for some test results? Can I bill their visit based on time?

A: No, you may only bill based on time spent counseling or coordinating care. Extra time spent waiting for test results would not qualify.

Q: The provider has documented that he spend an hour visiting with the patient, but he does not say what they where discussing. Can I still bill based on counseling time?

A: No, according to documentation guidelines, the records must describe the counseling and/or the activities to coordinate care.

Updated August 1, 2001
PREVENTIVE MEDICINE SERVICES

**Background Information**
Some preliminary information may be helpful in understanding the original establishment of the age categories in the preventive medicine codes.

**Infants/Children:** These codes were derived through the consensus of physician advisors that the type of services provided to infants/children varied by the age category of the patient: under one year, one to four years, five through eleven years, and the adolescent, twelve through seventeen years. Accordingly, the descriptors and codes 99381 through 99387 were promulgated for new patients and codes 99391 through 99397 for established patients, for these age groups.

**Adults:** For adult patients, also based upon physician consensus regarding content of services, the classifications utilized are eighteen through thirty-nine, forty through sixty-four, and over sixty-five years of age.

**Discussion**
Codes 99381-99397 do not include counseling, risk factor reduction interventions or immunizations. If risk management services are provided at the same session as a preventive medicine visit, both codes should be reported. For counseling and/or risk factor reduction interventions, see 99401-99412. For immunizations, see 90701-90749. Ancillary studies involving laboratory, radiology, or other procedures are reported separately.

The Preventive Medicine Services codes provide a means to report a routine or periodic history and physical examination in asymptomatic individuals. These codes are used to report the E/M services that are provided to the patient. They include only those evaluation and management services related to the age specific history and examination provided by the physician. They do not include counseling and/or risk factor reduction intervention nor to they include the provision of immunizations.

Further, the actual performance of diagnostic tests/studies for which specific CPT codes are available are coded separately; the performance of these tests is not included in the Preventive Medicine services, or in other evaluation and management codes.

To select the appropriate code from among the 99381-99397 series, three basic questions must be answered:

1) Was the examination conducted in the absence of complaints by the patient? (If the patient presents with a problem or complaint, use regular E/M codes for office or other site to report these services.

2) Is the patient new to, or established with the physician?
3) What is the specific age of the patient? (Note that a separate classification category exists for newborn care, which is distinct from the preventive medicine services section).

**The key factor in using the Preventive Medicine codes is the absence of complaints by the patient.**

You could justify use of the appropriate E&M code with a –25 modifier in addition to a preventive medicine code if documentation shows that during the physical the doctor discovered a problem significant enough to require work that fits the definition of a problem-oriented E&M service.

With the Preventive Medicine Services, the physician is looking for abnormalities that may not be apparent to the patient or parent of a child. Because of the family history or health habits of the patient, the physician may also need to counsel the patient to help prevent a disease or traumatic injury from occurring (primary prevention) or to attempt to reduce the symptoms of a disease (secondary prevention).

A common misconception is that the initial preventive medicine E/M service is reported for the first time the patient receives preventive medicine services, even if the patient has received problem-oriented services within the past three years. Because codes 99381-99387 are found within the new patient category, these codes should not be reported if a patient received any professional services from this or another physician of the same specialty from the same group practice, within the past three years.

Typically, the initial new patient preventive medicine E/M codes are used to report services provided to a patient who is new to an area and establishing him/herself with a new physician, without any presenting illness.

**School Physicals**

When a child presents to a pediatrician referred by a nursery school for a physical exam, the best choice is preventive medicine code 99382 or 99383, depending on the child's age, with diagnosis code V70.5 (health exam of defined sub-population, preschool children). If the purpose of the exam is administrative and for school admission, the diagnosis code is V70.3

Even if you use diagnosis code V70.9 (unspecified general medical exam), there is still no problem or illness triggering the visit.

*Remember:* You could justify use of the appropriate E&M code with a –25 modifier in addition to a preventive medicine code if documentation shows that during the physical the doctor discovered a problem significant enough to require work that fits the definition of a problem-oriented E&M service.
Pelvic Examination for Medicare patient for follow-up of ASCUS (Atypical Squamous Cells of Undetermined Significance), SIL (Squamous Intraepithelial Lesion), and CIN (Cervical Intraepithelial Neoplasia) taken from April 2000 Documentation Dispatch

Effective January 1, 1998, Medicare approved coverage of a screening pelvic examination for all female beneficiaries. A screening pelvic examination should include at least seven of the following elements:

- Inspection and palpation of breasts for masses or lumps, tenderness, symmetry, or nipple discharge;
- Digital rectal examination including sphincter tone, presence of hemorrhoids, and rectal masses;
- Pelvic examination (with or without specimen collection for smears and cultures) including:
  - External genitalia (general appearance, hair distribution, or lesions);
  - Urethral meatus (size, location, lesions, or prolapse);
  - Urethra (masses, tenderness, or scarring);
  - Bladder (fullness, masses, or tenderness);
  - Vagina (general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, or rectocele);
  - Cervix (general appearance, lesions, or discharge);
  - Uterus (size, contour, position, mobility, tenderness, consistency, descent, or support);
  - Adnexa/parametria (masses, tenderness, organomegaly, or nodularity); and
  - Anus and perineum

Coverage and Payment of Pelvic Screening

Payment for a screening pelvic examination is allowed every 36 months for women at low risk of developing cervical or vaginal cancer. Payment may be made more frequently if there is evidence that the woman is at high risk (on the basis of medical history or other pertinent findings) of developing cervical or vaginal cancer. High risk factors include:

Cervical Cancer:
- Early onset of sexual activity (under 16 years of age)
- Multiple sexual partners (five or more in a lifetime)
- History of sexually transmitted disease (including HIV infection)
- Fewer than three negative Pap smears within the previous 7 years

Vaginal Cancer:
- DES (diethylstilbestrol) – exposed daughters of women who took DES during pregnancy
Payment may also be made for a screening pelvic examination performed more frequently than every 36 months for a woman of childbearing age who has had such an examination that indicated the presence of cervical or vaginal cancer or other abnormality (ASCUS) during any of the preceding three years. Payment is not made for a screening exam more frequently than once every 12 months. REMEMBER – a screening exam is in the absence of symptoms and/or complaints.

**Medicare and Other Preventative Medicine**

If a Medicare patient schedules a preventive medicine visit, this is a non-covered service. (Medicare patients are informed of this.) Medicare **will** pay for:

- Screening fecal-occult blood test every 12 months (G0107)
- Screening Flexible sigmoidoscopy every 48 months (G0104)
- Female Pap smears every three years. (G0101 and Q0091)
- Male Prostate screening every 12 months
- G0102 digital rectal examination
- G0103 PSA test
- Screening Colonoscopy on individual at high risk every 24 months (G0105)

See the policies for these in the Medical Care Section of the Medicare manual.

If, during a preventive service, a Medicare patient indicates an acute problem, the physician must document the appropriate history, examination and medical-decision-making components. If it is a significant problem, an E/M code may also be billed. In this situation, Medicare instructs physician practices to subtract the fee for the E/M from the preventive medicine service and that is the amount you will bill the patient as an uncovered service.

**Other Things to Remember –**

An insignificant or trivial problem/abnormality that is encountered in the process of performing a preventive medicine service **and** which does not require additional work and the performance of the key components of an E/M service should **not** be reported.

It is **essential** that the appropriate diagnosis be assigned to each service. A V-code is assigned to the preventive medicine service and if the additional E/M service is provided, it is important to link the appropriate diagnostic code (ICD-9001-999) to indicate medical necessity to the carrier.

If a diagnostic code is assigned to the preventive medicine codes (99381-99387), the claim may be requested for review.
**PROLONGED SERVICES**

*With Direct (Face-to-Face) Patient Contact*

On a given date, a physician may provide both a visit and prolonged face-to-face services in either the inpatient or outpatient setting. If provided, both services are reported; supplies used and procedures performed during the level of service (visit) or during the prolonged services are also reported, as appropriate.

Codes 99354-99357 are used to report the total duration of face-to-face time spent by a physician on a given date providing prolonged service, even if the time spent by the physician on that date is not continuous.

- Reported in addition to other physician service, including E&M services at any level.

Code 99354 or 99356 is used to report the first hour of prolonged service on a given date, depending on the place of service.

- Either code also may be used to report a total duration of prolonged service of 30-60 minutes on a given date.
- Either code should be used only once per date, even if the time spent by the physician is not continuous on that date.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the E&M codes. Prolonged face-to-face services need not be continuous on a given date.

Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour, depending on the place of service.

- Either code may also be used to report the final 15-30 minutes of prolonged service on a given date.

*Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.*

<table>
<thead>
<tr>
<th>Total Duration of Prolonged Services</th>
<th>Codes(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30 minutes</td>
<td>Not reported separately</td>
</tr>
<tr>
<td>30-74 minutes (1/2 hour – 1 hr. 14 min.)</td>
<td>99354</td>
</tr>
<tr>
<td>75-104 minutes (1 hr. 15 min. – 1 hr. 44 min.)</td>
<td>99354 and 99355</td>
</tr>
<tr>
<td>105-134 minutes (1 hr. 45 min – 2 hr. 14 min.)</td>
<td>99354, and 99355 X 2</td>
</tr>
<tr>
<td>135-164 minutes (2 hr. 15 min. – 2 hr. 44 min.)</td>
<td>99354, and 99355 X 3</td>
</tr>
<tr>
<td>165-194 minutes (2 hr. 45 min.- 3 hr. 14 min.)</td>
<td>99354, and 99355 X 4</td>
</tr>
</tbody>
</table>

*Updated July 20, 2000*
Without Direct (Face-to-Face) Patient Contact:
Codes 99358 and 99359 are used to report the total duration of non-face-to-face time spent by a physician on a given date providing prolonged service, even if the time spent by the physician on that date is not continuous.

Code 99358:
- Used to report the first hour of prolonged service on a given date regardless of the place of service.
- May be used to report a total duration of prolonged service of 30-60 minutes on a given date.
- Should be used only once per date even if the time spent by the physician is not continuous on that date.

Code 99359:
- Used to report each additional 30 minutes beyond the first hour regardless of the place of service.
- Used to report the final 15-30 minutes of prolonged service on a given date.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported.

Physician Standby Services

Code 99360 is used to report physician standby service that is requested by another physician and that involves prolonged physician attendance without direct face-to-face patient contact.

The physician may not be providing care or services to other patients during this period.

This code is not reported if the period of standby ends with the performance of a procedure subject to a “surgical” package by the physician who was on standby. Standby service of less than 30 minutes total duration on a given date is not reported separately.

Updated July 20, 2000
Prolonged Service & Physician Standby Q&A:

Q: Can you use prolonged services codes with E/M services based on time spent counseling? For example if a doctor sees an established patient in the office for one hour and forty-five minutes to talk about her depression, can you bill an E/M visit code based on time and also a prolonged service code?

A: You may use a prolonged service code along with an E/M based on counseling time, however you should code the E/M to the highest possible level before using the prolonged service code. If the patient was seen for an hour and forty-five minutes (105 minutes), you must first code the office visit as a 99215 (40 minutes) and only then can you use the 99354 to report the additional time spent face-to-face with the patient.

Q: At what time is it appropriate to report code 99360 for standby services? Should it be reported at the time of notification or when the physician reaches the institution?

A: Based on the CPT guidelines, it is inappropriate to report 99360 from the time of notification as the time starts at actual attendance by the physician. The code is intended to be reported when the physician is present and standing by, ready to render services if necessitated by the situation.

Q: A pediatrician is requested by an obstetrician to “standby” during an attempted VBAC. Following this one hour of standby service, the pediatrician examines the newborn. Can both the standby service and the examination of the newborn be reported?

A: Yes, both services should be reported. Code 99360 (x2) for each 30 minutes of standby care, and 99431, history and examination of the infant are reported. Since the pediatrician did not perform a procedure subject to a “surgical package,” both services are reported. During the pediatrician’s hour of standby service, the pediatrician may not be providing care or services to other patients during this period.

Updated July 31, 2001
15016 SUPERVISING PHYSICIANS IN TEACHING SETTINGS

A. Definitions.--For purposes of this section, the following definitions apply:

- **Resident** means an individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the fiscal intermediary.

The fact that an individual hospital does not choose to include an eligible individual in its full-time equivalency count of residents does not change that individual's status as a resident in an approved GME program.

A medical student is never considered to be a resident. Any contribution of a medical student to the performance of a service or billable procedure (other than the taking of a history in the case of an E/M service) must be performed in the physical presence of a physician or jointly with a resident in a service, meeting the requirements set forth below for teaching physician billing.

- **Teaching physician** means a physician (other than another resident) who involves residents in the care of his or her patients.

- **Direct medical and surgical services** mean services to individual beneficiaries that are either personally furnished by a physician or furnished by a resident under the supervision of a physician in a teaching hospital making the reasonable cost election for physician services furnished in teaching hospitals. All payments for such services are made by the fiscal intermediary for the hospital.

- **Teaching hospital** means a hospital engaged in an approved GME residency program in medicine, osteopathy, dentistry, or podiatry.

- **Teaching setting** means any provider, hospital-based provider, or nonprovider setting in which Medicare payment for the services of residents is made by the fiscal intermediary under the direct graduate medical education payment methodology or freestanding SNF or HHA in which such payments are made on a reasonable cost basis.

Pay for physician services furnished in teaching settings under the physician fee schedule only if:

- The services are personally furnished by a physician who is not a resident; or

- The services are furnished jointly by a teaching physician and resident or by a resident in the presence of a teaching physician with certain exceptions as provided below.
05-97 FEE SCHEDULE FOR PHYSICIANS' SERVICES 15016 (Cont.)

In both situations, the services of the resident are payable through either the direct GME payment or reasonable cost payments made by the fiscal intermediary.

B. Special Situations.--If a resident participates in a service furnished in a teaching setting, pay for the services of a teaching physician under the physician fee schedule only if the teaching physician is present during the key portion of the service for which payment is sought.

1. Evaluation and Management (E/M) Services.--For a given encounter, the selection of the appropriate level of E/M service should be based on “Documentation Guidelines for Evaluation and Management Services” developed by the American Medical Association (AMA) and HCFA and published by the AMA. If a teaching physician documents his or her presence and participation in the E/M service, the level of service may be selected based on the extent of history and/or examination and/or the complexity of the medical decision making required by the patient and documented in his or her personal entry in the medical record, which may include references to notes entered by the resident.

Except as indicated in subsection 2, the teaching physician must be physically present during the portion of the service that determines the level of service billed. In all cases, the teaching physician must personally document his/her presence and participation in the services in the medical records. This documentation by the teaching physician may be either in writing or via a dictated note and expressed in the following ways for these major categories of E/M service.

a. Initial Hospital Care, Emergency Department Visits, Office Visits for New Patients, Office Consultations, and Hospital Consultations.

A personal notation must be entered by the teaching physician documenting his or her participation in the 3 key components of these services (i.e., history, examination, and medical decision making) as required by CPT and demonstrating the appropriate level of service required by the patient. If the teaching physician is repeating key elements of the service components obtained previously and documented by the resident, e.g., the patient's complete history and physical examination, the teaching physician need not repeat the documentation of these components in detail. Rather, the documentation of the teaching physician may be brief, summary comments that relate to the resident's entry and which confirm or revise the key elements defined for the purpose of this section as:

- Relevant history of present illness and prior diagnostic tests;
- Major finding(s) of the physical examination;
- Assessment, clinical impression, or diagnosis; and
- Plan of care.
Therefore, the documentation of the key elements above may be satisfied by combining entries into the medical record made by the resident and the teaching physician. The documentation requirements for some common clinical situations for teaching physicians are illustrated below.

(1) Illustration 1.--All required elements are obtained personally by the teaching physician without a resident present. In this situation, a resident may or may not have performed an independent service. If no resident has seen the patient, the physician should document on the same basis he or she would document an E/M service in a non-teaching setting. If a teaching physician's service follows a resident's service, then the teaching physician's documentation should refer to the resident's note and provide summary comments that establish, revise, or confirm the resident's findings and the appropriate level of service required by the patient. For example, the teaching physician would not have to restate the review of systems and family social history in the case of an initial hospital service. However, the teaching physician would have to examine and question the beneficiary to verify the key findings of the resident's notes since he or she was not present during the resident's interaction with the beneficiary.

(2) Illustration 2.--All required elements are obtained by the resident in the presence of, or jointly with, the teaching physician and documented by the resident. In this situation, the resident's note may document the teaching physician's direct observation, performance, and personal input into the key elements. The teaching physician's personal documentation may be limited. At a minimum, it must include a confirmation of each component of the resident's documentation and the teaching physician's presence during the service. The combination of entries must be adequate to substantiate the level of service required by the patient.

(3) Illustration 3.--Selected required elements of the service, for example, history and physical examination are obtained by the resident independently. The teaching physician repeats the key elements of the examination. These elements are discussed with the resident either prior to or after the teaching physician's personal service. In this situation, the resident's note may document the teaching physician's input into the history and medical decision making. The teaching physician's note must include summary comments that revise or confirm the findings of the resident's physical examination and discussion of the history and medical decision making. The combined entries must be adequate to substantiate the level of service required by the patient and billed.

b. Subsequent Hospital Care and Office Visits for Established Patient.--A personal notation by the teaching physician must be entered highlighting 2 of the 3 key components of these services (i.e., history, physical examination, and medical decision making). The same guidelines set forth in subsection are required for follow-up visits for established patients.

For E/M codes that are selected on the basis of time, see subsection 7.

Updated September 22, 2000
2. Exception for E/M Services Furnished in Certain Primary Care Centers.--For the E/M codes listed below, pay teaching physician claims for services furnished by residents without the presence of a teaching physician. When a GME program is granted the primary care exception, it applies to the following lower and mid-level E/M services:

<table>
<thead>
<tr>
<th>New Patient</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>99211</td>
</tr>
<tr>
<td>99202</td>
<td>99212</td>
</tr>
<tr>
<td>99203</td>
<td>99213</td>
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</tbody>
</table>

For this exception to apply, a center must attest in writing that all of the following conditions are met for a particular residency program. A center does not have to be approved in advance. Maintain a file of such attestations for later use in the case of questionable future claims for payment.

The services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's fiscal intermediary. This requirement is not met when the resident is assigned to a physician's office away from the center or makes home visits. In the case of a non-hospital entity, verify with the fiscal intermediary that the entity meets the requirements of a written agreement between the hospital and the entity set forth in 42 CFR 413.86(f)(1)(iii).

Any resident furnishing the service without the presence of a teaching physician must have completed more than 6 months of an approved residency program. If it becomes necessary to verify this information, teaching hospitals are required to maintain such information under the provisions of 42 CFR 413.86(f)(2).

The teaching physician in whose name the payment is sought must not supervise more than 4 residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must:

- Have no other responsibilities (including the supervision of other personnel) at the time of the service for which payment is sought;
- Assume management responsibility for those beneficiaries seen by the residents;
- Ensure that the services furnished are appropriate;
- Review with each resident during or immediately after each visit the beneficiary's medical history, physical examination, diagnosis, and record of tests and therapies; and
- Document the extent of his or her own participation in the review and direction of the services furnished to each beneficiary.

*Updated September 22, 2000*
The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians. The residents must generally follow the same group of patients throughout the course of their residency program, but there is no requirement that the teaching physicians remain the same over any period of time.

The range of services furnished by residents includes all of the following:

- Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;
- Coordination of care furnished by other physicians and providers; and
- Comprehensive care not limited by organ system or diagnosis.

The types of residency programs most likely to qualify for the primary care exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology.

Certain GME programs in psychiatry may qualify in special situations such as when the program furnishes comprehensive care for chronically mentally ill patients. These would be centers in which the range of services the residents are trained to furnish, and actually do furnish, include comprehensive medical care as well as psychiatric care. For example, antibiotics are being prescribed as well as psychotropic drugs.

3. Procedures.--In order to bill for surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

a. Surgery (Including Endoscopic Operations).--The teaching surgeon is responsible for the preoperative, operative, and post-operative care of the beneficiary. The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be key or critical portions of the procedure. The teaching surgeon may determine which post-operative visits are considered key and require his or her presence. However, if the post-operative period extends beyond the beneficiary's discharge and the teaching surgeon is not going to be involved in the beneficiary's follow-up care, the instructions on billing for less than the global package in §4824.B apply. During the period in which the teaching surgeon does not have to be physically present, he or she must remain immediately available to return to the procedure, i.e., he or she must not be involved in another procedure from which he or she cannot return. If the teaching physician is not immediately available, he or she must arrange for another physician to be immediately available to intervene in the original case should the need arise in order to bill for the original procedure. The designee is a physician who is not involved in or immediately available for any other surgical procedure. HCFA is not defining availability in terms of geographic location vis-a-vis the operating room.
(1) Single Surgery.--When the teaching surgeon is present for the entire period between the opening and closing of the surgical field, his or her presence may be demonstrated by notes in the medical records made by the physician, resident, or operating room nurse. For purposes of this teaching physician policy, there is no required information that the teaching surgeon must enter into the medical records.

(2) Two Overlapping Surgeries.--In order to bill for two overlapping surgeries, the teaching surgeon must be present during the key portions of both operations. Therefore, the key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure. The teaching surgeon must personally document the key portion of both procedures in his or her notes in order that a reviewer may clearly infer that the teaching physician was immediately available to return to either procedure in the event of complications. If the teaching physician leaves the operating room after the key portion(s) of the surgical procedure or during the closing of the surgical field to become involved in another surgical procedure, he or she must arrange for another physician to be immediately available to intervene in the original case should the need arise in order to bill for the original procedure. In the case of three concurrent surgical procedures, the role of the teaching surgeon (but not anesthesiologist) in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual beneficiary and is not payable under the physician fee schedule.

(3) Minor Procedures.--For procedures that take only a few minutes (5 minutes or less) to complete, e.g., simple suture, and involve relatively little decision making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.

b. Anesthesia.-- Pay an unreduced fee schedule payment if a teaching anesthesiologist is involved in a procedure with one resident. The teaching physician must document in the medical records that he or she was present during all critical (or key) portions of the procedure including induction and emergence. The teaching physician's presence is not required during the preoperative or post-operative visits with the beneficiary. If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a non-physician anesthetist, pay for the anesthesiologist's services as medical direction.

c. Endoscopy Procedures.--In order to bill for procedures performed through an endoscope (other than endoscopic operations that follow the surgery policy in subsection a), the teaching physician must be present during the entire viewing. The entire viewing includes insertion and removal of the device. Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

Updated September 22, 2000
4. Interpretation of Diagnostic Radiology and Other Diagnostic Tests.--Pay for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed or reviewed by a physician other than a resident. If the teaching physician's signature is the only signature on the interpretation, it may be assumed that he or she is indicating that he or she personally performed the interpretation. If a resident prepares and signs the interpretation, the teaching physician must indicate that he or she has personally reviewed the image and the resident's interpretation and either agrees with it or edits the findings. Do not pay for an interpretation if the documentation shows simply a countersignature of the resident's interpretation by the teaching physician.

5. Psychiatry.--For psychiatric services furnished under an approved GME program, the requirement for the presence of the teaching physician during the service may be met by concurrent observation of the service by use of a one-way mirror or video equipment. Audio-only equipment does not satisfy the physical presence requirement. In the case of time-based services such as individual medical psychotherapy, see subsection 7. Further, the teaching physician supervising the resident must be a physician, i.e., the Medicare teaching physician policy does not apply to psychologists who supervise psychiatry residents in approved GME programs.

6. Time-Based Codes.--For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, pay for a code that specifically describes a service of from 20 to 30 minutes only if the teaching physician is present for 20 to 30 minutes. Do not add time spent by the resident in the absence of the teaching physician to time spent by the resident and teaching physician with the beneficiary or time spent by the teaching physician alone with the beneficiary. Examples of codes falling into this category include:

- Individual medical psychotherapy (HCPCS codes G0071 - G0094),
- Critical care services (CPT codes 99291-99292),
- Hospital discharge day management (CPT codes 99238-99239),
- E/M codes in which counseling and/or coordination of care dominates (more than 50 percent) of the encounter, and time is considered the key or controlling factor to qualify for a particular level of E/M service,
- Prolonged services (CPT codes 99358-99359), and
- Care plan oversight (HCPCS codes G0064 - G0065).

Updated September 22, 2000
7. Other Complex or High-Risk Procedures.--In the case of complex or high-risk procedures for which national Medicare policy, local policy, or the CPT description indicate that the procedure requires personal (in person) supervision of its performance by a physician, pay for the physician services associated with the procedure only when the teaching physician is present with the resident. The presence of the resident alone would not establish a basis for fee schedule payment for such services. These procedures include interventional radiologic and cardiologic supervision and interpretation codes, cardiac catheterization, cardiovascular stress tests, and transeosophageal echocardiography.

8. Miscellaneous.--In the case of maternity services furnished to women who are eligible for Medicare, apply the physician presence requirement for both types of delivery as you would for surgery. In order to bill for the procedure, the teaching physician must be present for the delivery. These procedure codes are somewhat different from other surgery codes in that there are separate codes for global obstetrical care (antepartum, delivery, and postpartum) and for deliveries only. In situations in which the teaching physician's only involvement was at the time of delivery, the teaching physician should bill the delivery only code. In order to bill for the global procedures, the teaching physician must be present for the minimum indicated number of visits when such a number is specified in the description of the code. This policy differs from the policy on general surgical procedures under which the teaching physician is not required to be present for a specified number of visits.

Do not apply the physician presence policy to renal dialysis services of physicians who are paid under the physician monthly capitation payment method.

C. Election of Costs for Services of Physicians in Teaching Hospital.--A teaching hospital may elect to receive payment on a reasonable cost basis for the direct medical and surgical services of its physicians in lieu of fee schedule payments for such services. A teaching hospital may make this election to receive cost payment only when all physicians who render covered Medicare services in the hospital agree in writing not to bill charges for such services or when all the physicians are employees of the hospital and, as a condition of employment, they are precluded from billing for such services. When this election is made, Medicare payments are made exclusively by the hospital's intermediary, and fee schedule payment is precluded.

When the cost election is made for a current or future period, each physician who provides services to Medicare beneficiaries must agree in writing (except when the employment restriction discussed above exists) not to bill charges for services provided to Medicare beneficiaries. However, when each physician agrees in writing to abide by all the rules and regulations of the medical staff of the hospital (or of the fund that is qualified to receive payment for the imputed cost of donated physician's services), such an agreement suffices if required as a condition of staff privileges and the rules and regulations of the hospital, medical staff, or fund clearly preclude physician billing for the services for which costs benefits are payable. The intermediary must advise the carrier when a hospital elects cost payment for physicians' direct medical and surgical services and supply the carrier with a list of all physicians who provide services in the facility. You must ensure that billings received from these physicians or hospitals are denied.

Update September 22, 2000
D. Services of Assistants at Surgery Furnished in Teaching Hospitals.--

1. **General.** --Do not pay for the services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service unless the requirements of subsections 3, 4, or 5 are met. Each teaching hospital has a different situation concerning numbers of residents, qualifications of residents, duties of residents, and types of surgeries performed. Contact those affected by these instructions to learn the circumstances in individual teaching hospitals. There may be some teaching hospitals in which you can apply a presumption about the availability of a qualified resident in a training program related to the medical specialty required for the surgical procedures, but there are other teaching hospitals in which there are often no qualified residents available. This may be due to their involvement in other activities, complexity of the surgery, numbers of residents in the program, or other valid reasons. Process assistant at surgery claims for services furnished in teaching hospitals on the basis of the following certification by the assistant, or through the use of modifier -82, which indicates that, a qualified resident surgeon was not available. This certification is for use only when the basis for payment is the unavailability of qualified residents.

“I understand that section 1842(b)(7)(D) of the Social Security Act generally prohibits Medicare physician fee schedule payment for the services of assistants at surgery in teaching hospitals when qualified residents are available to furnish such services. I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review by the Medicare carrier.”

Retain the claim and certification for four years and conduct post-payment reviews as necessary. For example, investigate situations in which it is certified that there are never any qualified residents available, and undertake recovery if warranted.

Assistant at surgery claims denied on the basis of these instructions do not qualify for payment under the waiver of liability provision.

*Updated September 22, 2000*
2. **Definition.**—An assistant at surgery is a physician who actively assists the physician in charge of a case in performing a surgical procedure. The conditions for coverage of such services in teaching hospitals are more restrictive than those in other settings because of the availability of residents who are qualified to perform this type of service.

3. **Exceptional Circumstances.**—Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the special limitation in §15044, notwithstanding the availability of a qualified resident to furnish the services. There may be exceptional medical circumstances, e.g., emergency, life-threatening situations such as multiple traumatic injuries which require immediate treatment. There may be other situations in which your medical staff may find that exceptional medical circumstances justify the services of a physician assistant at surgery even though a qualified resident is available.

4. **Physicians Who Do Not InvolveResidents in Patient Care.**—Payment may be made for the services of assistants at surgery in teaching hospitals, subject to the special limitation in §15044, if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients. Generally, this exception is applied to community physicians who have no involvement in the hospital's GME program. In such situations, payment may be made for reasonable and necessary services on the same basis as would be the case in a non-teaching hospital.

However, if the assistant is not a physician primarily engaged in the field of surgery, no payment be made unless either of the criteria of subsection 5 is met.

5. **Multiple Physician Specialties Involved in Surgery.**—Complex medical procedures, including multistage transplant surgery and coronary bypass, may require a team of physicians. In these situations, each of the physicians performs a unique, discrete function requiring special skills integral to the total procedure. Each physician is engaged in a level of activity different from assisting the surgeon in charge of the case. The special payment limitation in §15044 is not applied. If payment is made on the basis of a single team fee, deny additional claims. Determine which procedures performed in your service area require a team approach to surgery. Team surgery is paid for on a “By Report” basis.

The services of physicians of different specialties may be necessary during surgery when each specialist is required to play an active role in the patient's treatment because of the existence of more than one medical condition requiring diverse, specialized medical services. For example, a patient's cardiac condition may require the cardiologist be present to monitor the patient's condition during abdominal surgery. In this type of situation, the physician furnishing the concurrent care is functioning at a different level than that of an assistant at surgery, and payment is made on a regular fee schedule basis.

*Updated September 22, 2000*
Consultation Policy and Procedure

Policy:

It is the policy of _______________ Associates to follow the Current Procedural Terminology’s (CPT) definition of a consultation, which is “a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source.”

Procedure:

I. The written request for consultation must be prepared by the requesting Medical Staff* or his/her house officer. The request and reason(s) for consultation must be documented in the patient’s medical record.

   A. In the inpatient setting, the request may be documented in the requesting Medical Staff’s or his/her house officer’s progress note, orders, or specific written request for the consultation. In the office setting, the requirement may be met by a specific written request for the consultation from the requesting Medical Staff or his/her house officer or a specific reference to the request in the consulted Medical Staff’s medical record.

   B. The consulted Medical Staff must be notified of a consultation request by a phone call or a written request.

   C. House officers should not initiate a consultation request without the consent of the patient’s requesting Medical Staff except in case of an emergency.

II. Diagnostic and therapeutic services may be initiated by the consulted Medical Staff on the day of the consultation as long as these services are documented and communicated to the requesting Medical Staff.

   A. In order to bill a consultation, the reason for the encounter must be to obtain the consulted Medical Staff’s opinion or advice regarding evaluation and/or management of a specific condition(s). If the reason for the encounter is to manage the patient’s condition(s), the service is not a consultation and must be billed using the appropriate office or other outpatient visit code (99201-99215) or hospital inpatient code (99221-99233).

   B. If subsequent to a consultation, the consulted Medical Staff assumes responsibility for management of a portion or all of the patient’s condition(s), the initial consultation visit may be billed; however, all visits following the initial consultation must be billed using the appropriate office or other outpatient visit codes for established patients (99211-99215) or subsequent hospital care codes (99231-99233).

   The consulted Medical Staff can only report one initial inpatient consultation code (99251-99255) per admission. Follow-up inpatient consultations (99261-99263) are visits to complete the initial
consultation or subsequent consultative visits requested by the requesting Medical Staff. If the consulted Medical Staff has initiated treatment at the initial consultation and participates thereafter in the patient’s management, the subsequent hospital care codes (99231-99233) must be used.

1. Follow-up office visits that are initiated by the consulted Medical Staff must be reported using the appropriate office or other outpatient visit codes for established patients (99211-99215). *(Exception: If the patient is admitted to the hospital during the course of the visit, all evaluation and management (E/M) services provided by that physician in conjunction with that admission are considered part of the initial hospital care.*) If an additional request for opinion or advice regarding the same or a new problem is received from the requesting Medical Staff and documented in the medical record, the office or other outpatient consultation codes (99241-99245) may be used again.

III. A consultation report must be prepared in accordance with applicable billing and compliance rules and regulations.

   A. The consulted Medical Staff must initiate his/her participation and supervision very early in the consultative process.

   B. The consultation report must include an opinion, pertinent recommendations, and any services ordered or performed.

   C. The completed consultation report must be available in a timely manner.

   D. The consultation report must be placed in the patient’s medical record. The consulted Medical Staff is responsible for providing written communication to the requesting Medical Staff.

IV. A consultation requested of a physician in the same group practice may be billed as a consultation if all consultation requirements are met.

V. A preoperative clearance on a new or established patient may be billed as a consultation if it is done at the request of the surgeon and all consultation requirements are met.

VI. Confirmatory consultations (99271-99275) are services provided to patients when the consulted Medical Staff is aware of the confirmatory nature of the opinion sought (e.g., when a second/third opinion is requested or required on the necessity or appropriateness of a previously recommended medical treatment or surgical procedure). If a confirmatory consultation is required (e.g., by a third party payor), modifier -32, mandated services, should also be reported.

VII. Consultations initiated by a patient and/or family member and not requested by another provider are not reported using the consultation codes but must be reported using the appropriate confirmatory consultation codes (99271-99275) or office or other outpatient visit codes (99201-99205, or 99211-99215).
Consultation Questions & Answers

Q: Can Mid-Level Providers (i.e. PA’s) be the requesting providers on a consult?

A: According to CMS, consults may be requested by doctors of medicine, doctors of osteopathy, dentists, podiatrists, optometrists, chiropractors, physician assistants, nurse practitioners, clinical nurse specialists, clinical social workers, nurse midwives and clinical psychologists.

Q: Does the reason for the consultation request need to be in writing or is it enough just to document something such as, “I was requested to see Mrs. Smith by Dr. Jones?”

A: The reason for the consultation should be clearly documented within the documentation.

Q: In an outpatient setting, is it okay for the request for consultation to be verbal? What about inpatient?

A: In the outpatient setting, the request itself may be verbal. However, The request and need for consultation must still be documented in the patient’s record. So consulting physicians who receive a verbal request then bear the responsibility for documenting them. (I.e. I was asked by Dr. Jones to see Mrs. Smith for evaluation of xyz condition.)

In the inpatient setting, the requesting doctor must document the request for the consult within the patient’s progress notes.

Q: Must the report sent back by the consulting provider to the provider that requested the consultation re-state all the components of the exam? Can you just send a copy of the consultation documentation?

A: All CMS says is that a written report must be sent. It must include anything that is pertinent to the consulting provider’s advice or opinion. It is certainly acceptable to just send a copy of the notes from the consultation visit.

Update July 30, 2001
Teaching Physicians Policy & Procedure

Policy:
It is the policy of the _______________ Associates (UMA) to comply with the physical presence and documentation requirements set forth in the “Medicare Final Rule for Teaching Physicians” issued by the Health Care Financing Administration (HCFA) on May 30, 1996. It is also the policy of UMA to comply with any/all teaching physician requirements formally adopted by other payors.

Procedure:
I. Evaluation and Management Services
   A. Selection of E/M Level of Service must be based on extent of History, Examination, and Medical Decision Making required to treat the patient.
   
   B. History, Examination, and Medical Decision Making are considered KEY components.
   
   C. Teaching Physician (T.P.) must personally perform OR be physically present while the resident performs (Attachment A: Presence Illustrations for E/M Services):
      1. All KEY components for Emergency Department Visits, Initial Hospital Care, New Patient Office Visits, and Consultations (Office and Hospital).
      2. Two of three KEY components for Subsequent Hospital Care, and Established Patient Office Visits.
   
   D. Teaching physician must personally document his/her presence and participation in the services:
      1. T.P. must personally document the KEY components.
      2. If a resident is involved in the service:
         (a) T.P. documentation may reference and summarize (by confirming or revising) the KEY components documented by the resident (Attachment B: Documentation Illustrations).
         (b) The -GC Modifier must be added on Current Procedural Terminology (CPT-4) codes for Medicare billing, whenever a resident is involved.
   
   E. Primary Care Exception: (Attachment C: Approved UNMC Primary Care Exception Clinics)
      1. Physical presence of a T.P. is NOT required for Level 1 through Level 3 New and Established Patient Office Visits (CPT-4 codes 99201, 99202, 99203, 99211, 99212, and 99213).
         (a) Teaching physician must review, with each resident, the patient’s medical history, physical examination, diagnosis, and record of tests and therapies during or immediately following each visit.
         (b) Teaching physician must document the extent of his/her own participation in the review and direction of services furnished to each beneficiary (Attachment B: Documentation Illustrations).
         (c) The -GE Modifier must be added on CPT-4 codes for Medicare billing.

Updated December 7, 2000
2. Physical presence of a T.P. is required if a more complex, unscheduled, Level 4 or Level 5 New or Established Office Visit (CPT-4 codes 99204, 99205, 99214, or 99215) arises during a service originally scheduled to be furnished under the exception. *(See 1-4 above for documentation requirements).*

3. **To qualify for the Primary Care Exception, all of the following criteria must be met:**

   (a) The service must be furnished in an outpatient center or ambulatory entity.
   (b) The patients must be an identifiable group who considers the center as their source of continuing health care.
   (c) Residents must:
      1. Have completed 6 months of training *(see (4)(a)below).*
      2. Provide comprehensive care in a continuity setting and be trained in all organ systems and disease processes.
   (d) Teaching physician must:
      1. Not direct more than 4 residents at any one time.
         a. One or more in the mix of four residents may be a resident with less than 6 months training.
         b. Teaching physician must be physically present for the key portions of the encounter provided in conjunction with residents with less than 6 months training.
         c. Teaching physician activities with residents with less than 6 months training must not interfere with the T.P.'s ability to provide the level of supervision necessary to bill under the Primary Care Exception.
         d. The **-GC Modifier** must be added on CPT-4 codes for Medicare billing when services are provided with residents who have less than 6 months training.
      2. Have no other responsibility at the time patients are being seen by the resident.
      3. Assume management of patients seen by the resident.
      4. Ensure that the services are appropriate.
      5. Review the resident's decision-making with the resident during or immediately after the patient's visit.
      6. Document the extent of his or her supervision of the resident's service.
II. Procedures

A. Surgery (Including Endoscopic Operations)

1. Single surgery:
   (a) Teaching physician must be present during all CRITICAL and KEY portions of the procedure and immediately available to furnish services during the entire procedure.
      (1) When the T.P. is present for the entire period between the opening and closing of the surgical field, documentation of the presence of the T.P. may be demonstrated by the notes in the medical record made by the T.P., resident, or nurse.
      (2) When the T.P. is not present for the entire period between opening and closing of the surgical field, but present for all CRITICAL and KEY portions of the procedure and immediately available to furnish services during the entire procedure, the T.P. must personally document his/her presence and participation.
   (b) Teaching physician is responsible for the preoperative, operative, and postoperative visits. Teaching physician may determine which post-operative visits are to be considered KEY and require his/her presence.
   (c) The -GC Modifier must be added on CPT-4 codes for Medicare billing, whenever a resident is involved.

2. Two overlapping surgeries:
   (a) Teaching physician must be present during all CRITICAL and KEY portions of both procedures.
   (b) When all of the KEY portions of the initial procedure have been completed, the T.P. may begin to become involved in a second procedure.
   (c) Teaching physician must be immediately available to furnish services during either procedure in the event of complications OR he/she must arrange for another physician to be immediately available to intervene in the original case should the need arise.
   (d) Teaching physician must personally document:
      (1) the KEY portion(s) of both procedures in his/her notes.
      (2) that he/she (and/or another designated physician) was immediately available to return to either procedure in the event of complications.
   (e) Teaching physician is responsible for the preoperative, operative, and postoperative visits. Teaching physician may determine which post-operative visits are to be considered KEY and require his/her presence.
   (f) The -GC Modifier must be added on CPT-4 codes for Medicare billing, whenever a resident is involved.

3. Minor procedures:
   (a) Teaching physician must be present during the entire procedure.
      (1) defined as procedures that take less than 3 - 5 minutes to perform.
      (2) Documentation of the presence of the T.P. may be demonstrated by the notes in the medical record made by the T.P., resident, or nurse.

Updated December 7, 2000
(b) Teaching physician is responsible for the preoperative, operative, and postoperative visits. T.P. may determine which post-operative visits are to be considered KEY and require his/her presence.
(c) The -GC Modifier must be added on CPT-4 codes for Medicare billing, whenever a resident is involved.

B. Anesthesia:
1. Teaching physician must be present during induction, emergence, and all CRITICAL and KEY portions of the procedure and be immediately available to furnish services during the entire procedure.
2. Teaching physician must personally document his/her presence and participation in the administration of the anesthesia.
3. The -GC Modifier must be added on CPT-4 codes for Medicare billing, whenever a resident is involved.

C. Endoscopic procedures:
1. Teaching physician must be present for the entire viewing, which includes insertion and removal of the device.
2. Documentation of the presence of the T.P. may be demonstrated by the notes in the medical record made by the T.P., resident, or nurse.
3. The -GC Modifier must be added on CPT-4 codes for Medicare billing, whenever a resident is involved.

III. Maternity Services:

A. Teaching physician must be present for the delivery.
B. If the T.P. is going to bill for global obstetrical care, he/she must also be present for the minimum number of visits indicated for antepartum and postpartum care, otherwise, the T.P. should bill the delivery-only code.
C. Documentation of the presence of the T.P. may be demonstrated by the notes in the medical record made by the T.P., resident, or nurse.
D. The -GC Modifier must be added on CPT-4 codes for Medicare billing, whenever a resident is involved.

IV. Other Complex or High Risk Procedures:
A. Teaching physician must be present to perform, or supervise the resident’s performance of complex or high-risk procedures, if national Medicare policy, local policy, or the CPT-4 code description indicates this requirement.
B. Includes the following procedures:
   1. Interventional radiologic and cardiologic supervision and interpretation codes
   2. Cardiac catheterization
   3. Cardiovascular stress tests
   4. Transesophageal echocardiography
C. Documentation of the presence of the T.P. may be demonstrated by the notes in the medical record made by the T.P., resident, or nurse.
D. The -GC Modifier must be added on CPT-4 codes for Medicare billing, whenever a resident is involved.

Updated December 7, 2000
V. Interpretation of Diagnostic Radiology and Other Diagnostic Tests:
A. Teaching physician must personally perform the interpretation or review the resident’s interpretation.
B. Teaching physician must document:
   1. that he/she has personally reviewed the image and resident's interpretation.
   2. his/her agreement or revision of the findings.
   3. a generic attestation is acceptable documentation when used by radiology and others providing diagnostic test reports.
C. The -GC Modifier must be added on CPT-4 codes for Medicare billing, whenever a resident is involved.

VI. Psychiatry
A. Teaching physician must be present for the entire service. This presence requirement may be met through concurrent observation of the service by the use of a one-way mirror or video equipment.
B. Teaching physician must document his/her presence and participation.
C. The -GC Modifier must be added on CPT-4 codes for Medicare billing, whenever a resident is involved.

VII. Time-Based Codes
A. Teaching physician must be present for the entire period of time for which the claim is made.
B. Teaching physician must document his/her presence and participation.
C. This includes the following CPT-4 categories and codes:
   1. individual medical psychotherapy (CPT-4 Codes 90842-90844)
   2. critical care services (CPT-4 Codes 99291-99292)
   3. prolonged services (CPT-4 Codes 99354-99359)
   4. care plan oversight (CPT-4 Code 99375)
   5. E/M service codes in which counseling and/or coordination of care dominates (more than 50%) the encounter, and time is considered the key or controlling factor to qualify for a particular level of E/M service.
D. The -GC Modifier must be added on CPT-4 codes for Medicare billing, whenever a resident is involved.

Updated December 7, 2000
__________________ Associates

_Teaching Physician Staffing Policy & Procedure/ Primary Care Exception Only_

**POLICY:**

It is the policy of the ____________ Associates (UMA) to comply with the teaching physician staffing requirements, for Primary Care Exception Clinics (Appendix A), as set forth in the “Medicare Final Rule for Teaching Physicians” issued by the Health Care Financing Administration (HCFA) on May 30, 1996. This is the policy that will be followed for all payors.

**PROCEDURE:**

1. Each clinic scheduler will receive adequate notice of planned absences from teaching physician in order to staff according to required guidelines. (Appendix B) The proper ratio of residents to teaching physicians is 4:1.

2. In the event of an unforeseen staff shortage, the following options will be available. There are not necessarily listed in the order of preferential action. Each situation that arises will be evaluated individually, and patient care issues as well as compliance issues will be considered in formulating a response.

   a. Immediately search for additional teaching physician to staff.
   b. Shift patients to other, on-site, non-resident, providers, if appropriate
   c. Refer patients to other clinics after triage, if appropriate
   d. Cancel resident schedules to reach proper staffing ratio
   e. Do not bill for services provided

Approved by UMA Compliance Committee – October 15, 1999

Updated December 7, 2000
List of HCFA Approved Primary Exception Clinics

**Family Practice Clinics**
University Family Health Center at the UNMC Outpatient Care Center
UMA – Summit Plaza
UMA – Family Medicine at Clarkson West

**Internal Medicine Clinics**
Medicine East at Turner Park
General Medicine at the UNMC Outpatient Care Center

**Pediatric Clinic**
General Pediatric Clinic at the UNMC Outpatient Care Center

**Obstetrics and Gynecology (OB/GYN)**
Residency Continuity Clinics at the UNMC Outpatient Care Center

**Geriatric Medicine**
Residency Continuity Clinics at the University Geriatric Center

**HCFA Primary Care Exception Clinic Requirements**

A. To qualify for the Primary Care Exception, all of the following criteria must be met:

1. The service must be furnished in an outpatient center or ambulatory entity.
2. The patients must be an identifiable group who consider the center as their source of continuing health care.
3. Residents must provide comprehensive care in a continuity setting and be trained in all organ systems and disease processes.
4. The teaching physician can direct no more than four residents at any one time.
5. The resident must have completed six months of training. Exception: If one (or more) of the four residents is still in his or her first six months of training, the teaching physician must be physically present for the key portion of the encounter between the patient and the resident.

B. In addition, the teaching physician must:

1. Have no other responsibilities at the time patients are being seen by the resident.
2. Assume management of patients seen by residents.
3. Ensure the services are appropriate.
4. Review the resident’s decision making with the resident during or immediately after the patient’s visit.
5. Document the extent of his or her supervision of the resident’s service.

*Updated December 7, 2000*
Attachment A

Presence Illustrations for E/M Services  
(Taken from HCFA Medicare Final Rule for Teaching Physicians May 30, 1996)

Illustration 1 - All required elements are obtained personally by the teaching physician without a resident present. In this situation, a resident may or may not have performed an independent service. If no resident has seen the patient, the physician should document on the same basis he or she would document an E/M service in a non-teaching setting.

If a teaching physician’s service follows a resident’s service, then the teaching physician’s documentation should refer to the resident’s note and provide summary comments that establish, revise, or confirm the resident’s findings and the appropriate level of service required by the patient. For example, the teaching physician would not have to restate the review of systems and family, social history in the case of an initial hospital service. However, the teaching physician would have to examine and question the beneficiary to verify the key findings of the resident’s notes since he or she was not present during the resident’s interaction with the beneficiary.

Illustration 2 - All required elements are obtained by the resident in the presence of, or jointly with, the teaching physician and documented by the resident. In this situation, the resident’s note may document the teaching physician’s direct observation, performance, and personal input into the key elements. The teaching physician’s personal documentation may be limited; at a minimum, it must include a confirmation of each component of the resident’s documentation and the teaching physician’s presence during the service. The combination of entries must be adequate to substantiate the level of service required by the patient.

Illustration 3 - Selected required elements of the service, for example history and physical examination, are obtained by the resident independently. The teaching physician repeats the key elements of the examination. These elements are discussed with the teaching physician either prior to or after the teaching physician's personal service.

In this situation, the resident's note may document the teaching physician's input into the history and medical decision-making. The teaching physician's note must include summary comments that revise or confirm the findings of the resident's physical examination and discussion of the history and medical decision-making. The combined entries must be adequate to substantiate the level of service required by the patient and billed.

Updated December 4, 2000
Attachment B

DOCUMENTATION ILLUSTRATIONS

Sample Dictation Templates for E/M Services: (Created by AAMC in June, 1997)

If a resident is involved in an E/M service, the T.P. documentation may reference and summarize (by confirming or revising) the KEY components documented by the resident. The T.P. can use one of the following templates when referencing and summarizing the KEY components:

Template A

History as documented above by Dr. Resident reviewed with patient and resident. It is noted that....................... (you may add anything else remarkable to history, PFSH, and ROS).

My exam confirms (revises) ..................... OR, I find upon exam that .....................

Lab/test (specify other diagnostic test performed) results show .................... indicating a..................... I confirm (revise) the resident's assessment as .................. and diagnosis of .................. and agree with the resident's plan of care as follows ..................

See resident's note for further details.

Template B

Resident's history reviewed, patient interviewed and examined. Briefly, history is as follows .....................

On exam I find ..................... (list what you did and your findings). Of note is .....................

Assessment and plan reviewed with resident. Lab/tests (specify other diagnostic test performed) show ..................... and I confirm (revise) the differential diagnosis is .....................

Care plan is .....................

See resident's note for further details.

Documentation Guide for use in Primary Care Exception Clinics:

Use when the resident performs a Level 1, 2, or 3 New or Established Office Visit (CPT-4 Codes 99201, 99202, 99203, 99211, 99212, or 99213) without the physical presence of a T.P. The Teaching physician’s note should be a brief attestation indicating that the T.P.:

- Discussed the care provided with the resident;
- Concurs with the resident’s assessment; and
- Concurs with the plan of care.

Updated December 4, 2000
INTRODUCTION TO CPT-4 PROCEDURAL CODING

A. THE CPT BOOK

The *Physician’s Current Procedural Terminology, Fourth Edition (CPT)* is a yearly publication by the American Medical Association (AMA). CPT is a systematic listing and coding of procedures and services performed by physicians. Each procedure and service is identified by a five-digit code. Almost all third-party payers now accept the Fourth Edition of CPT.

Because of the rapidly changing, adding, and deleting of CPT codes, it is absolutely vital that the coder use the appropriate year of CPT for the dates of services that are being coded. **NEVER USE LAST YEAR’S CPT BOOK!!**

B. ORGANIZATION OF CPT CODES

The main body of the material is listed in six sections. Within each section are subsections with anatomic, procedural, condition, or descriptor subheadings. These are arranged in numeric order with one exception—the entire Evaluation and Management section (99201-99499) has been placed at the beginning of the listed procedures.

SECTION NUMBERS AND THEIR SEQUENCES

- Evaluation and Management .................99201 to 99499
- Anesthesiology ..............................00100 to 01999
  - 99100 to 99140
- Surgery .................................10040 to 69979
- Radiology (Including Nuclear Medicine and Diagnostic Ultrasound) ..............70010 to 79999
- Pathology and Laboratory ......................80048 to 89399
- Medicine (except Anesthesiology) ............90701 to 99199

There are subsections listed within each section. For example: 11100 to 11420 Surgery/Integumentary Systems.

C. LOCATING A CPT CODE

1. Read the guidelines at the beginning of each CPT section.
2. Read carefully each procedures statement listed on the charge slip, operative report, laboratory report, or pathology you need to code.
3. Turn to the index and look up the main term in the procedure or service on the source document.
E/M services are listed under the main term Evaluation and Management.

To find a specific surgical code number, first look up the procedure in the index, then differentiate according to anatomical site.

**EXAMPLE:** Suture of superficial laceration of the eyelid.

Look up suture, then go down the list to eyelid. If you cannot find a procedure listed under the procedure/site, look up the anatomical site to see if a synonym for the procedural category is found.

**EXAMPLE:** Fulguration of a benign lesion on the face.

Fulguration sends you to destruction. Look for the subterms lesion and face.

4. Read through the code descriptions of all codes listed for the specific procedure or service you are coding. Note and compare all qualifiers in the descriptive statements.

5. Research HCPCS Level II and III codes, if you cannot locate an adequate code in CPT.

6. Assign the proper main code number.

If a proper code number cannot be found in CPT or Levels II and III codes, return to the CPT Index and locate the main term unlisted Services and Procedures and use the code listed for the subtopic that best fits the procedure or service that you are coding.

7. If you cannot find a code number to fit the description of the service performed in an HCPCS level, consult the CPT guidelines for specific instructions on handling unlisted procedures. A brief report describing the procedure performed should be written and attached to the claim form.

8. Assign any modifiers warranted by special circumstances.

**NOTE:** Procedure codes can be obtained in two areas of the index:

1. Anatomical site (ex: Joint)
2. Procedure (ex: arthrodesis)

**D. SYMBOLS OF CPT**

There are symbols, which precede the code number, used throughout the codebook. In addition, the surgical section uses an asterisk (*), which appears after the code number of minor surgery procedures.

< The triangle indicates that the code description has been substantially altered from the last annual edition of CPT-4.

! The bullet indicates that this is a new code, which appears for the first time in this edition of CPT.

; The semicolon is used to separate main and subordinate clauses in the code description.
This symbol was adopted to save space in the code book when there is a series of related codes. In these cases, the main clause will appear in the first description at the beginning of the series and is not repeated in the successive codes in the same series. New subordinate clauses, which differentiate one code form another, appear as indented on a new line and usually begin with a lower case letter. The exception to the first word beginning with a lowercase letter is when the subordinate clause begins with an eponym.

**Examples:**
- 97010  Physical medicine treatment to one area; hot or cold packs;
- 97012  traction, mechanical
- 97014  electrical stimulation (unattended)

*The asterisk, or starred, procedure indicates a surgery where the preoperative, intraoperative and postoperative services are so variable the surgery is billed on a fee-for-service basis and not as an all-inclusive surgical package. **Fee-for-service** means that the surgery pre- and postoperative cares, castings, etc., are to be coded and billed separately.**

**Example:**
- 20670* Removal implant; superficial, (e.g. buried wire, pin or rod)
  (separate procedure)

When a star follows a surgical procedure code number, the following rules apply:

a. The service as listed includes the surgical procedure only. Associated pre and postoperative services are not included in the service as listed. (NOT RECOGNIZED BY MEDICARE)

b. Preoperative services are considered as one of the following:

1. When the starred (*) procedure is carried out at the time of an initial visit (new patient) and this procedure constitutes the major service at that visit, procedure number 99025 **Initial (new patient) visit when starred (*) surgical procedure constitutes major service at that visit** is listed in lieu of the usual initial visit as an additional service.

2. When the starred (*) procedure is carried out at the time of an initial or other visit involving significant identifiable services (e.g., removal of a small skin lesion at the time of a comprehensive history and physical examination), the appropriate visit is listed in addition to the starred (*) procedure and its follow-up care. **Modifier –25 would be appended to the visit.**

3. When the starred (*) procedure is carried out at the time of a follow-up (established patient) visit, and this procedure constitutes the major service at that visit, the service visit is usually not added.

4. When the starred (*) procedure requires hospitalization, an appropriate hospital visit is listed in addition to the starred (*) procedure and its follow-up care.

c. All postoperative care is added on service by service basis (e.g., office or hospital visit, cast change, etc.)

d. Complications are added on a service-by-service basis (as with all surgical procedures.)
**Reimbursement:** While currently most carriers adhere to this rule, some carriers do not pay for both a starred surgical procedure and a visit on the same day. HCFA recommended in the November 25, 1991, Federal Register that evaluative services be paid on the same day as the starred surgical procedure only for separately identified E/M service. HCFA also recommended that most starred procedures include follow-up care. The AMA, on the other hand, suggests that follow-up care be reported separately.

Most carriers request modifiers to identify when a starred (*) procedure involves a separate service beyond the E/M code.

**F. GLOBAL SURGICAL PERIODS**

The concept of a global fee for surgical procedures is a long-established concept under which a single fee is billed and paid for all necessary services normally furnished by the surgeon before, during, and after the procedure.

CPT defines the surgical package as “…the operation per se, local infiltration, metacarpal/digital block or topical anesthesia when used, and the normal, uncomplicated follow-up care.” Follow-up care includes only that care which is usually a part of the surgical service.

Medicare does not pay separately for services that are incidental to, or parts of, another surgical procedure performed at the same time. If an overpayment is made as a result of a provider fragmenting his charges or billing for incidental procedures, the provider could be held responsible for refunding any overpaid amount, and may be subject to penalties.

Routine, follow-up visits included in the global package are reported for documentation purposes only using code 99024. This CPT code does NOT include a fee. It’s to be reported when follow-up care is being given within a global period.

HCFA directives establish the term *global surgery* with the following requirements:

1. All preoperative care performed by the surgeon within 24 hours of the surgery
   - Day before major surgery (90 day global)
   - Day of minor surgery (0-10 day global)

2. All intraoperative procedures

3. Treatment of all complications that *do not require an additional trip to the operating room*

4. A 90-day postoperative period for most major surgeries for all E&M services directly related to surgery. (There are a few surgeries such as a transplant case that may have more than 90 postoperative days.)

The global fee will include post-operative services such as:

- Dressing changes
- Local incision care,
- Removal of operative packs
- Removal of cutaneous sutures, staples, lines, wires, tubes, drains casts, and splints
- Insertion, irrigation and removal of urinary catheters
- Routine peripheral intravenous lines
- Nasogastric and rectal tubes
- Change and removal of tracheostomy tubes
The global surgery does not include the initial consultation, E&M encounters for concurrent conditions, diagnostic procedures needed to establish the diagnosis, additional surgeries needed to correct complications of surgery, or the services of other physicians who are treating concurrent conditions.

In order to facilitate uniform implementation, the CPT Editorial Panel has created four modifiers (24, 25, 78, and 79) to identify a service of procedure furnished during a global period that is not normally a part of the global surgery fee. For example, a service unrelated to the condition requiring surgery or for treating the underlying condition and not for normal recovery from the surgery may be reported in addition to the global fee. These modifiers will be discussed more in detail in the Modifier Section.

HCFA has directed that surgical fees for some of the CPT starred (minor) surgeries and nonincisional diagnostic or therapeutic endoscopic procedures include 1 to 10 days of postoperative care. All other services are billed on a fee-for-service basis. The HCFA designated postoperative follow-up periods for these minor surgeries are published in the Federal Register announcing the years changes in the yearly fee schedule as well as appearing in the updates to the Medicare Billing Manual.

G. LEVELS OF E/M CODES

Medicare, Medicaid, the Blues, and other insurance companies that audit claims follow the definitions for level of service in the CPT-4. The medical record is the one and only record that is used to substantiate the level of service. If the information in the medical record does not support the level of service, a refund or penalty will be requested from the provider, depending on the carrier. Therefore, it is extremely necessary to verify the information contained in the chart to the level of service that was billed. REMEMBER: If it is not documented in the medical record, it was not done!!

The levels of evaluation and management services are found in the front section of the CPT book. These consist of:

- Office and other outpatient visits (New and Established)
- Home visits
- Hospital Care (Initial and Subsequent)
- Skilled Nursing facility visits
- Rest Home visits
- Emergency department visits
- Critical Care Visits
- Consultations

This session will concentrate mainly on the office and other outpatient visits. First and foremost is clarification of the definitions of new and established patients.

New and Established Patients

A **new patient** is one who has not received any professional services from the physician or another member of the group in the same specialty within the past three years.

An **established patient** is one who has received professional services from the physician or another group member of the same specialty within the past three years. In the instance where a physician is on call for or covering for another physician, the patient’s encounter will be classified as it would have been by the physician who is not available.

Levels of E/M Services

75
Within each category or subcategory of E/M services, there are three or 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 services. For example: the second level of E/M services for office visit, new patient does not have the definition as the second level of services for the subcategory of office visit, established patient.

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.
The first three are **KEY** components:

1. History;
2. Examination;
3. Medical decision making;
4. Nature of presenting problem;
5. Counseling;
6. Coordination of care; and
7. Time

The **first three items** (history, examination, and medical decision making) are considered **key** components in selecting a level of E/M service.

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

The **final component**, time, is of variable importance.

**NOTE:** The physician has the ultimate responsibility of assigning the E/M codes for his/her services. This should **never** be decided by the coding or billing personnel.

When selecting a level of service, one must:

! Identify the category or subcategory of service.

! Review the reporting instructions for the selected category or subcategory.

! Review the level of E/M service descriptors and examples in the selected category or subcategory.

! Determine the extent of history obtained.

! Determine the extent of the examinations performed.

! Determine the complexity of medical decision making.
Select the appropriate level of E/M services.

**HISTORY**

The levels of E/M services recognize four types of history that are defined as follows:

- **Problem-focused** --- chief complaint; brief history of present illness or problem.
- **Expanded problem-focused** --- chief complaint; brief history of present illness; problem pertinent system review.
- **Detailed** --- chief complaint; extended history of present illness; extended system review; pertinent past, family, and/or social history directly related to the patient's problems.
- **Comprehensive** --- chief complaint; extended history of present illness; complete system review; complete past, family, and social history.

**EXAMINATIONS**

The levels of E/M services recognize four types of examination that are defined, as follows:

- **Problem-focused** --- an examination that is limited to the affected body area or organ system (one body area)
- **Expanded problem-focused** --- an examination of the affected body area or organ system and other symptomatic or related organ systems. (2-4 body areas)
- **Detailed** --- an extended examination of the affected body area(s) and other symptomatic or related organ systems (5-7 body areas)
- **Comprehensive** --- a general multi-system examination or a complete examination of a single organ system. Examination should included findings regarding 8 or more of the 12 organ systems. **Note:** The comprehensive examination performed as part of the preventive medicine evaluation and management service is multi-system, but its extent is based on age and risk factors identified. (8 or more body areas)

**DOCUMENTATION OF EXAMINATION**

<table>
<thead>
<tr>
<th>Recognized Examination Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body Areas</strong></td>
</tr>
<tr>
<td>- Head, including face</td>
</tr>
<tr>
<td>- Neck;</td>
</tr>
<tr>
<td>- Chest; including breast and axillae</td>
</tr>
</tbody>
</table>
Recognized Examination Elements

- Abdomen
- Genitalia, groin, and buttocks;
- Back, including spine;
- Each extremity.
- Ears, Nose, Throat, Mouth;
- Cardiovascular;
- Respiratory
- Gastrointestinal;
- Genitourinary;
- Musculoskeletal;
- Skin;
- Neurologic;
- Psychiatric; and
- Hematologic/lymphatic/immunologic.

The table below is a guideline as to how physical findings should be noted and recorded in the medical record:

<table>
<thead>
<tr>
<th>GENERAL DOCUMENTATION GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of Abnormal without elaboration is insufficient.</td>
</tr>
<tr>
<td>X Abnormal or unexpected findings of any examination of the unaffected or asymptomatic body area(s) or organ system(s) should be described.</td>
</tr>
<tr>
<td>X A brief statement or notation indicating Anegative or Anormal is sufficient to document normal findings related to unaffected area(s) or asymptomatic organ system(s).</td>
</tr>
<tr>
<td>X When the medical record indicates that a specific element of an examination has been deferred the reason(s) for the deferral should be documented.</td>
</tr>
</tbody>
</table>

MEDICAL DECISION MAKING

Medical decision-making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

! the number of possible diagnoses and/or the number of management options that must be considered;
the amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed; and

the risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient’s presenting problem(s), the diagnostic procedure(s), and/or the possible management options.

Four types of medical decision making are recognized:
  straightforward;
  low complexity;
  moderate complexity;
  high complexity.

To qualify for a given type of decision making, two of three elements in the following table must be met or exceeded.

Comorbidities/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.

<table>
<thead>
<tr>
<th>Type of Decision Required \ Making</th>
<th>Straight - forward</th>
<th>Low Complexity</th>
<th>Moderate Complexity</th>
<th>High Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of diagnoses or management options to be considered</td>
<td>minimal</td>
<td>limited</td>
<td>multiple</td>
<td>extensive</td>
</tr>
<tr>
<td>Amount and/or complexity of data to be reviewed</td>
<td>minimal to none</td>
<td>limited</td>
<td>moderate</td>
<td>extensive</td>
</tr>
<tr>
<td>Risk of complications and/or morbidity or mortality</td>
<td>minimal</td>
<td>low</td>
<td>moderate</td>
<td>high</td>
</tr>
</tbody>
</table>

Failure to document the consideration of other diseases and comorbidities in the decision making process is one of the biggest downfalls in justifying the level of service. For example: it is less of a risk to treat the patient with essential hypertension, than the patient with essential hypertension, emphysema, and congestive heart failure. The coordination of medication alone is a great risk.

NATURE OF PRESENTING PROBLEMS

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

Minimal -- A problem that may not require the presence of a physician, but service is provided under the physician=s supervision (Ex: blood pressure check, dressing change)
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 and compliance (Ex: otitis media, tonsillitis)

Low severity -- A problem where the risk of morbidity without treatment is low; there is no risk of mortality without treatment; full recovery without functional impairment is expected (Ex: stable chronic asthma on steroid and bronchodilator therapy)

Moderate severity -- A problem where the risk of morbidity without treatment is moderate; there is a moderate risk or mortality without treatment; uncertain prognosis OR increased probability of prolonged functional impairment (Ex: Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis)

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 (Ex: Multiple trauma, acute myocardial infarction, pulmonary embolus, acute renal failure)

COUNSELING
Counseling is a discussion with the 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 and/or follow-up;
- importance of compliance with chosen management options;
- risk factor reduction; and
- patient and family education

COORDINATION OF CARE
Coordination of care with other providers or agencies may be provided as consistent with the nature of the problem(s) and the patient=s and/or family needs.

TIME
The inclusion of time in the definitions of the E/M codes has been implicit in prior editions of CPT. The inclusion of time as an explicit factor beginning in CPT 1992 is done to assist physicians 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 which may be higher or lower depending on actual clinic circumstances.

Intra-service times are defined as face-to-face time for office and other outpatient visits and as unit/floor time for hospital and other inpatient services. This distinction is necessary because most of the work of typical office visits take place during the face-to-face time with the patient, while most if the work of typical hospital visits takes place during the time spent on the patient=s floor or unit.

1. Face-to-face time (office and other outpatient visits and office consultations): For coding purposes, face-to-face time for these services is defined as only that time that the physician spends face-to-face with the patient and/or family. This includes the time in which the physician performs such tasks as obtaining a history, performing an examination, and counseling the patient.
2. **Non face-to-face time for office services**: Time is also spent by physicians before and after the face-to-face time with the patient, performing such tasks as reviewing records and tests, arranging for further services, and communicating further with other professionals and the patient through written reports and telephone contact. The non face-to-face time for office services -- also called pre- and post-encounter time -- is not included in the time component described in the E/M codes. However, the pre and post face-to-face work associated with an encounter was included in calculating the total level of typical services in physician services. Thus, the face-to-face time associated with the services described by an E/M code is a valid proxy for the total work done before, during and after the visit.

The above section covering the Evaluation and Management codes is to be used as a reference. More detail is included to aid the coder in assisting the physician/provider of assigning the visit level. As mentioned before, the physician/provider has the ultimate responsibility in assigning the E/M code.

**H. MODIFIERS**

- Modifiers are a way for the provider to indicate that the procedure (CPT) listed has been altered—but not enough to warrant using a different CPT code.

- Examples –
  - To report technical component only
  - Performed by more than one physician
  - Service was reduced or increased
  - Procedure was bilateral
  - Unusual events occurred

- Additional example -

Patient presents to physician with knee joint pain and ear pain. Physician performs an expanded problem focused history; an expanded problem focused examination; and medical decision making of a low complexity. The physician decides at this point that the patient has arthritis in the knee and an otitis media. He injects the joint with 30 mg. of Triamcinolone. The following codes would be used to report this service.

| Otitis media | 99213-25 | Office or other outpatient visit for the E/M of an established patient, which requires at least two of these key components. Modifier -25 indicates significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service |
| Arthritis | 20610* | Injection of major joint or bursa (eg, shoulder, hip, knee joint, olecranon bursa). |
| J3301 | (3 units) Injection, triamcinolone acetonide, per 10 mg (Kenalog10, Kenalog-40, Kenaject-40) |

In the above scenario, the physician obtains reimbursement for the E/M visit for the otitis media; he also receives reimbursement for the knee joint injection for the diagnosis of arthritis of the knee. The third code (J3301) is reported for reimbursement of the substance injected.
Modifiers are used to give more definition to the service performed. It enhances the code and gives additional information. Some CPT modifiers are not acceptable by all carriers. The coder needs to know which modifiers will be accepted by which carriers.

-21  **Prolonged evaluation and management services:** When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than the usually required for the highest level of E/M services within a given category, it may be identified by adding modifier >-21' to the evaluation and management code. A report may also be appropriate.

  **MEDICARE DOES NOT RECOGNIZE MODIFIER -21**
  **(TO REPORT PROLONGED PHYSICIAN SERVICES WITH DIRECT (FACE-TO-FACE PATIENT CONTACT) USE CPT E/M CODES 99354-99357)**

-22  **Unusual procedural services:** When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier >-22' to the usual procedure number. A report also may be appropriate.

  **Example:** Surgical procedure, which usually takes one hour, takes 3 hours due to complications such as obesity, multiple adhesions, etc.  *(This modifier is to be used for surgical codes only and a report must be submitted with claim)*.

-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 the modifier >-23' to the procedure code of the basis service.

  **Example:** Sigmoidoscopy done under general anesthesia - 45330  Sigmoidoscopy
  45330-23 General Anesthesia applied  
  **MODIFIER -23 IS NOT RECOGNIZED BY MEDICARE**

-24  **Unrelated evaluation and management service by the same physician during a postoperative period:** The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier >-24' to the appropriate E/M service.

  **Example:** A patient had warts removed last week and now is in the office for bronchitis. The patient is returning within their 10 day global period for wart removal. Code the E/M with modifier 24 with the diagnosis of bronchitis.

-25  **Significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service:** The physician 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 the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. This circumstance may be reported by adding the modifier >-25' to the appropriate level of E/M service.

  **Example:** A patient presents for joint injection for arthritis. Internal Medicine physician performs injection. Patient also complains of a sore throat. Physician checks throat and orders antibiotics. This would be billed the following way:

  99212-25  Level 2 office visit  462 (pharyngitis)
**NOTE:** HCFA does not find it appropriate to approve E/M services with modifier -25 if a Procedure, such as a colonoscopy, was scheduled after an examination during a Prior visit, as the evaluation for the procedure will have been performed as part of This prior visit. Any modifier -25 billings for unrelated evaluation and management Services must be used for services not provided during either the procedure itself or or a prior visit.

-26 **Professional component:** Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding the modifier >-26' to the usual procedure number: **Example:** 71020-26 Professional component of a radiological examination, chest, two views, frontal and lateral (Radiologist=s reading--does not include the technical component of the actual x-ray).

-32 **Mandated services:** Services related to mandated or requested consultation and/or related services (e.g., PRO, third party payer) may be identified by adding the modifier >-32' to the basic procedure. **MEDICARE DOES NOT RECOGNIZE MODIFIER -32**

-47 **Anesthesia by surgeon:** Regional or general anesthesia provided by the surgeon may be reported by adding the modifier >-47' to the basic service. (This does not include local anesthesia.) **NOTE:** Modifier >-47 would not be used as a modifier for the anesthesia procedures 00100 - 01999. **MODIFIER -47 IS NOT RECOGNIZED BY MEDICARE**

-50 **Bilateral procedure:** Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by the appropriate five digit code describing the first procedure. The second (bilateral) procedure is identified by adding modifier >-50' to the procedure number.

**NOTE:** Nonparticipating providers have been required since January 1, 1991, to cut their Limiting charge on nonassigned claims for the surgical procedure(s) by 50%. **Participating providers bill out at 100%**

Some carriers indicate that a single procedure code modified with >-50' is used to Report both bilateral services. (Nebraska Medicaid requires one line listing)

-51 **Multiple procedures:** When multiple procedures, other than Evaluation and Management Services, are performed on the same day or at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by adding the modifier >-51' to the additional procedure or service code(s). Note: This modifier should not be appended to designated Aadd-on≡ codes (e.g. 22612, 22614)
NOTE: For Medicare purposes, effective January 1, 1995, payment on these services will be:

1st (major) procedure: 100%
2nd through 5th procedure 50%
More than 5 procedures are by report only.

For certain services which are defined as multiple or additional surgeries, these reductions will not apply. For other dermatologic procedures, a physician may submit a bill when 3 or more lesions are removed.

Multiple surgery rules do not apply if surgeons of different specialties are each performing a different procedure (with specific CPT codes); if one of the surgeons performs multiple procedures, the rules apply to that surgeon.

Example: In a surgical case of a multiple trauma patient, there might be two surgeons of different specialties performing surgery at the same time (e.g. an Orthopedic surgeon and a neurosurgeon. These surgeries are not multiple procedures but are distinct and separate to each specialty.

NOTE: For Medicare purposes, procedures which are considered additional services are not subject to the multiple surgery payment adjustments, and -51 does not need to be used.

-52 Reduced services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier >-52', signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. (This modifier is used when the patient intervenes and demands the physician to stop the procedure.)

-53 Discontinued Procedure: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to an extenuating circumstance or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding the modifier >-53' to the code for the discontinued procedure. Note: This modifier is not used to report elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating room suite. (Example: Patient is under anesthesia and undergoing the initial steps of surgical procedure and goes into shock causing discontinuation of the procedure.)

-54 Surgical Care only: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding the modifier >-54' to the usual procedure number. (Example: Obstetrical care where one physician in billing for pre and post-op care but his partner does the actual delivery).

-55 Postoperative management only: When one physician performs the out of hospital postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier >-55' to the usual procedure number.
Preoperative management only: When one physician performs the preoperative care and evaluation and another performs the surgical procedure, the preoperative component may be identified by adding the modifier >-56' to the usual procedure number.

MEDICARE DOES NOT RECOGNIZE MODIFIER -56
PREOPERATIVE MANAGEMENT IS BUNDLED IN WITH -54
NOTE: Medicare payment for postoperative care by more than one physician will be apportioned according to the number of days of the total 90 day period each doctor renders care. In most cases, it is felt that the surgeon will perform the in-hospital care, but may turn over the out-of-hospital care to another physician. Therefore HCFA has determined percentages for families of procedures for paying the usual out-of-hospital post-operative care furnished by another physician. (Refer to Medicare Fee Schedule Data Base (MPFSDB) that was mailed as attachment 7 (P-97-1) Communiqué.

-57 Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery, may be identified by adding the modifier >-57' to the appropriate level of E/M service.

NOTE: Decision to Operate: Modifier >57: Decision for Major Surgery= has been established. An evaluation and management service on the day before major surgery or on the day of major surgery, that results in the initial decision to perform surgery is not included in the global surgery payment for the major surgery (90 day global period) and, therefore, may be billed and paid separately using the A57" modifier. This is effective for dates of service on or after January 1, 1994.

-58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier >-58' to the staged or related procedure. NOTE: This modifier is not used to report treatment of a problem that requires a return to the operating room. See modifier >-78'. Example of use of -58 Modifier: Dermatology would use this modifier when skin grafts are done in staged procedures.

-59 Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure of service was distinct or independent from other services performed on the same day. Modifier >-59' is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injuries in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier >-59'. Only if no more descriptive modifier is available, and the use of modifier >-59' best explains the circumstances, should modifier >-59' be used. (NOTE: Modifier >-59' replaces the old Medicare modifier AGB). EXAMPLE: Patient presents to his physician in the morning complaining of ear pain and is treated with antibiotics. The patient leaves the physician’s office and later that day falls and sprains his ankle. He returns that day to the physician’s office for evaluation of his sprained ankle. The physician would then bill out the second visit (sprained ankle) with a >-59' modifier to indicate that it was a separate and distinct procedural service performed on the same day as another service.

-60 Altered Surgical Field: Certain procedures involve significantly increased operative complexity and/or time in a significantly altered surgical field resulting from the effects or prior surgery, marked scarring, adhesions, inflammation, or distorted anatomy, irradiation, infection, very low weight and/or trauma as documented in the patient’s medical record. These circumstances should be reported by adding the modifier ‘-60’ to the procedure number or by use of the separate five digit modifier code. Note: For unusual procedural services not involving an altered surgical field due to the late effects of previous
surgery, irradiation, infection, very low weight and/or trauma, append modifier “22” or use the separate five-digit code 09922.

**MODIFIER ‘-60’ IS NOT RECOGNIZED BY MEDICARE.**

-62 **Two Surgeons:** Under certain circumstances the skills of two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. Under such circumstances the separate services may be identified by adding the modifier >-62’ to the procedure number used by each surgeon for reporting his services.

*NOTE:* For Medicare, and many other payers, payment would be 125% of usual allowed charge split between two surgeons.

-66 **Surgical team:** Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the Asurgical team concept. Such circumstances may be identified by each participating physician with the addition of the modifier >-66’ to the basic procedure number used for reporting services. A report may also be appropriate. Each surgeon submits his services with modifier >-66’. **EXAMPLE:** A multi-trauma victim with fractures and head injury might require the use of a neurosurgeon and an orthopedic surgeon.

-76 **Repeat procedure by same physician:** The physician may need to indicate that a procedure or service was repeated subsequent to the original visit. The circumstance may be reported by adding the modifier >-76’ to the repeated service. **EXAMPLE:** A patient presents to his doctor with breathing problems. The physician orders a chest x-ray and then the patient is given a nebulizer breathing treatment. After the treatment, the physician orders a second x-ray to see if the treatment has helped. The second chest x-ray would have the >-76’ modifier attached to it.

-77 **Repeat procedure by another physician:** The physician may need to indicate that a basic procedure performed by another physician had to be repeated. This situation may be reported by adding modifier >-77’ to the repeated service. **EXAMPLE:** A patient presents to his primary care physician with epistaxis (nose bleed). His primary care physician packs the nose and sends the patient over to an ENT specialists. The ENT physician repacks the nose after examination. The ENT physician would submit his nose packing with a -77 modifier.

-78 **Return to the operating room for a related procedure during the postoperative period:** The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier >-78’ to the related procedures. (For repeat procedures on the same day, see >-76’.) **EXAMPLE:** An OB patient delivered but has extensive hemorrhage. The patient is returned to the operating room for a D & C. **NOTE:** A new postoperative period does not begin with the use of the >-78’ modifier.

-79 **Unrelated procedure or service by the same physician during the postoperative period:** The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier >-79’. (For repeat procedures on the same day, see >-76’.)
**NOTE:** The Medicare Part B Physician Manual states: When a less extensive procedure is performed to avoid a risky, extensive surgery, and the less extensive procedure is unsuccessful, surgeons often must perform the more difficult procedure within the postoperative period of the original surgery. The Carrier should make full payment for a surgery performed during the postoperative period of an unsuccessful lesser procedure. Payment rules for the treatment of complications do not apply to this situation. The physician should bill for the second surgery with a modifier -79. A new global period commences with the second surgery. (Surgery Section, page 340 under Ad=.)

**-80 Assistant surgeon:** Surgical assistant services may be identified by adding modifier -80 to the usual procedure number(s).

**MEDICARE DOES NOT RECOGNIZE MODIFIER -80**

**(ASSISTANT SURGERY IS NOT COVERED WHEN IT IS FURNISHED IN A TEACHING HOSPITAL)**

**-82 Assistant surgeon (when qualified resident, surgeon not available):** The unavailability of a qualified resident surgeon is a prerequisite for use of modifier -82 appended to the usual procedure number(s).

**81 Minimum assistant surgeon:** Minimum surgical assistant services are identified by adding the modifier -81 to the usual procedure number.

**82 NOTE:** Medicare covers an assistant-at-surgery if the procedure customarily requires services of an assistant surgeon and the surgery itself is covered.

Assistant Surgery is **not** covered when it is furnished in a teaching hospital with a training program related to the medical specialty required for the surgical procedure and there is a qualified resident available to perform the service **unless:**

1) There are emergency medical circumstances which are life threatening situations such as multiple traumatic injuries requiring immediate treatment.

2) There is no approved training program related to the medical specialty required for the surgical procedure or the primary surgeon has an across-the-board policy of never involving residents in the prepartive, operative or postoperative care of his or her patients. This exception generally applies to the community physicians who have no involvement in the hospital=s graduate medical education program. In such a situation, reimbursement may be made for medically necessary services on the same basis as would be the case in a nonteaching hospital. However, if assistant is not a physician primarily engaged in that field of surgery, payment would not be available. **Unless** –

Complex medical procedures, including multi-stage transplant surgery and coronary bypass may require of team of physicians. In these situations, each of the physicians perform a unique distinct function requiring special skills integral to the total procedure. Each physician is engaged in a level of activity different from assisting the surgeon in charge of the case. **OR,**

Services of physicians of different medical specialties are necessary during surgery, and where each specialist is required to play an active role in the patient=s treatment because of the existence of more than one medical condition requiring diverse, specialized medical services. For example, a patient=s cardiac condition may require a cardiologist to be present to monitor the patient=s condition during abdominal surgery.

(Surgery Section, page 351 and 352, Medicare Part B Physicians Manual. Please refer to that section for additional information on Assistant Surgery Coverage by Medicare).
-90 **Reference (outside) laboratory:** When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding the modifier >-90' to the usual procedure number. (Purchased services - must add Box 20 and 32 information for Medicare claims).

-99 **Multiple modifiers:** Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier >-99' should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

**Level II Modifiers (Medicare specific) – For details, see pages vi – viii of the HCPCS 2001**

**Why You Should Be Using HCPCS**

The following summarizes why our practice should be using HCPCS codes:

1. HCFA mandated the use of HCPCS codes on Medicare claims, and many Medicaid offices also require them.
2. HCPCS codes improve a provider’s ability to communicate services or supplies correctly without resorting to narrative descriptors.
3. Using HCPCS reduces resubmission of claims for correction or review. When an inaccurate code or incomplete narrative description is submitted, the claim’s adjudicator must assign a code or return the claim. This time delay can be costly, and the payer’s reassignment of the code may be incorrect.
4. Using up-to-date and accurate HCPCS codes on office routing slips allows office staff to assign fees to services and supplies quickly and efficiently, saving you both time and money.
5. Making your coding system compatible with your carriers helps expedite claims processing.
6. Consistent submission of “clean claims” (those with all information necessary for processing) will help avoid being targeted for an audit by your carrier for frequent development of your claims.
7. Using HCPCS is essential for:
   - If you bill Medicare for an injection using only a CPT code, you will not be reimbursed correctly. You must identify the drug administered with the correct Level II or III HCPCS code.
   - Supplies billed as “over and above those usually included with the office visit” (CPT code 99070) will generally not be reimbursed unless identified with Level II or III HCPCS codes.

**INTEGUMENTARY SYSTEM**

The integumentary system is made up of structures that cover the body: skin, hair, nails, sebaceous glands, and sweat glands. The breasts and subcutaneous tissue are also included in the integumentary system.

**Special Reports**

A service that is rarely performed, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include:

- Definition or description of the nature, extent, and need for the procedure
- The time, effort, and equipment necessary to provide the service
- The complexity of symptoms, final diagnosis, and pertinent physical findings
- Diagnostic and therapeutic procedures
- Concurrent problems
- Extent of follow-up care required
**Incision and drainage of abscess**

Definition of terms:

- **Abscess**: localized collection of pus
- **Carbuncle**: skin infection composed of a cluster of boils caused by staphylococcal bacteria
- **Furuncle** (boil): painful skin node caused by staphylococcal bacteria in a hair follicle
- **Suppurative Hidradenitis**: a disease characterized by chronic inflammation and/or infection of the sweat glands located in the mammary (breast), axillary (underarm), scalp, genital, inguinal (groin), or anal regions of the body. Small firm masses form in the skin which grow larger and drain pus.
- **Paronychia**: an infection of the folds of skin around the cuticle.
- **Lesion**: an abnormal change in the tissues in an area of the body, such as a sore, rash, wound, injury, or growth...usually localized.
- **Cyst**: a closed sac in or under the skin that contains fluid or other material.

This procedure may be simple or complicated. In most cases, it will be simple and code 10060 will be used. However, multiple abscesses may be incised and drained. The physician determines whether or not the case is complicated. Patient anatomy, condition, extent of disease, etc help determine the level of complication. If multiple or complicated, code 10061 will be used.

**Incision and removal of foreign body**

Definition of terms:

- **Foreign body**: an object or substance located in an area of the body where it does not belong.

This procedure may be simple or complicated. The physician makes the decision and the documentation must support the complication if complicated is selected. The simple procedure includes an incision made through the skin and subcutaneous tissue, the removal of the foreign body and closure with sutures. The simple procedure is coded as 10120; complicated as 10121.

**Incision and drainage of hematoma, seroma or fluid collection**

Definition of terms:

- **Hematoma**: a mass of blood or blood clots caused by a break in the wall of a blood vessel, usually due to injury.
- **Seroma**: localized accumulation of serum (clear, fluid portion of the blood) within a tissue or organ.

This procedure consists of an incision made in the skin over the affected area and the contents drained from it. The wound is normally closed with sutures. Code 10140 would be selected for
Excision: Debridement

Definition of term:

Debridement

The removal of dirt foreign material, damaged and dead tissue, or debris from infected skin, burn or wound to promote healing.

Codes 11000 and 11001 are used to describe the debridement of eczematous or infected skin. Eczema is an inflammation of the skin characterized by redness, swelling, itching, blistering, scaling, etc. The contaminated skin may be cut away using scissors or a scalpel, or the affected area may be debrided with large amounts of saline solution. These codes are not to be used for debridement of nails or burns.

Codes 11040-11044 are used to describe the debridement of skin, subcutaneous tissue, muscle and bone.

Debridement is coded separately ONLY in the following circumstances:

- It is performed at a different time other than closure
- The procedure is very difficult or time-consuming
- Significant amounts of tissue are removed to clear the wound to prepare it for closure
- Gross contamination requires prolonged cleaning

Biopsy of skin

A biopsy is the removal of a small amount of living tissue from the body for examination of abnormalities. This is used to determine the extent of a disease, confirm a diagnosis, or estimate the outcome of a disease.

Codes 11100 and 11001 are to be used ONLY when biopsies for specific areas are not otherwise listed.

Example: A biopsy of the soft tissue of upper arm or elbow area would be coded as 24065, not 11100. There is a substantial difference in reimbursement.

When reporting multiple biopsies, do not add the multiple procedure modifiers to codes for additional lesions. The value for these procedures already includes the reduced allowance for secondary procedures.

When a lesion is removed in its entirety, do not code a biopsy even though it was removed for that purpose. Since it was completely removed, it should be coded as - Excision of a lesion (benign or malignant).

This procedure includes the simple closure of the wound.

Removal of Skin Tags

A skin tag is a small outgrowth of flap of skin and is common in older persons. They are often found on the neck. Skin tags are generally snipped off at the base with small scissors. The procedure includes the simple closure of the wound or ligature strangulation.
Shaving of Epidermal or Dermal Lesions

This procedure (codes 11300-11313) represents the removal of a lesion by slicing through its base with a knife or similar instrument. Tissue is removed through the epidermis and skin. Sometimes a caustic chemical may be applied to the wound to control bleeding. Electrocautery may also be applied to stop bleeding.

Remember that shaving is the main process involved. If chemical or electric destruction is the main process, use code in the 17000 range instead.

Shaving includes any local anesthesia and/or chemical or electrical cauter of the wound. Code selection depends upon the size and anatomic site.

Excision, Benign Lesions

A benign lesion is a noncancerous, abnormal area of the tissues of the body, such as a sore, rash, wound, injury or growth. The choice of code for lesion removal depends on the site and size (lesion diameter).

If the closure of the wound after lesion removal is a simple wound repair, the closure is not coded separately. However, if the wound requires a layered closure, the closure is coded in addition to the lesion excision code.

Listed below is a table of inches – metric equivalents that can be used when selecting the proper code.

<table>
<thead>
<tr>
<th>Inches</th>
<th>Metric Equivalents</th>
</tr>
</thead>
<tbody>
<tr>
<td>3/16”</td>
<td>0.5 cm</td>
</tr>
<tr>
<td>¼ - 3/8</td>
<td>0.6 – 1.0 cm</td>
</tr>
<tr>
<td>7/16 – 13/16</td>
<td>1.1 – 2.0 cm</td>
</tr>
<tr>
<td>13/16 – 1 3/16</td>
<td>2.1 – 3.0 cm</td>
</tr>
<tr>
<td>1 ¼ - 1 9/16</td>
<td>3.1 – 4.0 cm</td>
</tr>
<tr>
<td>1 9/16</td>
<td>4.0 cm</td>
</tr>
</tbody>
</table>

When procedures are unusual or complicated, modifier 22 should be added to the procedure. Appropriate documentation should accompany the claim. Select codes 11400 – 11446 to bill for excision of benign lesions.

Excision, Malignant Lesions

A malignant lesion is a cancerous growth that invades adjacent normal tissue and may metastasize to distant parts of the body. Basal cell epithelioma, squamous cell carcinoma and melanoma are examples of malignant skin lesions. Local anesthesia and simple closure are included in these procedures (11600-11646). However, if a layer/intermediate closure is required, it may be reported separately using Repair codes (12031-12057). These codes do not include treatment by radiation or chemosurgery.

When a surgeon removes a border or margin of normal tissue around the lesion that is far in excess of the size of the malignant lesion, the excision of malignant lesion codes may not adequately describe the extent of surgery actually performed. Instead, the radical resection codes are used to report the procedure. These codes are listed by anatomic site in the Musculoskeletal System subsection. If a skin graft is required to cover the defect that remains after the radical excision, report the appropriate skin graft code as well.

♦ Example: Code 24077 Radical resection of tumor, soft tissue of upper arm or elbow area.

The reimbursement for this code would be substantially higher per procedure.
If a skin graft is required to cover the defect that remains after the radical excision, report the appropriate skin graft code as well.

When a malignant lesion is excised and requires a skin graft for closure, but is not considered a resection, use the code 15000 to report the procedure instead of 11600-11646. The appropriate skin graft code would be reported as well.

**Repair**

The choice of code for wound repair depends on the site, length of the wound in centimeters and type of repair.

There are three types of wound repair: simple, intermediate and complex.

**Simple**

A simple repair is indicated for superficial wounds or lacerations that involve the skin and/or subcutaneous. These wounds do not substantially involve deeper tissues or body parts and can be closed by one-layer, simple suturing.

**Intermediate**

Includes layer closure, usually involving fascia or muscle, where at least one of the layers requires a separate closure.

**Complex**

Wounds requiring reconstructive surgery, complicated wound closures skin grafts or unusual and time-consuming techniques.

Do not code closure of wounds with adhesive strips (butterfly or steri-stips). Code only the appropriate E/M.

The following table may be used in selecting a code for wound repair.

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Centimeters</th>
</tr>
</thead>
<tbody>
<tr>
<td>1”</td>
<td>2.5 cm</td>
</tr>
<tr>
<td>1”-2”</td>
<td>2.6 – 5.0 cm</td>
</tr>
<tr>
<td>1-2 15/16”</td>
<td>2.6 – 7.5 cm</td>
</tr>
<tr>
<td>2 –2 15/16”</td>
<td>5.1 – 7.5 cm</td>
</tr>
<tr>
<td>3-4 15/16”</td>
<td>7.6 – 12.5 cm</td>
</tr>
<tr>
<td>4 15/16 – 7 7/8”</td>
<td>12.6 – 20.0 cm</td>
</tr>
<tr>
<td>7 15/16 – 11 13/16”</td>
<td>20.1 – 30.0 cm</td>
</tr>
<tr>
<td>11 13/16”</td>
<td>30.0 cm</td>
</tr>
</tbody>
</table>

When selecting wound repair codes, consider the following guidelines.

Review the length of a wound, measured in centimeters and determine the tissue involvement.

Add together and code as one repair wounds of the same classification (simple, intermediate or complex) and same site grouping. Some insurance carriers will prefer that you report each repair individually instead of reporting the sum of the lengths. However, adding them together is the preferred method.
List the most complicated classification of repair first. Add the 51 modifier if multiple repairs listed.

Simple tying of blood vessels (ligation) to stop bleeding is considered part of a wound repair. In addition, simple examination or exploration of exposed nerves, blood vessels, or tendons in an open wound is considered an essential step in a wound repair and is not billed separately.

**Destruction**

Destruction is the eradication or obliteration of a lesion. Electrosurgery, cryosurgery, chemical destruction, laser and other methods are used for this purpose.

When reporting the destruction of multiple lesions in the same operative session, do not add the 51 modifier to secondary procedures for additional lesions. The value for these procedures already reflects a reduced allowance in payment.

**Benign and Premalignant Lesions**

Codes 17000-17010 cover the destruction of benign facial lesions and the destruction of premalignant lesions in any location. A premalignant lesion is one that tends to become cancerous. Examples of premalignant skin lesions are lentigo maligna, actinic keratoses and leukoplakia.

Codes 17100-17108 cover the destruction of benign skin lesions other than cutaneous vascular proliferative lesions on any area of the body other than the face.

Codes 17106-17108 cover the destruction of cutaneous vascular proliferative lesions. These are a number of different superficial, deep pink or pale purple discoloration of the skin. They may be congenital and often appear on the face, scalp, or neck. They sometimes occur on other body parts of the body as well. These lesions generally tend to be benign. They are sometimes referred to as port-wine stains and telangiectasia. The treated area is measured in square centimeters and this determines the proper code selection.

Code 17110 covers the destruction of warts, molluscum contagiosum, which appears as a white, solid raised area and milia, which are block sweat glands and hair follicles and are generally present of the face.

Codes 17200-17201 cover the destruction of skin tags. This is not to be confused with the excision of skin tags. These codes describe electrosurgical destruction only.

**Malignant Lesions**

The methods used to destroy malignant lesions include electrosurgery, cryosurgery, and laser or chemical destruction. Several methods of destruction may be used in combination to treat a lesion. The choice of method depends upon the type of lesion, its size, its location and the physician’s preference.

**Breast**

The codes for breast procedures reflect unilateral procedures. If a bilateral procedure is performed, use the 50 modifier. You may also wish to use the LT (left) and RT (right) modifiers when reporting to Medicare and Medicaid.
**Puncture Aspiration**

Codes 19000 and 19001 represent the aspiration of cysts of the breast. This procedure may be done to remove fluid from a cyst for relief of pain. It may also be done to determine whether a lump is a cyst or a solid tumor.

**Biopsy**

If a biopsy is performed on both the right and left breasts and the pathology report shows different diagnoses for each side, show the specific diagnosis for each breast biopsy on the claim.

When a lump is entirely removed, it is coded as an excision of a lesion even though the intent was to biopsy.

A needle core biopsy (19100) and a fine needle aspiration biopsy (88170) need to be distinguished. Both procedures may utilize a fine needle, although the core biopsy is almost always done with a larger bore needle.

An incisional biopsy (19101) is the removal of part of a lesion for examination to detect abnormalities.

**Endoscopies**

Procedures under an Endoscopy subheading are not considered “open” surgical procedures. A diagnostic endoscopy is always included in a surgical bronchoscopy. When both procedures are performed at the same operative session, only the surgical bronchoscopy should be reported.

A **flexible endoscopy** is performed with a flexible tube with an eyepiece at one end and a light at the other. A **rigid endoscopy** is performed with a rigid metal tube.

**Cell washing** is a process in which a fluid is applied or washed over an area of tissue and retrieved by suction for microscopic examination.

**Brushing** is a process in which a brush is swept across an area and cells are collected from the tissue for microscopic examination.

If a single lesion is biopsied but not excised, only the lesion biopsy code should be reported. If a biopsy of a lesion is obtained and the remaining portion of the lesion is then excised, only the code for the excision should be reported.

If a biopsy and an excision are performed during the same operative session, both the biopsy and excision codes would be reported, provided the biopsy was taken from a lesion other than the one excised and the excision code does not include the phrase “with or without biopsy.”

If multiple biopsies are obtained, whether from the same or different lesions, and none of the lesions is excised, only the biopsy code should be used and should be listed only once.

When coding lower endoscopic procedures, the procedure performed is distinguished depending on the length of bowel visualized. An **Anoscopy** visualizes up to 5 cm; a **Proctoscopy** visualizes 6 to 25 cm; a **Flexible Sigmoidoscopy** visualizes 26-60 cm; and a **Colonoscopy** visualizes over 60 cm.

Foreign objects may be removed or broken up with a scope by the use of suction, forceps or other means.

Endoscopies are often performed to control bleeding. Some common methods are used:

- Injection sclerosis of varices – a method in which veins are injected with a sclerosing solution that hardens and forms a clot-like collection of material that adheres to the blood vessel walls which stops the bleeding.
Band ligation of varices – a method in which an elastic band that functions like a rubber band is placed over the varix, suction is applied to draw it up into the device and the band is released over the base of the varix, thus ligating it.

The codes labeled “to control bleeding, any method” may be used to report other procedures such as the use of an electric current which causes the end of the instrument to become very hot and it is applied to tissue to cauterize it. A laser may also be used to coagulate and seal affected blood vessels.

Endoscopic procedures are also performed for the removal of tumor(s), polyp(s) and other lesion(s). Some of the methods used are:

- **Hot biopsy forceps** – a technique in which forceps (tweezer-like instrument) are inserted that are connected to a source of electric current. The forceps grasp the tumor or polyp. The tumor is pulled away from the surrounding tissues and an electric current is applied through the forceps, which kills the tissue. Once the tissue is damaged sufficiently, it will slough off and pass through the digestive tract.

- **Bipolar cautery** – a method used for treating lesions with a cautery tool capable of cutting tissue and coagulating blood vessels.

- **Snare technique** – procedure in which a snare (an instrument with a wire loop or similar apparatus at one end) connected to an electric current is passed over the stalk of the polyp and tightened. An electric current is passed through the snare, cutting the stalk while coagulating blood vessels around it. The polyp may be retrieved with the snare, a basket or forceps.
What is ICD-9 coding?

- A coding system that translates written diagnoses into numbers.
- ICD-9 codes identify diseases, symptoms, conditions, problems, complaints and/or other reasons for medical service.
- The codes are then used by commercial and government payers to determine their liability for payment for services based on diagnosis.

Where did ICD-9 come from?

- It began in 1948, started by the World Health Organization to track sickness and deaths worldwide.
- The Ninth Revision was first published in 1977.
- ICD-10 is now being used in Europe. It is an alphanumeric system that is larger and much more specific. Eventually, this system will be introduced in the United States.

ICD-9 coding may seems challenging at first, but –

- The process of finding the correct code becomes easier as you work with it.
- Medical terminology helps. Consider using a medical dictionary to locate and define unfamiliar terms.
- Coding can be very rewarding – most Coders feel a great sense of satisfaction when they can find the correct codes for difficult diagnoses.
FORMAT

The ICD-9 manual is laid out in a Three Volume format –

Volume 1  Tabular List of Diseases and Injuries
Volume 2  Alphabetic Index of Diseases and Injuries
Volume 3  Tabular List and Alphabetic Index of Procedures

However, in the clinical office setting we only use Volume 1 and Volume 2, which are called the ICD-9-CM (clinical modification). Volume 3 is used by facilities only.

Within the ICD-9-CM the two volumes are reversed – the first volume found in the manual is Volume 2 (Alphabetic Index), followed by Volume 1 (Tabular List).

Updated Books are published each year in October. They are available for purchase from a number of different vendors.
Within the Alphabetic Index there are three sections –

**Alphabetic Index to Diseases and Injuries**
- Main Terms in Alphabetical Order
  *Main Terms are in Boldface*
- Subterms are indented two spaces to the right under the main term
- Carry-over lines are indented more than two spaces from the level of the preceding line

Example:

<table>
<thead>
<tr>
<th>Main Term</th>
<th>Pain(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subterm</td>
<td>joint</td>
</tr>
<tr>
<td></td>
<td>ankle</td>
</tr>
<tr>
<td>Carry-Over</td>
<td>719.40</td>
</tr>
<tr>
<td></td>
<td>719.47</td>
</tr>
</tbody>
</table>

- Also in this section are two *SPECIAL TABLES*. These are found under their Main Terms
  * Hypertension
  * Neoplasm

**Table of Drugs and Chemicals**
- Laid out in Table format
- Classification of drugs and other chemical substances
- Helps to identify poisoning states and external cause of adverse effects

**Index to External Causes of Injuries and Poisonings**
- Alphabetic listing environmental events, circumstances, and other conditions as the cause of injury and other adverse effects
- Presented in the same format as the Alphabetic Index to Diseases and Injuries (e.g. Main Term, Subterm, Carry-Over)

Example:

<table>
<thead>
<tr>
<th>Main Term</th>
<th>Fall, falling</th>
<th>E888</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subterm</td>
<td>from, off</td>
<td></td>
</tr>
<tr>
<td>Carry-Over</td>
<td>sidewalk (curb)</td>
<td>E880.1</td>
</tr>
<tr>
<td>2nd Carry-Over</td>
<td>moving</td>
<td>E885.9</td>
</tr>
</tbody>
</table>
The Tabular List is a numeric listing with 17 chapters. About half of the chapters are devoted to conditions affecting a certain body system. The remainder classifies condition according to etiology. The 17 chapters are listed below.

CLASSIFICATION OF DISEASES AND INJURIES
1. Infectious and Parasitic Diseases (001-139)
2. Neoplasms (140-239)
3. Endocrine, Nutritional and Metabolic Diseases and Immunity Disorders (240-279)
5. Mental Disorders (290-319)
6. Diseases of the Nervous System and Sense Organs (320-389)
7. Diseases of the Circulatory System (390-459)
8. Diseases of the Respiratory System (460-519)
10. Diseases of the Genitourinary System (580-629)
11. Complications of Pregnancy, Childbirth, and the Puerperium (630-676)
12. Diseases of the Skin and Subcutaneous Tissue (680-709)
15. Certain Conditions Originating in the Perinatal Period (790-779)
16. Symptoms, Signs and Ill-Defined Conditions (780-799)
17. Injury and Poisoning (800-999)

There are also two sections of Supplementary Classifications –

- Supplementary Classification of Factors Influencing Health Status and Contact with Health Services (V01-V82)
- Supplementary Classification of External Causes of Injury and Poisoning (E800-E999)

The Tabular List and the Supplementary Classifications are structured the same way —

- SECTIONS (groups of three digit categories)
- CATEGORIES (three digit numbers)
- SUBCATEGORIES (four digit numbers)
- SUBCLASSIFICATIONS (five digit numbers)

All codes have at least three digits
Most have a fourth digit
Many have a fifth digit

A Decimal Point separates the first three digits from its Subcategory and/or Subclassification.

REMEMBER – ONLY 96 CODES ARE JUST THREE DIGITS!!!!
CONVENTIONS

Conventions include general notes, instructional notes using specific terms, cross-references, abbreviations, punctuation marks, symbols, typeface and format.

Abbreviations:

**NEC – Not Elsewhere Classified** – No separate code for the condition exists even though the diagnostic statement may be very specific. Commonly, these codes are classified to the fourth digit 8.

*Look up Condyloma in Volume 2*

**NOS – Not Otherwise Specified** – Indicates the code is unspecified. The Coder should continue looking for a more specific code or try to get more information from the Provider. If no other alternative exists, these codes may then be used. Often, they are classified to the fourth digit 9.

*Look up 420.90 (acute pericarditis) in Volume 1*

Punctuation Marks:

- Parentheses enclose Supplementary words. These words may be present or absent and DO NOT effect code selection. The terms within the parentheses are called NON-ESSENTIAL MODIFIERS.
  
  *Find Pneumonia in Volume 2*

- Square Brackets enclose synonyms, alternate wording or explanatory phrases.
  
  *Look up code 041.5 in Volume 1*

- Colons are used after an incomplete term that MUST BE followed by one or more modifiers to make it assignable to a give category.
  
  *See code 245.0 (acute thyroiditis) in Volume 1*

- Braces are used in Volume 1 to enclose a series of terms which are each modified by a statement appearing at the right of the brace.
  
  *Find 045.1 in Volume 1*

Colored Symbols:

- **Gray Box with White X** is used in Volume 2 to indicate that a code needs an additional digit.
  
  *Look up Pain, Abdominal in Volume 2*

- **Red Stop Sign (Octagon)** is used in Volume 1 to indicate that a code needs an additional digit.
  
  *See code 250.0 (Diabetes mellitus w/o Complications) in Volume 1*

- **Blue Rectangle** is used in Volume 1 to mark codes that are not acceptable as a primary diagnosis.
  
  *Find 774.5 (Perinatal Jaundice from other causes) in Volume 1*

- **Yellow Diamond** is used in Volume 1 to let you know that a code is Nonspecific. These are NOS and NEC codes.
  
  *Look up 780.39 (Other Convulsions) in Volume 1*
MAIN TERMS WITHIN DIAGNOSES

The very first step in finding the correct diagnosis code is finding the main term within the diagnosis. Main Terms can represent –

- Diseases
  - influenza, bronchitis
- Conditions
  - fatigue, fracture, injury
- Nouns
  - diseases, disturbance, syndrome
- Adjectives
  - double, large

ANATOMICAL SITES ARE NOT USED FOR MAIN TERMS.

- Bronchial Asthma
  - Under Asthma, Not Bronchial
- Abdominal Pain
  - Under Pain, Not Abdominal
- Bowel Ischemia
  - Under Ischemia, Not Bowel

EXERCISE ONE

Underline the Main Term in each of the following diagnostic statements –

1. Breast Mass  3. Heel Spurs
2. Deviated Nasal Septum  4. Excessive Eye Strain
BASIC STEPS IN CODING

STEP 1 Locate the Main Term in the Alphabetic Index (Volume 2).

STEP 2 Refer to any notes and Non-Essential Modifiers under the Main Term. Remember Non-Essential Modifiers have NO bearing on code selection.

STEP 3 Refer to any Subterms and Carry-Over lines indented under the Main Term. Remember these DO have an effect on code selection.

STEP 4 Verify the code in the Tabular List (Volume 1).

STEP 5 Read and be guided by any instructional terms in the Tabular List. Pay attention to the inclusion and exclusions that may appear under a particular code, category, section, or chapter.

STEP 6 Code to the highest level of specificity. The 3 digit disease category codes are used only if there are no decimal digits listed in that category. Four digit subcategory codes are used only if no fifth digit subclassifications are provided.

STEP 7 Follow any cross-referenced instructions. You may have to use two or more codes if necessary to completely classify a diagnosis. The ‘Code Also’ instructions in the Tabular List provide the best guide to the Coder in determining the need for multiple codes.

OTHER RULES TO REMEMBER

1. ALWAYS consult the Alphabetic Index (Volume 2) first and then verify within the Tabular List (Volume 1) before selecting a code.

2. Be sure to link the proper diagnosis to the proper procedure. If patient comes in with a cough and a wart, be sure that the diagnosis code for the wart (and not the cough) is listed with the procedure code for wart removal.

3. Read any footnotes or other notes and be sure to follow any directions that tell you to “see” or “see also”.

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EXERCISE 2

Circle the Main Term and Find the Appropriate ICD-9-CM code.

1. Tension headache
2. Bronchial croup
3. Senile cataract
4. Paranoid delusion
5. Acute otitis media
6. Acute hemorrhagic otitis media with effusion
7. Parkinson’s disease
8. Coronary insufficiency
9. Lumbalgia due to displacement of intervertebral disc
10. Varicose veins of lower extremities
V – CODES

The group of V – Codes help to explain reasons for services when a patient is not current ill. Some of these include –

- Preventive care
- Patient referred for tests
- Follow-up services
- Therapy treatment

The codes may also show situations that influence a patient’s health status but are not a current illness or injury. Examples of these are –

- Family or Personal history of cancer
- Counseling for family problems
- Screening or Observation for a suspected condition

Main Terms for V – Codes include

<table>
<thead>
<tr>
<th>Examination</th>
<th>Observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission (Encounter) for Tests</td>
<td>Screening (for) Care (of)</td>
</tr>
<tr>
<td>Aftercare</td>
<td></td>
</tr>
<tr>
<td>Therapy</td>
<td></td>
</tr>
</tbody>
</table>

Will insurance cover procedures linked to a V-Code?

Reimbursement for these claims will be dependent on the individual insurance policy.

EXERCISE 3

Find the appropriate ICD-9-CM code

1. Family history of breast cancer
2. Screening for glaucoma
3. Follow-up exam after surgery
4. Dietary counseling for diabetes
SUSPECTED CONDITIONS

When the medical record states a diagnosis as “questionable, probable, likely or rule out,” you may not code that diagnosis as if it exists. Instead code the documented symptoms or complaints of the patient.

Always code signs and symptoms that currently exist if that is the highest degree of certainty you can code (see codes 780-799).

What if the patient is asymptomatic???

If the patient is having no symptoms, consider using a V – Code as the diagnosis.

Is this a screening? Is it an examination?

Chronic conditions can be coded as long as the patient is receiving treatment for the condition.

Remember – Never, ever code a suspected condition as if it exists!

EXERCISE 4

Circle the condition you can code and then find the appropriate ICD-9-M code –

1. Chest pain, R/O acute myocardial infarction
   ________________

2. Abdominal discomfort RUQ, possible gall bladder disease
   ________________

3. Fatigue, suspected iron deficiency anemia
   ________________

4. Diabetes mellitus ruled out
   ________________
COMBINATION CODING & MULTIPLE CODING
(When one code isn’t enough or two codes are too many)

Combination codes – two diagnoses or diagnoses with an associated secondary process (manifestation) or complication are included in the description of a single code. Two Main Terms may be joined together by combination terms –

- associated with
- complicated (by)
- due to
- during

EXAMPLE: Two Diagnoses One Code
Bronchitis with Influenza 487.1

Multiple codes – more than one code is needed to fully identify a given condition. You MUST use multiple codes when “Code Also” appears in the code you are choosing.

- Underlying Cause = primary diagnosis
- Effect (manifestation) = secondary diagnosis

Multiple coding is used a lot with Diabetes Mellitus. To properly code these conditions you must know the two types of diabetes.

- Type I  Insulin Dependant
- Type II Non-insulin Dependant

EXAMPLE:
Diabetic nephrosis in an insulin dependant female whose diabetes is well controlled

First code the underlying condition – 250.41
Then the manifestation - 581.81

Multiple coding SHOULD NOT be used when a combination code accurately identifies the diagnosis!

EXERCISE 5
Find the proper ICD-9-CM codes for the following Diagnosis. Some are combination codes (just one code), why others are multiple codes (two codes).

1. Cholecystitis with bile duct calculus
2. Malarial fever with hepatitis
3. Influenza with URI
4. Endocarditis due to typhoid
NEOPLASMS

A neoplasm is a new growth that is harmful to the body. Within the Alphabetic List (Volume 2) there is a special table to help code neoplasms. In that table six types of neoplasms are identified.

<table>
<thead>
<tr>
<th>Noninvasive tumors that remain localized and do not spread</th>
</tr>
</thead>
<tbody>
<tr>
<td>Invasive tumors that can spread to other parts of the body</td>
</tr>
<tr>
<td>Cancer (cancer)</td>
</tr>
<tr>
<td>Malignant neoplasms still confined to one spot and have to</td>
</tr>
<tr>
<td>spread to surrounding tissues</td>
</tr>
<tr>
<td>Behavior cannot be determined; may become malignant at a later date</td>
</tr>
<tr>
<td>Diagnosis is so vague that it does not indicate either the behavior or the type of neoplasm</td>
</tr>
</tbody>
</table>

In order to properly code a malignant neoplasm, you must know whether a site is Primary or a Metastasis (Secondary).

| site where the malignancy originates or the first point of origin |
| cells from a malignant neoplasm separate from the primary neoplasm and travel via blood stream, lymph system, or through body cavities to other parts of the body, where they become implanted and grow. This new site is called Secondary. |

TIPS FOR CODING NEOPLASMS

1. **Look up the main term within Volume 2**
   - This will either give you a code to verify in the Tabular list or direct you where to look in the Neoplasm Table
   - If main term is not listed go directly to neoplasm table

2. **Turn to the Table of Neoplasms and look under site**
3. **Identify correct column and find code**
4. **Verify code in Volume 1**

EXERCISE 6

Find the correct code for the following –

1. Dermatofibroma

2. Ca in situ, cervix

3. Malignancy, metastasized to brain

4. Adenoma of the breast
CODING INJURIES

When coding injuries, you find the code by looking up the general type of injury. Within each injury type there is a further break down by anatomical site. Some main terms or types of injuries are –

- Burn
- Contusion
- Dislocation
- Foreign body
- Fracture
- Injury
- Rupture
- Strain, Sprain
- Wound

The term injury includes blast injury, blunt trauma, crushing, hematoma, laceration, rupture, tear, puncture, concussion (except cerebral) and traumatic rupture of organs.

When coding multiple injuries, the most severe injury will be the primary diagnosis. Some multiple sites of injury are specified within the diagnosis. Interpret “with” as indicating both sites and the term “and” as involvement of either or both sites.

EXERCISE 6

Find the appropriate code(s) for the following injuries –

1. Fracture of clavicle with foreign body
2. Sprain, lumbosacral spine
3. Fracture & dislocation of patella
4. Bruise, right hip
CODING BURNS

When it comes to coding burns there are some important rules to remember.

When burns of more than one site are present, the most severe (highest degree) is coded first. If the burns are of the same local site (same three digit code), you code to the highest degree listed.

EXAMPLE –

- 3rd Degree Burn arm & 1st degree Burn head/neck
  943.30, 941.10

- 3rd Degree Burn of shoulder & 2nd Degree Burn of upper arm
  943.39

It is also important to use a second code telling the extent of body surface involved. The code used to relay this information is 948.XX. The last two digits of the code help to describe the extent. The fourth digit is the entire percentage of body burned and the fifth digit is how much of the body was inflicted with third degree burns. To calculate the percentage of body area burned, you use what is called the rules of nine. The rule on nines establishes estimates of body surface involved as follows:

- Head and Neck 9 percent
- Each Arm 9 percent
- Each Leg 18 percent
- Anterior (Front) Trunk 18 percent
- Posterior (Back) Trunk 18 percent
- Genitalia 1 percent

EXAMPLE –

- 3rd Degree Burn leg 945.32, 948.11
- 2nd Degree Burn arm, 3rd Degree burn leg 945.30, 943.20, 948.21

EXERCISE 11

Find the appropriate codes for the following burns.

1. 2nd Degree burn hand, 1st Degree burn arm

2. 3rd Degree burn back

3. 1st Degree burn knee, 2nd Degree burn ankle

4. 3rd Degree burn trunk, 3rd Degree burn leg
EXTERNAL CAUSES (E CODES)

External cause codes help to provide circumstances of an injury or illness. These can include -

- How an accident occurred.
- Whether a drug overdose was accidental or purposeful.
- Where the accident happened.

Coders may find it necessary to use more than one E Code to describe circumstances of an illness or injury.

These codes help to establish liability among payers such as medical insurance plans, car insurers or Workers’ Compensation programs.

*E Codes are not acceptable as a primary or solo code.*

‘E’ CODES MUST BE LISTED FOR ALL CODES IN THE 800-900 CATEGORY

EXERCISE 9

Let’s try one together –

1. Fractured ankle when falling from horse
   a) Find the ICD-9 code for the injury
   b) Look in the Index of External Causes in Volume 2. What is the main term of the accident?
   c) Find the E code in Volume 2 & Verify it in Volume 1

Now try one on your own –

2. Broken collar bone, due to confirmed child abuse by father

   ICD-9-CM Code
   __________________________

   E Code
   __________________________
POISONINGS & ADVERSE EFFECTS

Adverse effect – a side effect cause by a substance being correctly administered (given exactly as prescribed)

When coding an adverse effect, two codes are needed –
1st Code List ICD-9-CM code for Adverse Effect
2nd Code Follow with E Code for Therapeutic Use of Responsible Drug(s)

Some Terms that usually indicate correct dosage are –

- Allergic reaction
- Cumulative effect of drug (toxicity)
- Hypersensitivity to drug
- Idiosyncratic reaction
- Paradoxical Reaction
- Synergistic reaction

Poisoning – a substance not being used exactly as prescribed

When coding a poisoning, three codes are needed –
1st Code Poisoning Code for Responsible Drug(s)
2nd Code ICD-9-CM Code for Manifestation (Condition resulting from poisoning)
3rd Code E Code to indicate circumstance of poisoning

Some Terms that usually indicate poisoning are –

- Intoxication (not toxicity)
- Overdose
- Suicide Attempt
- Wrong Dosage
- Wrong Medication

EXERCISE 10

1. Lethargy due to unintentional overdose of sleeping pills
   a) How many codes needed? __________________________
   b) What are the correct codes? __________________________

2. Syncope due to hypersensitivity to antidepressant medication
   a) How many codes needed? __________________________
   b) What are the correct codes? __________________________
Complications of Surgery and Medical Care

Codes from 996-999 are assigned for complications of surgical and medical care that are not classified elsewhere. Codes from this series are assigned only when a causal relationship exists between the condition and the care received. The fact that the condition develops following surgery or other care does not necessarily mean that it is a complication of that care.

Diagnoses qualified as postoperative require caution in coding and may also need clarification from the attending physician.

A complication of surgery or medical care has no time limit. It may occur during the same hospital episode, shortly thereafter, or even years later. NOTE also that the term complication does not have the connotation of improper or inadequate care as the cause.

Postoperative complications are classified in two ways in ICD-9-CM:

! Postoperative complications that affect a specific anatomical site or body system or result from a specific operation are usually classified to categories 001-799.

! Complications that affect multiple sites or body systems are generally classified to categories 996-999

Example: Cardiac insufficiency due to mitral valve prosthesis 429.4
Postoperative atelectasis of lung 997.3 + 518.0

It is absolutely vital for the coder to carefully examine both the alphabetical index and the tabular list to note for inclusions, due to, and exclusions in order to be guided to the proper code for complication.

! Location of Complication Codes in the Alphabetic Index -

To locate the codes for complications in the Alphabetic Index, the coder should refer first to the main term for the condition and then search for a subterm indicating it is due to a procedure. For example, the diagnosis of postoperative thrombophlebitis can be located by referring to the main term Thrombophlebitis because the Alphabetic Index provides a specific entry for this condition.

Thrombophlebitis 451.9
postoperative 997.2

Another example is the code for a diagnosis of postgastrectomy dumping syndrome. The appropriate code can be located by referring to either the main term Syndrome or Postgastrectomy dumping syndrome (564.2)

When no entry can be found under the main term for the condition, the coder should refer to the main term Complications and an appropriate subterm, such as one of the following:

! Resulting condition
! Type of procedure, such as bypass, dialysis, or nephrostomy
! Anatomical site or body system affected, such as respiratory, obstetrical, or cardiac
! General terms, such as mechanical, surgical procedure, or graft
Complications Due to Internal Device, Implant, or Graft

Subcategories 996.0-996.7 classify complications that occur only as the result of an internal device, implant, or graft. The term internal device is used broadly and includes such things as catheters even though they may not seem significant enough to be designated as internal devices.

Complications of internal devices and implants are classified first as either mechanical or nonmechanical in nature. Mechanical complications are those that result from some failure of the device, implant, or graft (such as displacement or malfunction) and are classified to subcategories 996.0-996.5, with the fourth digit indicating the body system involved. Specific examples of mechanical complications include the following:

- Perforation of uterus by intrauterine contraceptive device 996.32
- Leakage of mitral valve prosthesis at site of valve insertion 996.02

Abnormal reactions to the presence of a device, implant, or graft that is functioning properly are classified to the 996.6-996.7 subcategories. Infections and inflammations are coded 996.6x; other nonmechanical reactions are assigned to code 996.7x. In both subcategories fifth digits are now available to indicate the general site of the device, implant or graft. Specific examples of nonmechanical complications include the following:

- Infected cardiac pacemaker pocket 996.1
- Inflammation of urethra due to indwelling catheter 996.64

These are just a few examples of complications. Complications are important to report to third party carriers because they are not included in the course of recovery during the global surgery procedure, and, therefore, are reimbursable.
ICD-9-CM Practice Exercise 11

1. Acute appendicitis with generalized peritonitis

2. Diabetes mellitus, insulin dependent, out of control

3. Elective sterilization, patient request

4. Viral Hepatitis

5. Neonatal hypoglycemia

6. Family planning counseling

7. Bipolar disorder in manic phase, mild

8. Thalassemia

9. Pernicious anemia

10. Psychomotor epilepsy

11. Acute lobar pneumonia

12. Chronic pulmonary edema

13. Allergic rhinitis to tree pollen

14. Bleeding gastric ulcer

15. Gangrenous umbilical ulcer

16. Endometrial polyp

17. Cellulitis of eyelid

18. Recurrent derangement of knee

19. Pregnancy delivered, frank breech presentation
   single live born female

20. Congestive heart failure with pleural effusion
Medicare Place of Service Designation

When billing under the physician’s name, the midlevel must provide care in the following locations:
- Office, Institutional Office or patient’s home.

When providing service in these locations, services must be billed by the “SERVICE PROVIDER” as the “billing provider:”
- Hospital-Based Facilities
  - Lied Transplant Center
  - Infectious Disease
  - Hematology/Oncology
  - Pediatric Oncology
  - Orthopaedics
  - OB/GYN
  - ENT
  - Liver Failure
  - Lung Clinic
  - Geriatrics
  - Cardiology
  - Psychiatry
  - Surgical Oncology
  - GI
  - Radiation Oncology
  - Clarkson’s Kidney Transplant Clinic
  - Clarkson’s Pancreas Transplant Clinic
  - Burn Center
  - Wound Center
  - Endostomal Therapy Clinic
  - Clinical Research Center
- Hospital Inpatient Unit
NPP Office (POS** 11)
Direct Billing
Decision Tree

Is this a Medicare Patient?
—
** YES
** NO

Bill under supervising MD/DO (May bill direct if Payor allows—see payor guide)

Was the supervising MD/DO in the clinic?
—
** YES
** NO

Bill direct

Was it a new patient?
—
** YES
** NO

Did this pt. have a significant new problem at this visit?
—
** YES
** NO

Bill direct

Bill under supervising MD/DO#

** Place of Service
Who does Medicare consider an NPP?
PA, NP, CNS, CRNA, CP, CSW.

Who does Medicare NOT consider an NPP?
RN’s, LPN’s, Dieticians, Pharm-D’s. Provided they have lease agreements in place to perform services “Incident-To,” but only 99211 and procedures within their scope of practice defined by the State. EXCEPTION: Pharm-D’s are NOT included in the lease arrangements at UMA so they CANNOT bill “Incident-To.”

What is “Incident-To”?
Services furnished as an integral, although incidental, part of the physician’s personal professional service. Services must be furnished in the clinic setting; under physician’s direct personal supervision, and furnished by someone who qualifies as an employee of the physician or group.

Define “direct supervision.”
Physician must be present in the office suite and immediately available to provide assistance.

Who qualifies as an employee?
To be considered an employee when billing under a supervising physician, the NPP performing the service may be part-time, full-time, or leased employee of the supervising physician, physician group practice, or of the legal entity that employs the physician who provides the direct personal supervision.

Can a NPP supervise an RN and bill “Incident-To” to Medicare? Ex: NP conducting a f/u visit. The NP asks the RN to clean the patient’s ears.
Yes, in the clinics. The service would be limited to 99211 & limited to 85% of physician fee schedule.

Can a UNMC NPP provide and bill for services in the UMA clinics?
Yes, an NPP can bill direct or under physician in this setting as long as the “Incident-to” requirements are met.

Can an NHS NPP, who is not a leased employee to UNMC/UMA, bill for services provided in the UMA clinics?
No, a NPP must be employed by UMA or leased to UMA.

What is appropriate to bill when NPP dictates note for pt and physician comes along behind and documents his/her own note?
The provider who performed most of the service should bill.

Is it appropriate for a NPP to document the physician’s involvement when pt comes in for f/u with a “new problem?”
Yes, that is acceptable. Another option would be to have the NPP document visit up to discussion of new problem, then MD/DO documents – bill under MD/DO. If the patients insurance recognizes the NPP, he/she may also elect to bill direct under their number.

Can a NPP use a “scribe” when billing “Incident-To?”
No, it is not appropriate to use a scribe in this situation. Although, a scribe could be used if NPP was billing direct.

What types of services can be provided by an NPP?
Types of services that can be provided by NPP’s includes those that are within the State Law or regulation governing an NPP’s scope of practice in the State in which the services are performed.

Can a Locum Tenens arrangement be made between an NPP and a physician?
No, Locum Tenens only applies to physicians.

If an NPP sees a patient and dictates, then a physician comes along and also sees the patient and dictates, can both services be billed?
No, the provider who performed most of the service should bill.
How should a midlevel bill for services when a carrier does not recognize them?
If a carrier does not recognize a midlevel, bill under the supervising physician.

Quality Documentation

CONTACT INFORMATION

NP/PA services can be billed direct under the midlevel provider number for the following:

- Medicare – BCBSKS**
- Medicare – BCBSND**
- UHC RR Medicare
- Exclusive Healthcare
- Midlands Choice
- Mutually Preferred
- Tricare
- Wellmark
- Unity Choice HMO
  ** If billing a new patient visit, the service MUST be billed under NPP’s provider number.

NP/PA services must always be billed under the MD/DO provider number for the following:

- BCBSN/Blue Preferred
- HMO NE
- Medicaid (Nebraska)
- Medicaid (Iowa)
- Principal (Coventry)
- UHC Midlands (Share Advantage)

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* Not Available
** Terminates 12/31/01