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While federal and private payers have different objectives (such as the age of the population covered) and use different contracting practices (such as fee schedules and coverage policies), the plans and providers set similar elements of the quality in common for all patients. Nevertheless, it is important to consult with individual private payers if you have questions regarding coverage.

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## Contents

**Introduction** .................................................................................................................. vii

**Chapter 1**  
The Purpose of Clinical Documentation Improvement ........................................... 1

- The Quality of Documentation ................................................................................. 1
- Mastering the Documentation Process ................................................................. 4
- Frequently Asked Questions ................................................................................. 6

**Chapter 2**  
Implementation of a CDI Program ............................................................................... 9

- Conduct Appropriate Training and Education .................................................. 10
- Enforcement of Protocols .................................................................................. 11
- Frequently Asked Questions ........................................................................ 11

**Chapter 3**  
Evaluation and Management Documentation ..................................................... 15

- An Overview of E/M Documentation Guidelines ................................................ 17
- Levels of E/M Service ..................................................................................... 17
- Determining Code Level Based on MDM ......................................................... 18
- Determining Code Level Based on Time ......................................................... 20
- Hotspots for E/M Claims Denials ................................................................ 21
- Frequently Asked Questions ........................................................................ 22

**Chapter 4**  
Procedural Documentation ..................................................................................... 29

- Global Surgery Package .................................................................................. 30
- Frequently Asked Questions ........................................................................ 33
- Exercises ........................................................................................................ 37

**Chapter 5**  
Medical Necessity .................................................................................................... 39

- Medical Necessity and CMS .......................................................................... 39
- Recovery Audit Contractors (RAC) .................................................................. 40
- Frequently Asked Questions ................................................................. 42
Chapter 6
Clinical Conditions and Diagnosis Coding ........................................ 45
  Introduction .................................................................................. 45
  Use Both Alphabetic Index and Tabular List ...................................... 45
  Level of Detail in Coding ............................................................... 46
  Excel With Auditing Advice for ICD-10-CM and CDI ....................... 46
  Frequently Asked Questions ...................................................... 47

Chapter 7
Incident-to Guidelines and Shared Visits ............................................ 55
  Incident-to Guidelines .................................................................. 55
  Split/Shared Services .................................................................. 55
  Split/Shared Services vs. Incident-to Billing Services ....................... 55

Chapter 8
Electronic Medical Records ................................................................. 57
  Templates ..................................................................................... 57
  Copy and Paste ........................................................................... 58
  Communication ........................................................................... 59
  Ace EMR Documentation With These Guidelines and Tips .............. 59
  Exercises .................................................................................... 64
  Frequently Asked Questions ...................................................... 68

Chapter 9
Communication ............................................................................... 71
Clinical Documentation Resources .................................................. 73
  1. Toolkit for Generating Provider Queries ....................................... 73
  2. Simplifying Documentation Requirements .................................... 75
  3. 30.6.1 - Selection of Level of Evaluation and Management Service (Rev. 11288, Issued: 03-04-22, Effective: 01-01-22, Implementation: 02-15-22) .................................................. 78
  4. Excerpts From the Centers for Medicare & Medicaid Services, MLN Booklet Evaluation and Management Services Guide .................................................. 80
  5. Fact Sheet - Physician Fee Schedule (PFS) Payment for Office/Outpatient Evaluation and Management (E/M) Visits .......................................................... 82
  7. Centers for Medicare & Medicaid Services. National Physician Fee Schedule Relative Value Files .......................................................... 91
  9. Medicare Benefit Policy Manual, MCM, 60 - Services and Supplies Furnished Incident-To a Physician’s/NPP’s Professional Service .................................................. 124
CHAPTER 1

The Purpose of Clinical Documentation Improvement

The Quality of Documentation

Quality assurance in patient care is only evident if it is documented in the medical record. Quality services may have been provided; however, if this is not evident within the medical record, problems may arise.

For example, another provider (or the same provider several weeks later) will not necessarily know the details of the previous encounter. Providers can’t always rely on the patient to fill them in. For example, the provider may ask the patient what medications they are taking, and the patient responds, “I take the purple one in the morning.” If the provider has not documented the type of medication and proper dose in the patient’s record, they will have no idea what the patient is taking and whether is they are taking it correctly.

If the provider instructs the patient on risks and benefits of a procedure and how to properly take medication but fails to document the instructions given and that the patient understood all the instructions, the provider has made himself vulnerable if the patient has any type of misadventure.

Records are scrutinized by multiple entities. Providers and facilities are being challenged to put their best foot forward in many ways. The only evidence the providers have of their veracity and the quality of care provided is the medical record.

Another reason for a quality assessment review of the clinical documentation is the number of requests for medical documentation from contractors paid by CMS for Hierarchical Condition Category (HCC) and Healthcare Effectiveness Data and Information Set (HEDIS®) studies. These programs are abstracting data from the medical records for calculating risk adjustments based on the severity of diseases.

“The ultimate purpose of the CMS-HCC model is to promote fair payments to Medicare Advantage (MA) plans that reward efficiency and encourage high quality care for the chronically ill. Its use is intended to redirect money away from MA plans that disproportionately enroll the healthy, while providing the MA plans that care for the sickest patients the resources to do so” as stated in the Evaluation of the CMS-HCC Risk Adjustment Model.

Requests for medical records come from many sources, for different reasons other than reimbursement. For example:

- CMS contractors, HCC, HEDIS
- Patients
- Attorneys
- Other providers
- Workers’ compensation
- Payers for precertification
- Pre-employment applications
- Military application
- SSI applications
Conduct Appropriate Training and Education

Providers must be trained on the importance of detailed and quality documentation. Most providers have an inherent knowledge of what should be documented for clinical standards; however, there is a gap between clinical standards and the coding systems.

To effectively educate the provider, we must first understand the level of respect that is required. The documentation specialist must demonstrate respect for the providers and their situations. They must establish integrity and accountability.

Coding professionals, auditors, and documentation specialists must earn credibility with those being trained. All professionals responsible for educating providers must do so with current, accurate, and authoritative information. Trainers should never be aggressive, demanding, or insulting. It is important that the provider or administrator set the stage and conditions for training whenever possible.

There are times that individuals are required to undergo training as part of compliance measure for a facility or private practice. It is important to understand that providers and staff members may be frustrated and perceive the training as a waste of their time. At times, they may be difficult to work with. Never take unpleasant responses and inappropriate comments personally. As a trainer, it is the documentation specialist’s responsibility to communicate the information in the most professional manner, to create the most positive and effective results.

You must understand what the provider responds to best. Some providers simply want to be told what to do. Others want to read every document you can provide to support the instruction and guidance. When providing feedback to a provider regarding documentation deficiencies, the most effective action is to provide examples of their own documentation with feedback for improvement because it allows them to understand the deficiency and how to improve.

When training providers, it is best not to use abstracts. Use data that is meaningful and information pertinent to the deficiency. The documentation specialist must focus on data that needs attention and correction. This may involve the process of demonstrating a loss in reimbursement. Demonstrating the risk factors in terms of payment recoupment, prepayment audits, and potential fines and consequences as the result of being noncompliant is also effective. Normally, providers will respond to at least one of these demonstrations.

Education is an important part of any compliance program and is the logical next step after problems have been identified and the practice has designated a person to oversee educational training.

Ideally, education programs will be tailored to the physician practice’s needs, specialty, and size, and will include both general compliance and specific training.

There are three basic steps for setting up educational objectives:

1. Determine who needs training (both in coding and billing and in compliance);
2. Determine the type of training that best suits the practice’s needs (eg, seminars, in-service training, self-study, or other programs); and
3. Determine when and how often education is needed, and how much each person should receive.
Specific information is required to describe the patient encounter each time the patient presents for medical services. Clinicians may review past records or speak with other healthcare professionals, gather specific information from the patient through a series of questions, and physically assess the patient. The clinician will then summarize their findings and create a plan to treat the patient. Each encounter will generally contain:

- The chief complaint is a description of why the patient is presenting for healthcare services. It can also be referred to as the reason for the patient visit.
- The history of present illness (HPI) is how the patient describes the symptoms they are experiencing, and which have prompted the patient to seek medical attention.
- The physical examination is performed by the healthcare provider through a series of assessments and observations, focused around the symptoms described by the patient.

The healthcare provider makes a determination (also known as a diagnosis) about the cause of the symptoms, which is the provider’s assessment of the problem. Based on that assessment, the provider creates a plan to relieve or resolve the patient’s symptoms.

The most common format used in medical records is the SOAP format:

S — Subjective: where the patient provides information about their symptoms and what, if anything, they have done to relieve the symptoms.

O — Objective: indicates the physical exam findings of the provider.

A — Assessment: the provider’s assessment of the patient’s condition, and where the provider indicates either a definitive or working diagnosis. In absence of a diagnosis, signs and symptoms may be documented until further testing can be performed.

P — Plan: the provider’s plan is documented in direct relation to the assessment above. In cases where a definitive diagnosis has not been reached, the documentation should reflect tests that are being ordered, with an indication of the provider’s thought process.

Regardless of the format used by the provider, it is imperative the documentation of an evaluation and management visit accurately reflect the work performed during the visit.

If a minor office procedure is performed during an evaluation and management service, the documentation for that procedure can be included in the notes for the evaluation and management service. It is not necessary to have a separate operative report.

A documentation specialist must be familiar with the documentation requirements of the evaluation and management (E/M) and procedure codes used by physicians and non-physician practitioners (NPPs) to bill for their services.
• Post-surgical pain management by the surgeon
• Any related supplies, services, or procedures normally required for the surgery

Medicare will only cover postoperative complications that require a return to the operating room. Procedure rooms and minor treatment rooms are not considered operating rooms.

Global Surgery Status Indicators

Surgical CPT® codes (10004-69990) have global surgery status indicators that are assigned based on risk factors associated with medical procedures. The status indicators can be found on the Medicare Physician Fee Schedule Relative Value File found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html.

An excerpt is provided below:

<table>
<thead>
<tr>
<th>HCPCS</th>
<th>MOD</th>
<th>DESCRIPTION</th>
<th>GLOB DAYS</th>
<th>PRE-OP</th>
<th>INTRA OP</th>
<th>POST OP</th>
<th>MULT PROC</th>
</tr>
</thead>
<tbody>
<tr>
<td>11006</td>
<td></td>
<td>Debride genit/per/abdo m wall</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>11008</td>
<td></td>
<td>Remove mesh from abd wall</td>
<td>ZZZ</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1101F</td>
<td></td>
<td>Pt falls assess- docd le1/yr</td>
<td>XXX</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>11010</td>
<td></td>
<td>Debride skin at fx site</td>
<td>10</td>
<td>0.1</td>
<td>0.8</td>
<td>0.1</td>
<td>2</td>
</tr>
<tr>
<td>11011</td>
<td></td>
<td>Debride skin musc at fx site</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>11012</td>
<td></td>
<td>Deb skin bone at fx site</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>11042</td>
<td></td>
<td>Deb subq tissue 20 sq cm/&lt;</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>11043</td>
<td></td>
<td>Deb musc/fascia 20 sq cm/&lt;</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>11044</td>
<td></td>
<td>Deb bone 20 sq cm/&lt;</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>11045</td>
<td></td>
<td>Deb subq tissue add-on</td>
<td>ZZZ</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

In the Global Days column, the Global Surgery Status Indicators identify the following:

• 000: Endoscopies or minor procedures with preoperative and postoperative relative values on the day of the procedure only are reimbursable. Evaluation and management services on the same day of the procedure are generally not payable. (eg, CPT®, 43255, 53020, 67346).

• 010: Minor procedures with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period are reimbursable services. Evaluation and management services on the day of the procedure and during the 10-day postoperative period are not reimbursable. (eg, CPT® 17261, 40800, 64612).

• 090: Major procedures with one-day preoperative period and 90-day postoperative period are a component of global package of the major procedure. Evaluation and management services on the day prior to the procedure, the day of the procedure, and during the 90-day postoperative period are not reimbursable. (eg, CPT® 21048, 32664, 49582).
Introduction

Proper ICD-10-CM code selection can be accomplished when you follow ICD-10-CM conventions, general guidelines, and chapter-specific coding guidelines. The Tabular List is organized into 22 chapters categorized by etiology or anatomic site. Section I.C. of the ICD-10-CM Official Guidelines for Coding and Reporting includes instructions for correct code selection and sequencing specific to each chapter. There are no official guidelines for each three-character category within each chapter of the ICD-10-CM code book.

It is important to turn to the official coding guidelines in the front of the ICD-10-CM code book to take notes for each of the chapter-specific coding guidelines.

The information contained in this reference guide is meant as a supplement and is not intended to replace the official coding guidelines found in the ICD-10-CM code book. It is important to read and understand every guideline and convention found in ICD-10-CM.

Use Both Alphabetic Index and Tabular List

Always use both Tabular List and Index to Diseases and Injuries (Alphabetic Index). Verify the code number in the Tabular List. Never code directly from the Alphabetic Index because important instructions often appear in the Tabular List. Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular List. A dash (-) at the end of an Alphabetic Index entry indicates additional characters are required. Even if a dash is not included at the Alphabetic Index entry, refer to the Tabular List to verify that no 7th character is required or that no additional notes exist which can impact code selection. To locate an ICD-10-CM code, take the following steps:

1. Locate each term in the Alphabetic Index:
   - Locate the main term in the Index to Diseases and Injuries (Alphabetic Index).
   - Refer to any notes under the main term.
   - Read any terms enclosed in parentheses following the main term.
   - Refer to any modifiers of the main term.
   - Do not skip subterms indented under the main term.
   - Follow any cross-reference instructions, such as see also.
   - Use of a medical dictionary can help you to identify main terms and understand the disease process to assist with accurate coding.

There can be more than one way to find the correct code. For example, to find the code for COPD you could also locate it under Disease, diseased/pulmonary/chronic obstructive or Disease, diseased/lung/obstructive (chronic).
To correctly assign an ICD-10-CM code, the provider needs to document: the type, location, and laterality of a fracture; the severity of a disease; the episode (initial versus subsequent); readmission status (if applicable); temporal factors; manifestation; etiology — infectious agents (or possible agent of poisoning); contributing factors; HPI; and associated conditions, such as a pregnancy.

**Question:** What are some key concepts I can teach my provider for good ICD-10-CM documentation?

**Answer:** It is crucial that providers understand the ICD-10-CM Official Guidelines, which may vary based on body systems or diseases processes.

“With” or “in:” The word “with” or “in” should be interpreted to mean “associated with” or “due to” when it appears in a code title (either under a main term or sub-term), the Alphabetic Index, or an instructional note in the Tabular List. A causal relationship is presumed when two conditions are linked by these terms unless specific documentation clearly states that the conditions are unrelated, or another guideline exists that specifically requires a documented linkage.

“Code also” note: A “code also” note indicates that two codes may be necessary to fully describe the patient’s condition. The sequencing of these codes depends on the circumstances of the encounter.

**Initial/subsequent/sequela:** For some codes, chart documentation must support if the encounter is the initial encounter, a subsequent encounter, or sequela. Providers must remember to differentiate between an additional or subsequent encounter, as this distinction will allow their coders to correctly report this information.

**Acute or chronic:** Documentation of acute versus chronic is commonly missed, or insufficient. Some providers even follow the logic that if it’s an old patient, the condition is chronic; if it’s a young patient, the condition is acute. Obviously, this is not a reliable diagnostic rubric.

**Laterality (right, left, or bilateral):** When the condition can be on the left, the right, or bilateral, the provider needs to correctly document this information. Without the mention of laterality, it would not be possible to zero in on a specific code. Indicating laterality is no longer as simple as appending an RT Right side modifier to a CPT® code; it is now a large part of assigning an ICD-10-CM code.

**Recurring themes add specificity:** For a basic condition, there is a family of codes where the basic code repeats itself, with various manifestations to cover the range of aspects associated with the condition, such as the encounter type, healing, nonunion, malunion, and laterality, among others.

**Question:** What are some key documentation concepts to teach my trauma physicians for trauma and injury coding?

**Answer:**

1. **Episode of care:** The episodes of care are generally divided into three categories, and the provider needs to correctly document each one:
   a. **Initial encounter**, defined as the patient receiving active treatment
   b. **Subsequent encounter** occurs when the active treatment is complete, and physician provides follow-up care
Incident-to Guidelines

Incident-to services are performed incident-to the physician’s services. These can be services performed by the patient’s staff. For example, a nurse giving an injection. This service is performed by the nurse under the physician’s supervision. Incident-to services are also performed by midlevel providers known as nonphysician practitioners (NPPs), including physician assistants (PAs), advanced registered nurse practitioners (ARNPs), and certified nurse midwives.

To bill services incident-to, the services must be as a result of the physician’s treatment plan and the physician must be in the office suite providing supervision. They do not need to be in the room, but they must be in the office to bill the services incident-to (for example, a nurse administering an injection). If the physician was out of the office seeing patients at the hospital, the services could not be billed because the physician is not providing supervision. Incident-to is not recognized in a facility setting.

Medicare has very strict guidelines, but other carriers may have different guidelines. It is imperative to understand Medicare’s guidelines but understand what other payers’ guidelines are. If you meet the requirements for incident-to billing, the claim is submitted under the physician’s name as if they personally performed the service and the reimbursement will be at 100 percent. Services performed by NPPs that are not incident-to are billed under the NPP’s own national provider identifier (NPI) number and reimbursed at 85 percent.

Many practices think that the NPPs cannot provide services on their own but that is not true. NPPs can provide services on their own. The only difference is that the claim is billed in their name and there is a reduction in reimbursement. For example, if a patient comes for a follow up as part of the physician’s treatment plan and is seen by the NPP, the service is billed under the physician’s NPI. If the patient comes in for a new problem, obviously it would not be a service that is part of the physician’s treatment plan since the patient is presenting with it for the first time. This service would be billed by the NPP and paid at 85 percent of the fee schedule.

Split/Shared Services

A shared/split visit occurs when an NPP and physician are involved in the same patient case. If performed in the office setting and the incident-to requirements are met, the service can be billed by the physician. If not, it is billed by the NPP. In the hospital inpatient, outpatient, and ED settings, if the physician performs a face-to-face encounter, the service can be billed by the physician or the NPP. If the physician only reviews the chart and discusses the case with the NPP, the service is billed by the NPP.

Split/Shared Services vs. Incident-to Billing Services

- Shared/split services involve a physician and an NPP.
- A variation could be two physicians or two NPPs.
- Both the physician and NPP must separately document and sign the record.
Keep a Separate Section for the CC

Providers should have a separate section that denotes the CC — it should be clear to anyone reading the record why the patient was seen. Some EMRs do not clearly specify the CC as its own separate section.

**Red flag:** The CC is the first thing that a payer’s auditor will look for, and if the CC is not there, it is will be a black mark against the provider. An absent CC prevents the provider from building on the patient’s history, and they can’t use that history to determine the level of service.

**Remember:** The chief complaint should help support the medical necessity of the visit.

HPI records are often better if written free-handed because then all pertinent information is listed. However, if the provider is using a template, they need to ensure that it is based on the currently accepted CMS documentation guidelines, as shown in Table 9.1:

<table>
<thead>
<tr>
<th>HPI Element</th>
<th>Questions to Ask the Patient</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td>Where is the illness located?</td>
<td>left leg, stomach, elbow, head</td>
</tr>
<tr>
<td>Quality</td>
<td>Can the patent describe how the condition feels?</td>
<td>aching, burning, radiating pain, raw, itching</td>
</tr>
<tr>
<td>Severity</td>
<td>What is the level of sensation of pain on a scale of 1 to 10, with 1 being the least severe, and 10 being the most severe?</td>
<td>10 on a pain scale of 1 to 10</td>
</tr>
<tr>
<td>Duration</td>
<td>How long has the patient had the condition; when did it begin?</td>
<td>Started 3 days ago; condition has lasted 2 weeks</td>
</tr>
<tr>
<td>Timing</td>
<td>When does the condition occur?</td>
<td>constant, or comes and goes</td>
</tr>
<tr>
<td>Context</td>
<td>Does the condition appear when the patient is engaging in a certain activity or at a certain time of the day?</td>
<td>pain occurs when lifting large objects at work; pain is worse upon awakening</td>
</tr>
<tr>
<td>Modifying Factors</td>
<td>Do any factors improve or worsen the condition?</td>
<td>pain decreases when heat is applied; pain increases when standing up</td>
</tr>
<tr>
<td>Associated Signs and Symptoms</td>
<td>What other associated symptoms does the patient have?</td>
<td>numbness in toes also occurs with leg pain</td>
</tr>
</tbody>
</table>

**Table 9.1:** HPI Elements

**Tip:** If a patient is being seen to follow up for one or more chronic illnesses, the HPI can be documented by indicating what chronic illness(es) the patient is being seen for and the current status of the illness(es). In this circumstance, it is not necessary, or even practical, to try to document individual elements of the HPI.
A physician query is a method of communication used by coders and clinical documentation professionals to request clarification of patient diagnoses or procedures from the physician. The physician query is used to clarify documentation by resolving conflicting, ambiguous, illegible, or incomplete information about significant conditions, procedures, or reasons for tests in the medical record of the patient. Queries may also be required to determine the correct code for a primary diagnosis or procedure, or to clarify if a causal relationship exists between two diagnoses. In addition to obtaining clarification, the query may serve as an educational tool to improve physician documentation and the coders’ understanding of clinical scenarios.

Queries can be done while the patient is still admitted to the hospital or prior to leaving the physician’s office. This allows the physician an opportunity to clarify a diagnosis or procedure prior to the patient’s departure. These are called concurrent reviews and queries. A query conducted after the patient has left is called a retrospective query. In the outpatient setting, review of the patient’s medical record prior to admission can provide opportunities to query at the encounter. This is often called prospective documentation review. The facilities’ processes should include some manner of recording the queries, such as an electronic database, or inclusion of the query in the medical record.

The query should include:
- Patient name
- Admission date and/or date of service
- Health record number
- Account number
- Date query initiated
- Name and contact information of the individual initiating the query
- Statement of the issue in the form of a question along with clinical indicators specified from the chart

The query should not be constructed in a manner that can be interpreted as leading the physician. Queries can be verbal, open, multiple choice, or yes/no, and should provide documentation from the medical record to obtain a more concise diagnosis from the physician. When multiple choice or yes/no queries are utilized it is important to provide choices for a physician including options like “other” or “unspecified.” Unlike querying in the inpatient setting, outpatient queries should not include terms like “probable,” “suspected,” “ruled out,” etc. These options do not apply as per outpatient coding guidelines only confirmed diagnoses can be coded.

A valuable skill and necessary tool for a documentation specialist is learning how and when it is appropriate to query a physician. Querying assists with accurate diagnostic, procedural, and risk adjustment coding. During concurrent coding, querying for clarification can help to determine if a patient has additional procedures or complications that may affect discharge management. Particularly in the outpatient setting, conducting a prospective review and initiating relevant queries
Fact Sheet - Physician Fee Schedule (PFS) Payment for Office/Outpatient Evaluation and Management (E/M) Visits

Effective January 1, 2021, for PFS payment of office/outpatient E/M visits (CPT codes 99201 through 99215), Medicare generally adopts the new coding, prefatory language, and interpretive guidance framework that has been issued by the AMA’s CPT Editorial Panel (available at the following website: https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management).

Practitioners will no longer use history and exam to select the office/outpatient E/M visit level. Instead, an office/outpatient E/M visit includes a medically appropriate history and exam, when performed. Practitioners should perform history and exam to the extent clinically appropriate, and reasonable and necessary.

The CPT Editorial Panel eliminated CPT code 99201 (Level 1 office/outpatient visit, new patient). For levels 2 through 5 office/outpatient E/M visits, practitioners report visit level based upon either the level of medical decision-making as revised in the AMA/CPT guidance, or the total time personally spent by the reporting practitioner on the day of the visit (including face-to-face and non-face-to-face time).

ADD-ON CODE FOR PROLONGED VISITS

When the practitioner selects a visit level using time, the practitioner may report prolonged office/outpatient E/M visit time using HCPCS add-on code G2212 (Prolonged office/outpatient E/M services). Practitioners should not report prolonged office/outpatient E/M visit time using CPT codes 99354 and 99355 (Prolonged service with direct patient contact), 99358 and 99359 (Prolonged service without direct patient contact), 99415 and 99416 (Prolonged clinical staff services), or 99417 (Prolonged office/outpatient E/M services with or without direct patient contact). The following table provides reporting examples.

<table>
<thead>
<tr>
<th>HCPCS Code(s)</th>
<th>Total Time Required for Reporting*</th>
</tr>
</thead>
<tbody>
<tr>
<td>99205</td>
<td>60-74 minutes</td>
</tr>
<tr>
<td>99205 x 1 and G2212 x 1</td>
<td>89-103 minutes</td>
</tr>
<tr>
<td>99205 x 1 and G2212 x 2</td>
<td>104-118 minutes</td>
</tr>
<tr>
<td>99215</td>
<td>40-54 minutes</td>
</tr>
<tr>
<td>99215 x 1 and G2212 x 1</td>
<td>69-83 minutes</td>
</tr>
<tr>
<td>99215 x 1 and G2212 x 2</td>
<td>84-98 minutes</td>
</tr>
<tr>
<td>99215 x 1 and G2212 x 3 or more for each additional 15 minutes.</td>
<td>99 or more</td>
</tr>
</tbody>
</table>

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

HCPCS code G2212 (Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services). (Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)).
6. **Centers for Medicare & Medicaid Services. Electronic Health Records Provider.**
https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/docmatters-ehr-providerfactsheet.pdf

**Electronic Health Records Provider**

The cost of health care in the United States continues to rise, but the overall health of the nation is not necessarily improving or keeping pace with other countries.[1] In 2009, the United States government began taking new steps to transform our nation’s health care delivery system with the use of electronic health record (EHR) technology. An EHR is a digital version of a patient’s paper chart and broader health history designed to be used both internally and externally by multiple entities.[2, 3]

The 111th Congress passed the American Recovery and Reinvestment Act, and on February 17, 2009, President Obama signed it into law.[4] One of the purposes of this Act is to furnish “funding to strengthen the health information technology infrastructure” through the Health Information Technology for Economic and Clinical Health (HITECH) provision.[5]

At the June 15, 2009, American Medical Association Conference in Chicago,[6] President Obama encouraged health care providers to move from paper health records to EHRs. More recently, The Office of the National Coordinator (ONC) for Health Information Technology (IT) released a 10-year vision paper for the state of health IT by 2024. The goal is to achieve interoperability among the various health IT platforms, which in turn would help reduce costs, allow patients more control over their information and decision making, and generally improve patient health.[7] Why is it so important for providers to implement EHRs?

**The Benefits of Electronic Health Records**

Documentation is often the communication tool used by and between providers. Documenting a patient’s record with all relevant and important facts, and having that information readily available, allows providers to furnish correct and appropriate services that can improve quality, safety, and efficiency. EHRs can help improve communication between providers through real-time access to valuable information. Surveyed medical providers reported the following benefits of using EHRs:

- Real-time access to complete patient records at the point of care (real-time access can improve care delivery and improve care transitions from one service or provider to another, which can lead to improved population health over time[8]);
- Clinical alerts and reminders that reduce and prevent medical errors;
- Decision support, diagnostic aids, and elimination of duplicate tests;
- Reliable e-prescribing with fewer medication errors;
- Interface between e-prescribing systems and State Prescription Drug Monitoring Programs;
- Reduction in paperwork;
- Greater coordination of care;
- Legible records;
- Interface with labs;
- Patient portals that allow electronic interaction between the provider and patient;
- Electronic referrals; and
- Improved coding and billing.[9]
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