WPS™
A HEALTH SOLUTIONS COMPANY

Lakeland Medical Office Association

Denials, Rejections and Documentation Requirements

March 2025

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Disclaimer

This material is a tool to assist the provider community. Medicare rules change often.

The basis for answers given today rely on facts given in the question. Medicare rules determine final coverage.

Access CMS' website for current coverage, regulations and rulings.

CPT Copyright Notice

Agenda & Objective

- Common denials and rejections
- Choosing your level of service
- Evaluation and Management Documentation

Acronyms

- AMA – American Medical Association
- CERT – Comprehensive Error Rate Testing
- E/M – Evaluation and Management
- IOM – Internet-Only Manual
- MDM – Medical Decision-Making
- NP – Nurse Practitioner
- NCCI – National Correct Coding Initiative
- PTAN – Provider Transaction Access Number
- SDOH – Social Determinants of Health

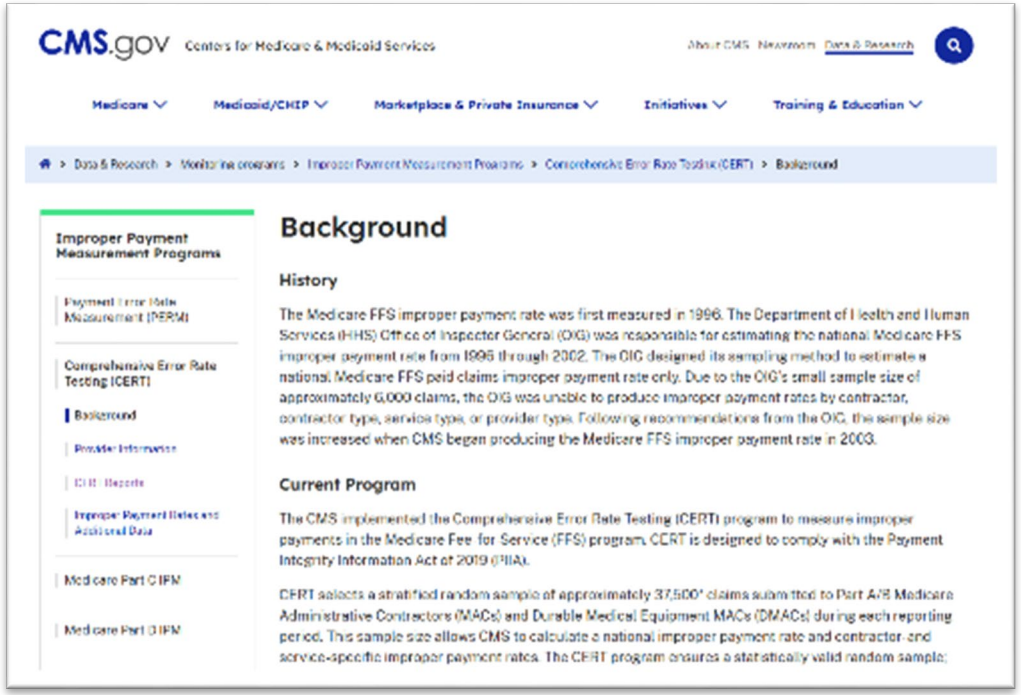
Denials and Rejections

Who Reviews Claims

- CERT Program
- Office of Inspector General (OIG)
- Recovery Audit Contractor (RAC)
- Medicare Administrative Contractor (MAC)

CERT Program

- Measures improper payments
- Reviews Medicare claims
- Requests documentation
- Errors include
  - Documentation not received
  - Does not meet Medicare coverage, coding, and billing rules
  - Others



CERT Root Cause

- 2024 Medicare Fee-for-Service Supplemental Improper Payment Data

Table 7: Top Root Causes for Office visits - established

Root Cause Description	Error Category	Sample Claim Count
Documentation supports lower level of E/M service than what was billed*	Incorrect Coding	179
Documentation supports higher level of E/M service than what was billed*	Incorrect Coding	22
Documentation for the billed date of service - Inadequate	Insufficient Documentation	11
Attestation for unsigned documentation - Missing	Insufficient Documentation	10
Documentation to support the services were provided or other documentation required for payment of the code - Missing	Insufficient Documentation	9
Separately identifiable E/M service documentation - Inadequate	Insufficient Documentation	8
Documentation to support the services were provided or other documentation required for payment of the code - Inadequate	Insufficient Documentation	7
Documentation for the billed date of service- Missing	Insufficient Documentation	7
LCD/LCA requirements, other documentation required for payment - Missing	Insufficient Documentation	7
A separate and identifiable service is not supported as billed (i.e., removal of a modifier as a coding error)*	Incorrect Coding	5
Note: Root causes frequently associated with partial improper payments are identified with an asterisk.		

Top CERT Errors Part B

- Table D1 in the 2024 Report
- E/M projected errors
  - Office visit, new $268,205,732
  - Office visits, established $1,077,121,456
  - Hospital visit, initial $404,839,595
  - Hospital visit, subsequent $744,651,796

Cert Resources

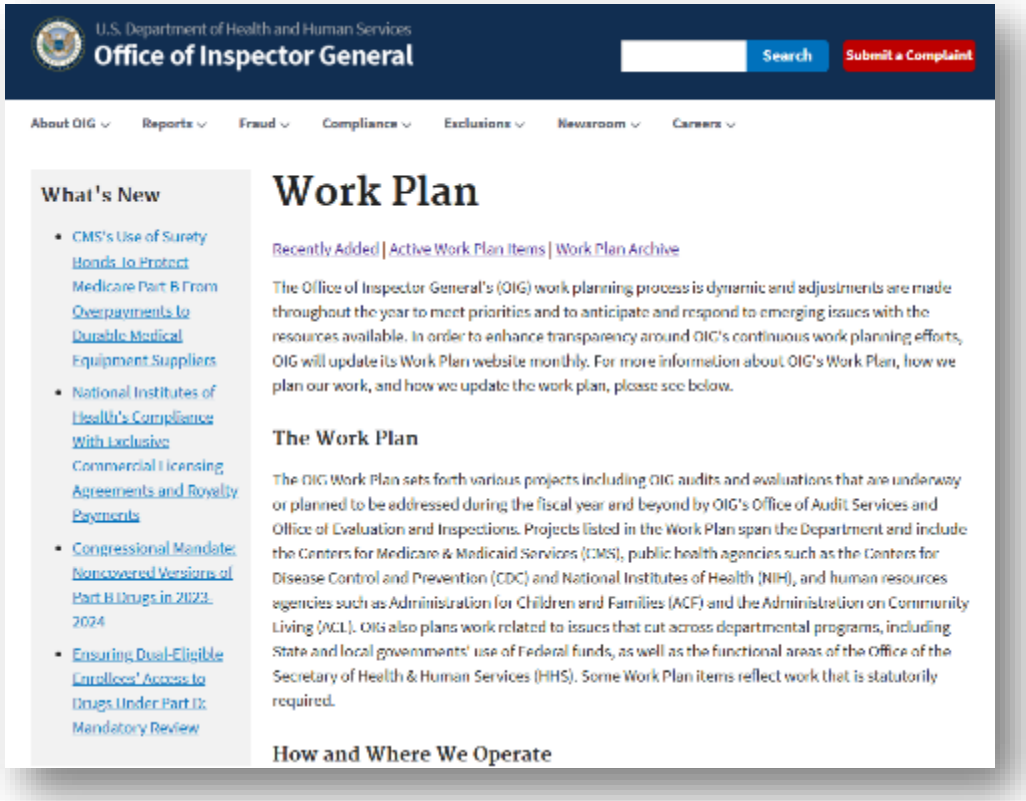
- CMS
  - What's the Comprehensive Error Rate Testing (CERT) Program?
  - Comprehensive Error Rate Testing (CERT)
  - CERT Reports
- WPS
  - Evaluation and Management Codes – CERT Denials

OIG Purpose

- Protect patients and Medicare trust fund
- Detect fraud, waste, and abuse
- Conduct audits and reviews
- Recover misspent funds
- Maintain exclusion list

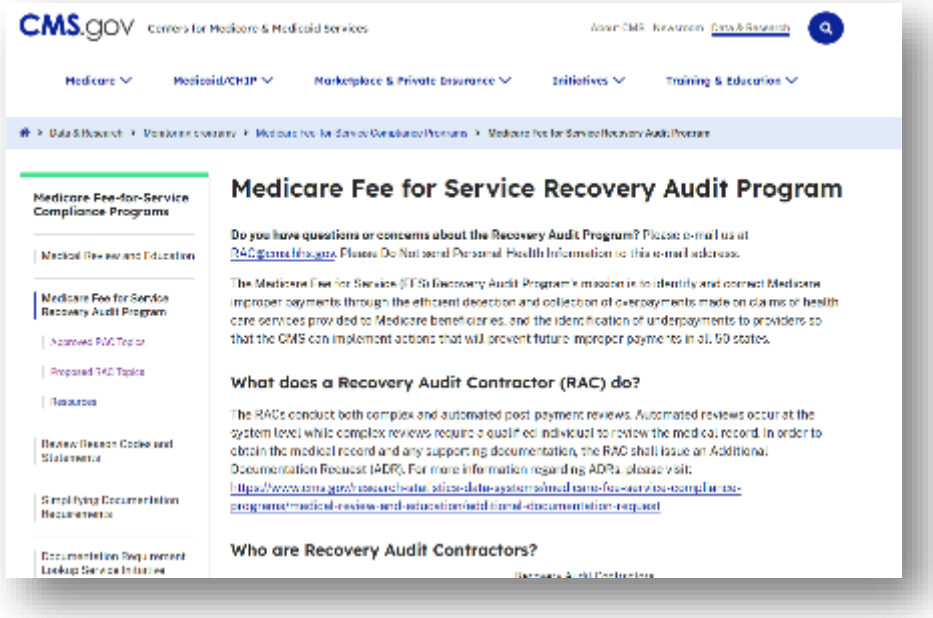
OIG Information

- OIG Work Plan
- Current Items
  - Medicare Part B Remote Patient Monitoring (RPM)
  - Medicare Part B Payment for Incident – to Services
- Physician Relationships With Payers



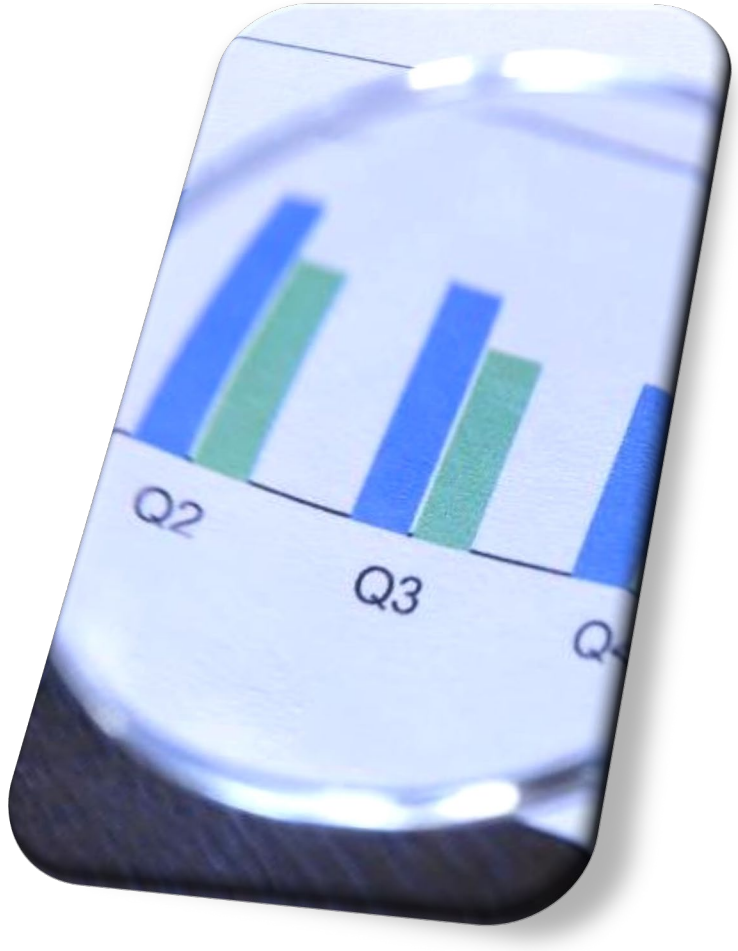
Recovery Audit Program

- Automated post payment reviews
- Complex reviews
  - May issue Additional Documentation Request (ADR)
- Contractors by region
  - J8 – Region 1
  - J5 – Region 2
- Performant Recovery



RAC Resources

- Medicare Fee for Service Recovery Audit Program
- 0001 – Inpatient Hospital MS - DRG Coding Validation
- 0011 – Inappropriate Billing of Home Visit Professional Service Evaluation and Management Codes During Hospital Inpatient Stay



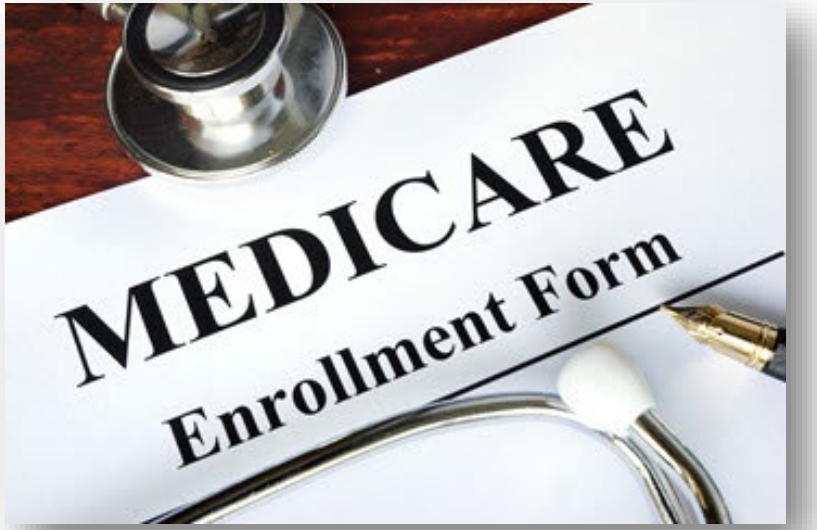
WPS

- Targeted Probe and Educate (TPE)
- Data analysis
  - J8 only
  - Part B claims
  - Dates of service 11/01/2024 through 01/31/2025
    - Unprocessable 58,958
    - Denials 304,100

Common Denials and Rejections

Unprocessable – Provider Eligibility

- Rendering provider not entered
- Provider not eligible
- Rendering provider and group do not match
- Rendering provider not enrolled



Unprocessable – Patient Eligibility

- Name and Medicare number do not match
- Patient is not eligible
- Submit to another contractor

Unprocessable – Place of Service Conflict

- Do not match
  - Procedure code
  - Place of service match
- Place of Service (POS) Codes for Professional Claims

Unprocessable – Multiple E/M

- Billing a new patient when
  - Same provider
  - Same group
  - Same specialty
  - Previous three years
- Multiple E/M on same day
  - Above rules apply
  - Can allow if
    - Unrelated
    - Could not be performed at the same time

Unprocessable – Invalid Modifiers

- Verify modifier used is appropriate for E/M
  - Modifier 24 Fact Sheet
  - Modifier 25 Fact Sheet
  - Modifier 57 Fact Sheet
  - Modifier FS – Correct Billing of Split (Shared) Fact Sheet
  - Modifier FT Fact Sheet
- Verify whether a modifier required
  - Global surgery
  - NCCI edits

Unprocessable – Field 11

- Your responsibility to determine whether Medicare is primary or secondary
- Complete Field 11 on the CMS 1500 form or electronic equivalent
- Enter none when Medicare is primary

Denials – Patient Eligibility

- Patient in managed care plan
- Patient has insurance primary to Medicare
- Patient does not have Medicare Part B
  - Talk to patient
  - Look at insurance cards
  - Use Secure Net Access Portal (SNAP)

Patient – Hospice

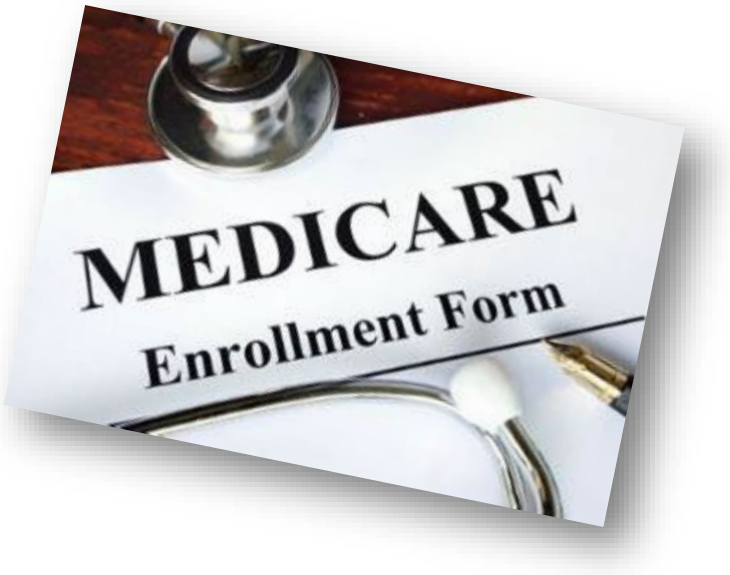
- Patient elected hospice
  - Use self-service portal
  - Talk to the patient
- May need modifier
  - GV modifier – attending physician
  - GW modifier - unrelated
  - Billing Services During a Hospice Election

Denials – Duplicate Services

- Do not use automated resubmits
- Evaluate your Medicare reports
- To determine status
  - 276/277 HIPAA Eligibility Transaction System (HETS)
  - Use the self-service portal

Denials – Provider Eligibility

- Provider not eligible for payment
- Provider cannot provide service billed
- Solutions:
  - Verify PTAN entered correctly
  - Verify provider eligible
  - Verify provider can perform E/M service

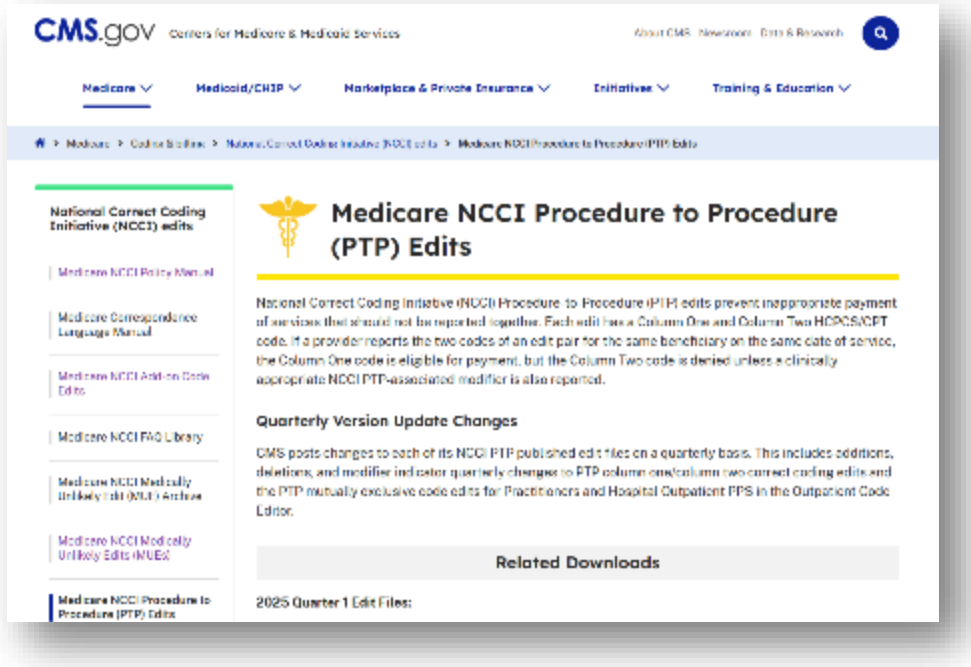


Denials – Multiple visits

- Billing a new patient when
  - Same provider
  - Same group
  - Same specialty
  - Previous three years
- Multiple E/M on same day
  - Above rules apply
  - Can allow if
    - Unrelated
    - Could not be performed at the same time

Denials – Missing Modifiers

- E/M services are part of
  - Global surgery guidelines
  - NCCI edits
- Research to determine if E/M is separately payable
  - Yes – use appropriate modifier



Denials – Timely Filing

- One year from date of service
  - Medicare denies after that time
  - No appeal rights
- Cannot collect from the patient
- Timely Filing of Claims
- If primary insurer pays in full – submit the claim
  - Administrative reasons
  - Claim is in the door timely

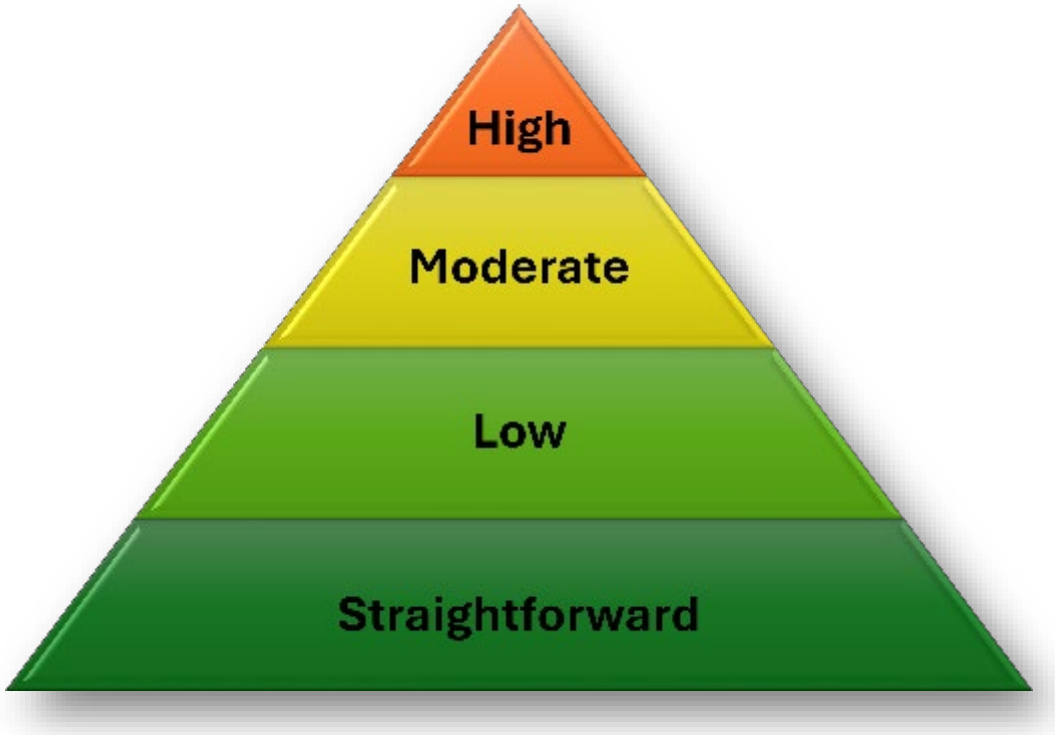
E/M Choosing Level of Service

Medical Necessity

- Social Security Act 1862(a)(1)(A)
- Services must be:
  - Reasonable
  - Medically necessary
  - Not statutorily excluded

Levels of Service

- Chose level based on:
  - Time
  - MDM
- Categories of service
  - Straightforward
  - Low
  - Moderate
  - High
- Must meet or exceed two of three levels for the components



Using Time to Choose your Level

- Time identified in the code descriptor
- On the same calendar date
- Includes
  - Face-to-face
  - Non-face-to-face
- Time is by the practitioner
  - Does not include ancillary staff
- Document specific time

Non-Face-to-Face Time

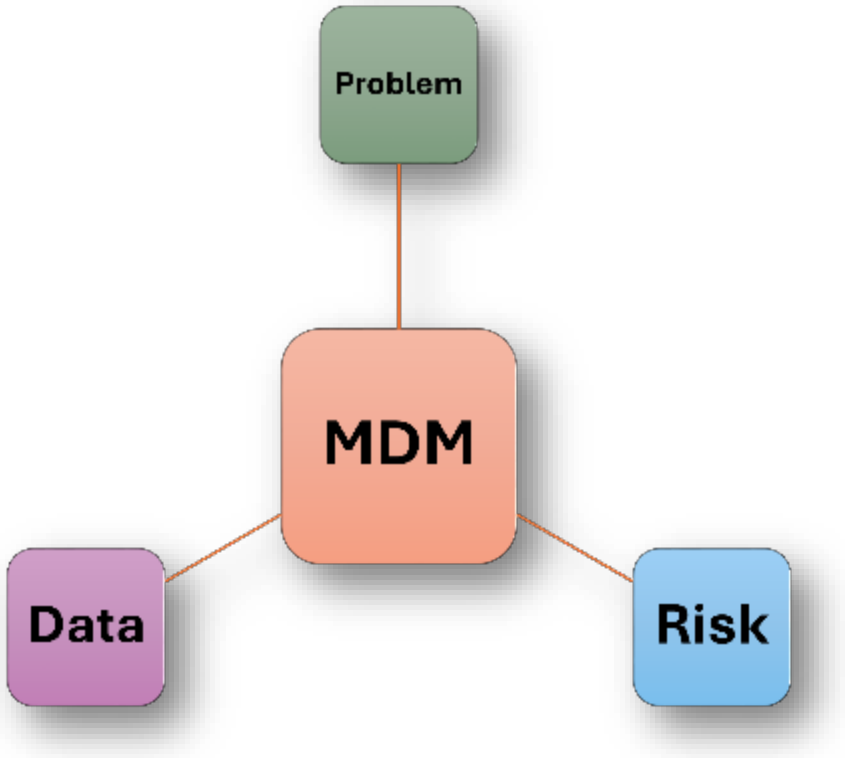
- Preparing to see patient
- Obtaining or reviewing separate history
- Performing exam
- Counseling or educating patient/family/caregiver
- Ordering
  - Medications
  - Tests
  - Procedures
- Referrals and communications
  - Not separately reported
- Documenting encounter
- Independently interpreting results
  - Not separately reported
- Care coordination
  - Not separately reported

Do Not Count

- Performance of services separately reported
- Travel time
- Teaching that is general and not specific for management of individual patient

Elements of MDM

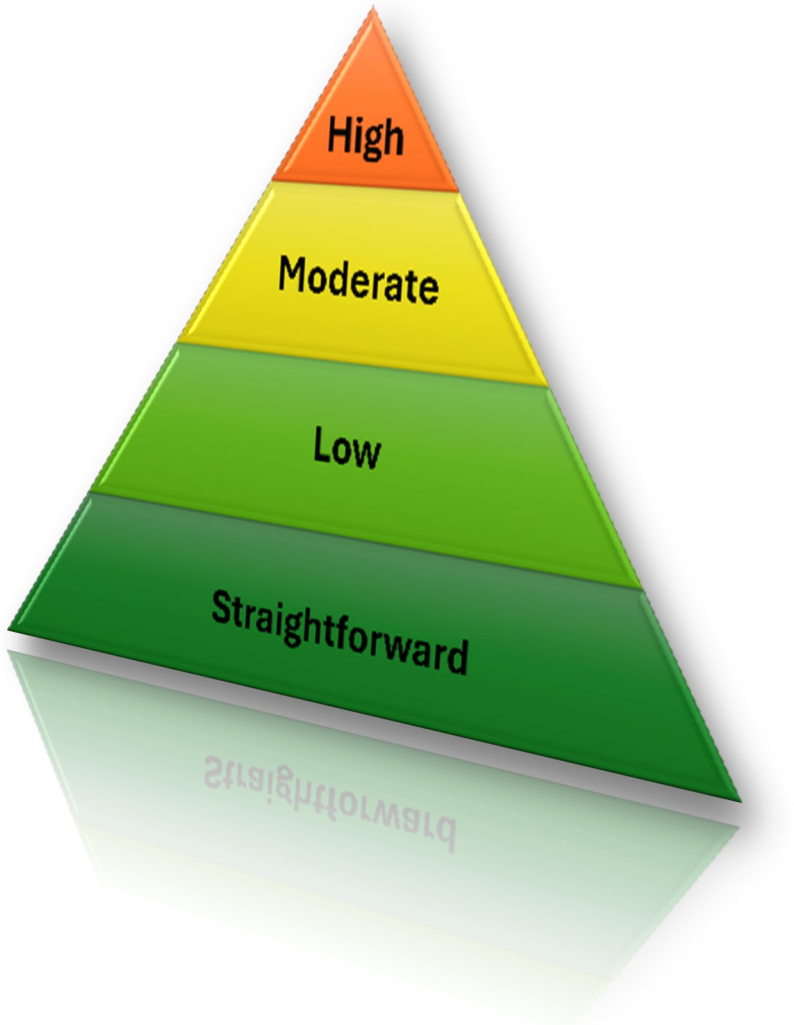
- Problem
  - Number
  - Complexity
- Data
  - Amount
  - Complexity
- Risk
  - Complications
  - Morbidity
  - Mortality



Problem

Problem Overview

- Addressed during encounter
- Complexity specific to patient
- Levels
  - Straightforward
  - Low
  - Moderate
  - High

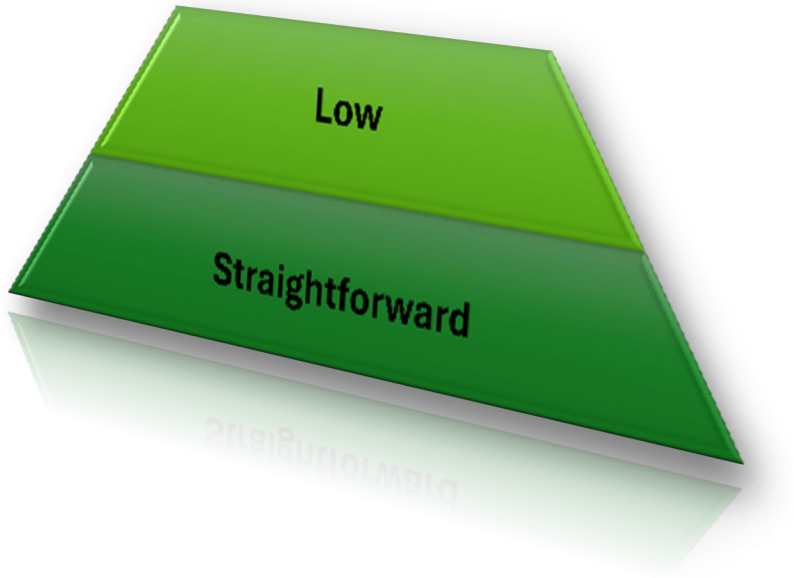


Self – Limited or Minor Problem

- Self-limited
- Minor problem
- Possible examples
  - Cold
  - Sinus infection
  - Rash
- May be different for each patient!

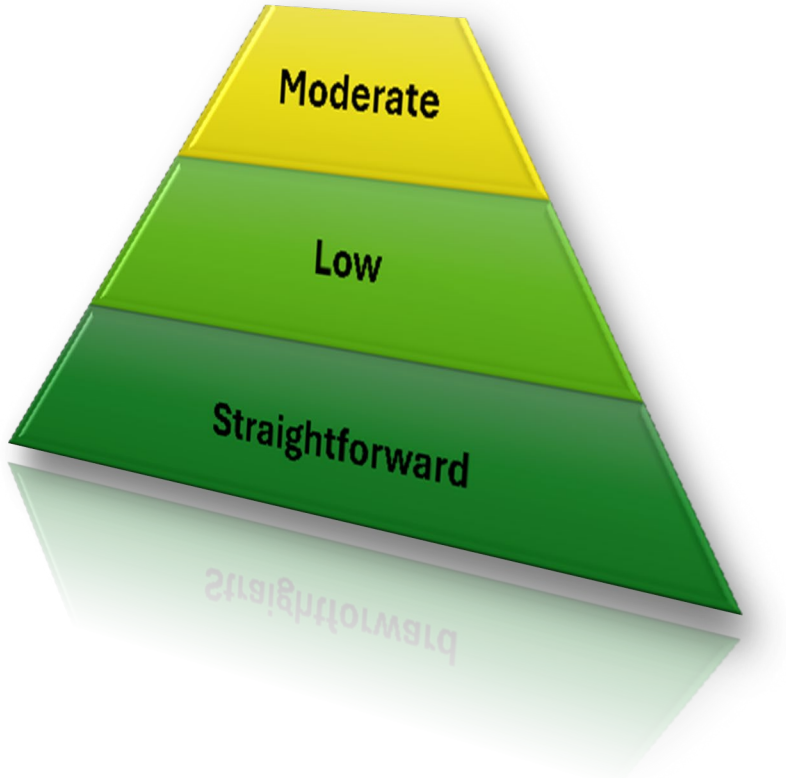
Low Problem

- 2 or more self-limited
- 1 stable chronic
- 1 acute uncomplicated
- 1 stable acute
- 1 acute uncomplicated
  - Hospital inpatient
  - Observation care



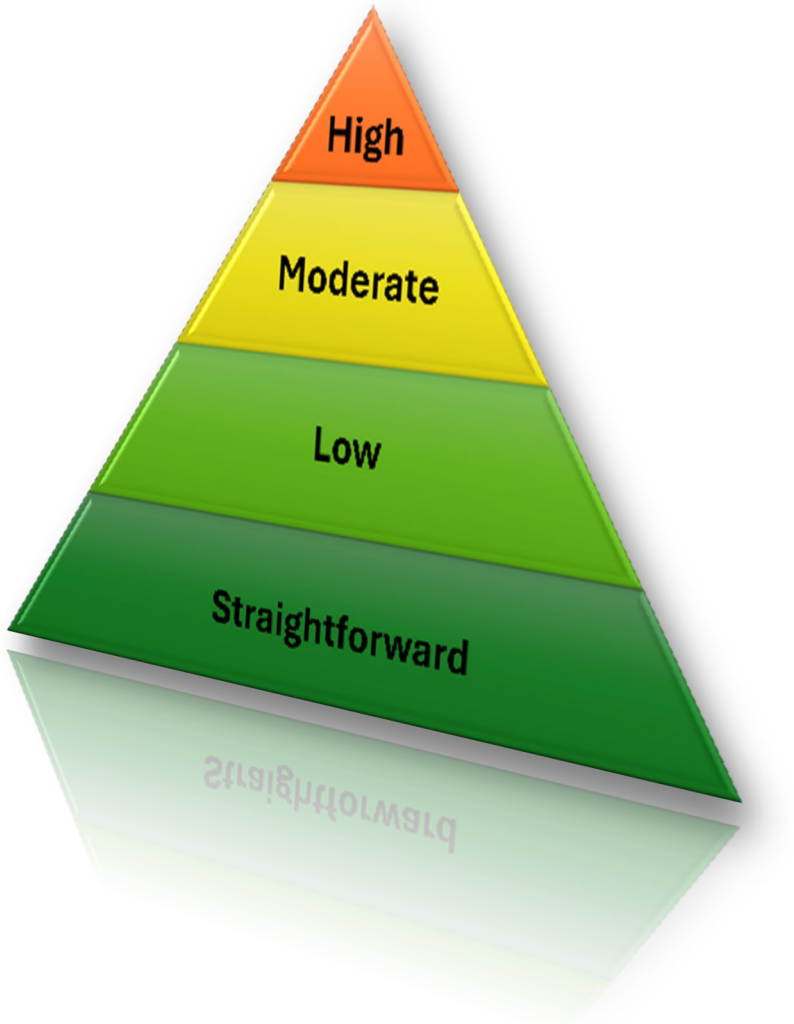
Moderate Problem

- 1 or more chronic with exacerbation
  - Not at goal
  - Acutely worsening
- 2 or more chronic
- 1 undiagnosed new problem
- 1 acute with systemic symptoms
  - Cardiovascular
  - Respiratory
- 1 acute complicated



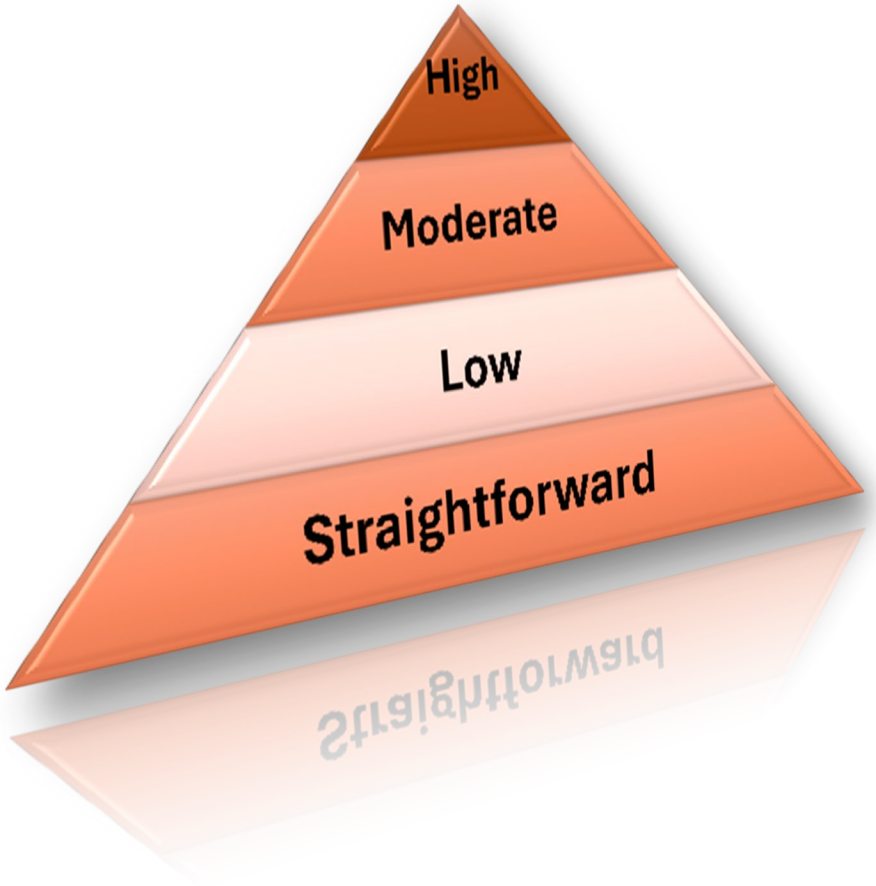
High Problem

- 1 or more chronic
  - Severe exacerbation
- 1 acute chronic threat to
  - Life
  - Bodily function
- Examples
  - Sepsis
  - Severe breathing problems



Data Analyzed

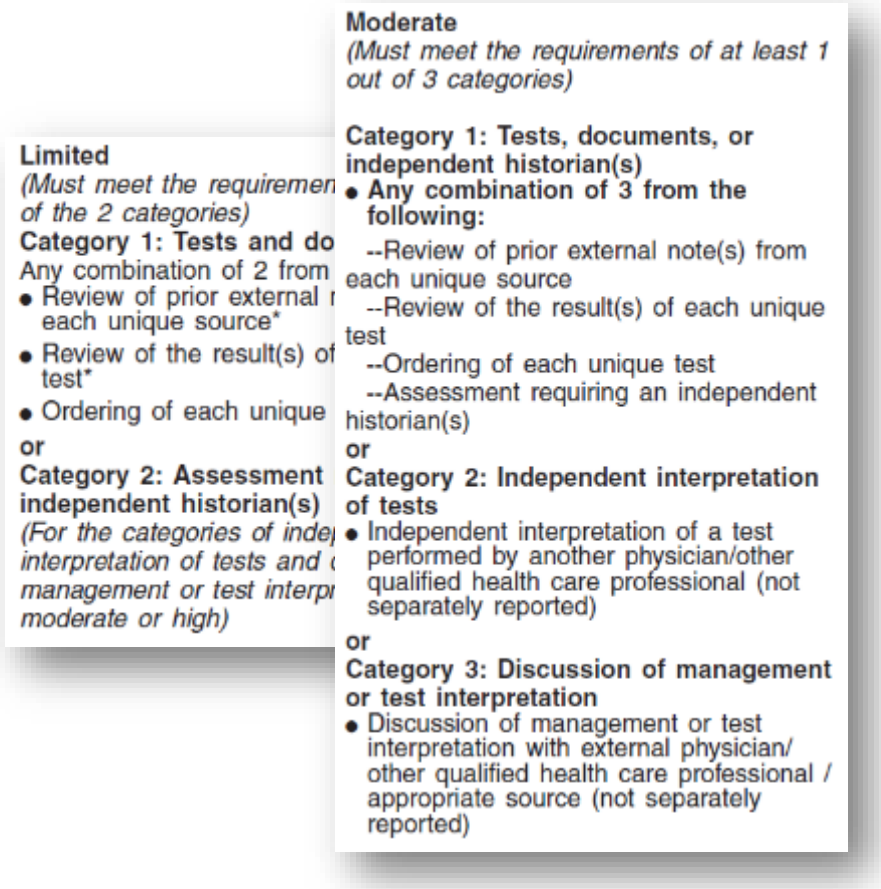
Data Overview



- Data analyzed
  - Used during MDM
  - Determine plan of care
- Levels
  - Straightforward
  - Limited
  - Moderate
  - High

Categories

- Based on the level of care
- Each category shows:
  - Increasing level of review
  - Increasing level of analysis
- Requirements listed for each



Limited
(Must meet the requiremen
of the 2 categories)
Category 1: Tests and do
Any combination of 2 from
- Review of prior external
each unique source*
- Review of the result(s) of
test*
- Ordering of each unique

or
Category 2: Assessment
independent historian(s)
(For the categories of inde
interpretation of tests and
management or test interpr
moderate or high)

Moderate
(Must meet the requirements of at least 1 out of 3 categories)

Category 1: Tests, documents, or independent historian(s)
- **Any combination of 3 from the following:**

--Review of prior external note(s) from each unique source
--Review of the result(s) of each unique test
--Ordering of each unique test
--Assessment requiring an independent historian(s)

or
Category 2: Independent interpretation of tests
- Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported)

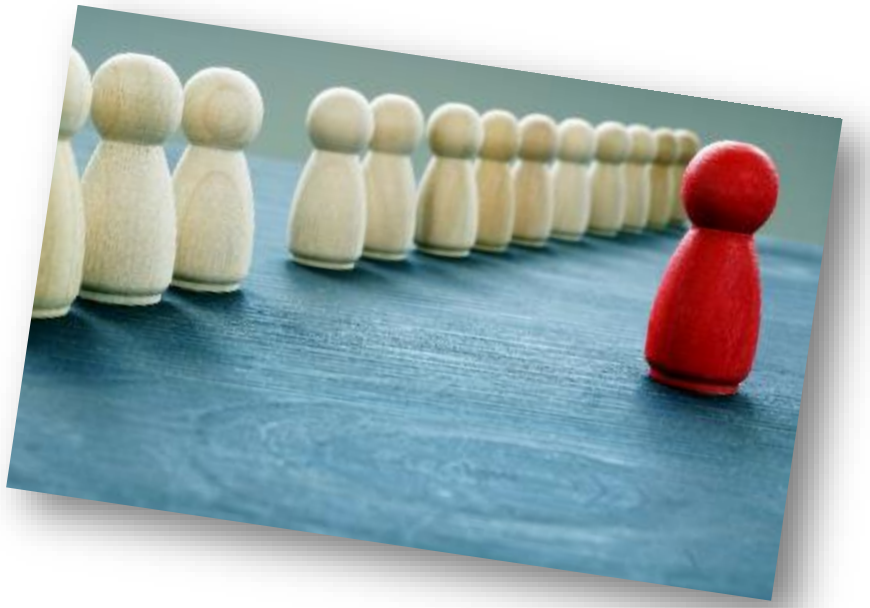
or
Category 3: Discussion of management or test interpretation
- Discussion of management or test interpretation with external physician/ other qualified health care professional / appropriate source (not separately reported)

Tests Defined

- Imaging
  - Independent interpretation
- Laboratory
- Psychometric
- Physiologic data
- If not separately billed
- Exception pulse oximetry is not a test

Unique Defined

- Test
  - Overlapping is not unique
- Unique source:
  - Different physician or practitioner
  - Distinct group
  - Different specialty or subspecialty
  - Unique entity
- Review of all materials from any unique source



External Defined

- Outside
  - Records
  - Communications
  - Test results
- External physician or practitioner
  - Different group practice
  - Different specialty or subspecialty
  - Different facility or organizational

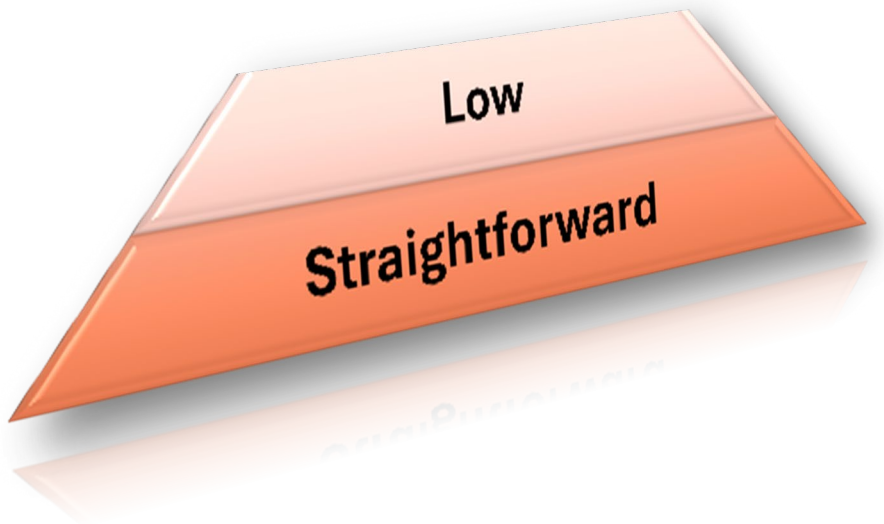
Discussion Defined

- Direct Interactive exchange
  - Real time communication
  - May be asynchronous
    - Short period of time
- Must be direct
- Between appropriate source
- Does not need to be on the date of the encounter
- Counted only if used in MDM

Data – Straightforward

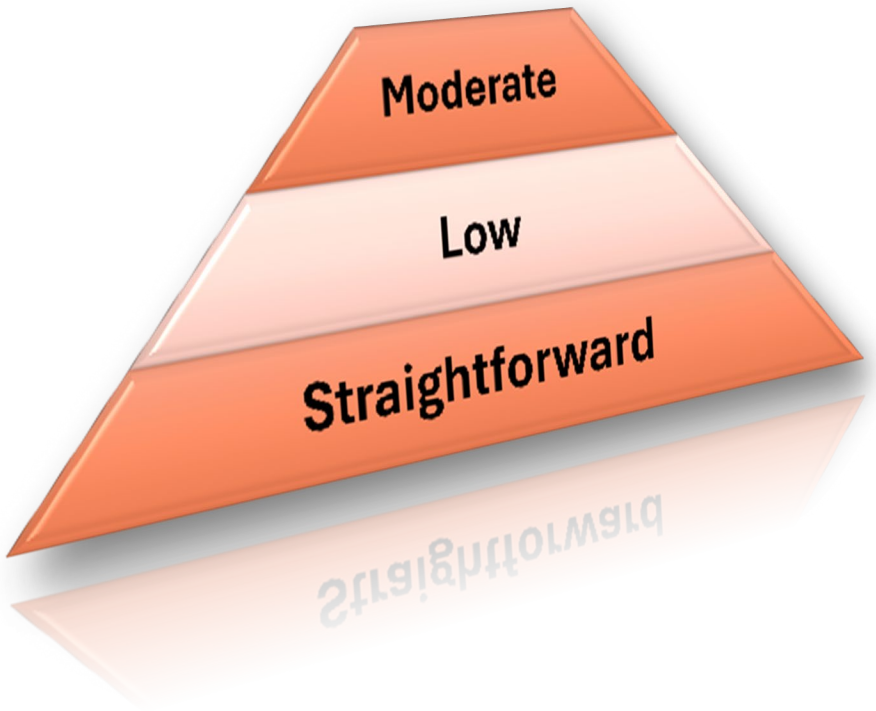
- Minimal or none
- No data required
- Scenarios
  - No tests ordered
  - No test reviewed

Data – Low



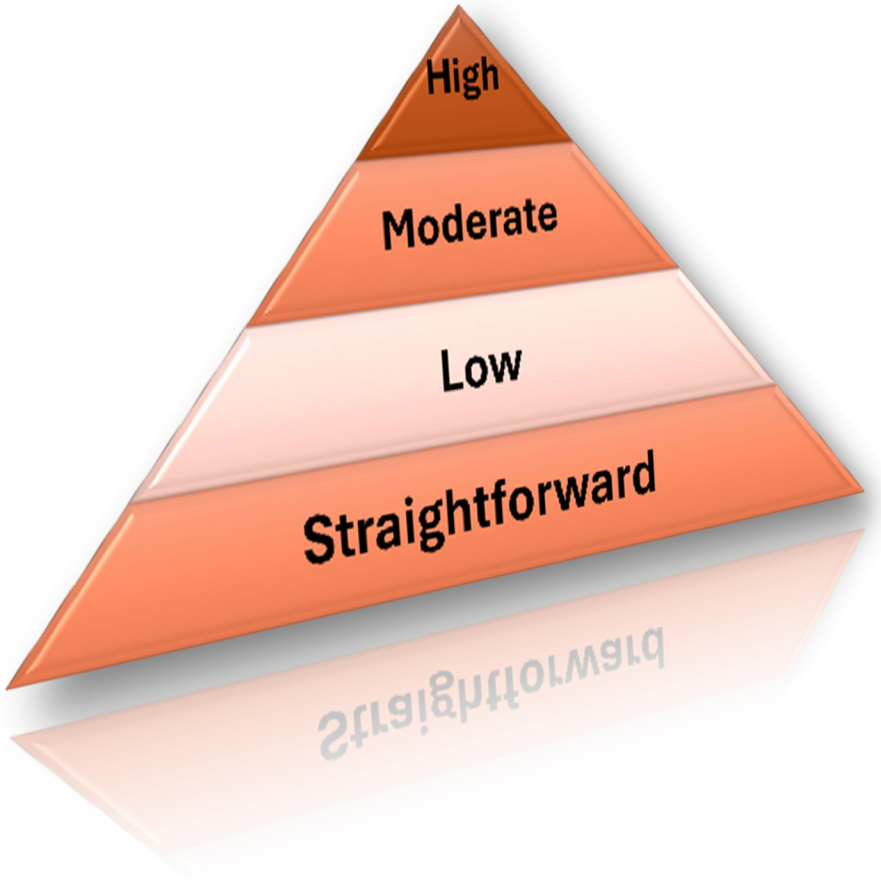
- Must meet requirements of at least 1 or 2 categories
  - Tests and documents
    - Must have two
  - Assessment requiring independent historian
- CPT Evaluation and Management (E/M) revisions FAQs

Data – Moderate



- Must meet 1 of 3 categories
- Tests, documents, and independent historian
  - Requires three
- Independent interpretation of tests
  - Not billed separately
  - Document the interpretation
- Discussion of management or test interpretation

Data – High

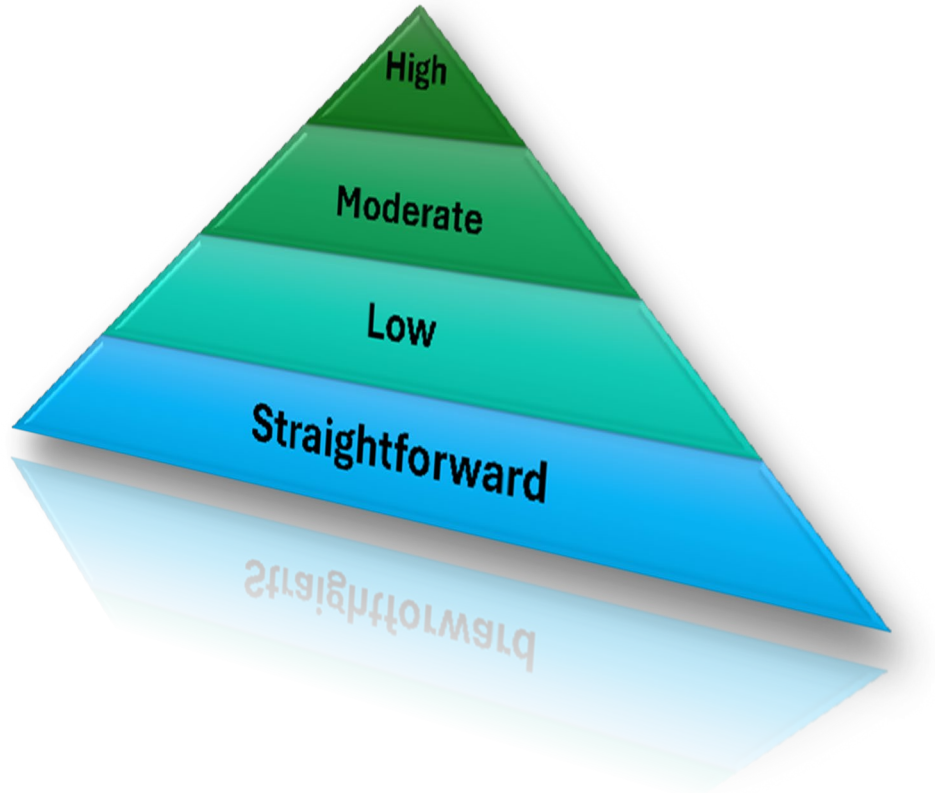


- Must meet the requirements of 2 out of 3 categories
  - Tests – requires three
  - Independent interpretation of tests
  - Discussion of management or test interpretation

Risk

Risk Overview

- Risk of patient management
  - Complications
  - Morbidity
  - Mortality
- Level of risk based on:
  - Problems addressed
  - Patient management decisions
    - Testing
    - Treatments
    - Hospitalizations
- Different for each patient!

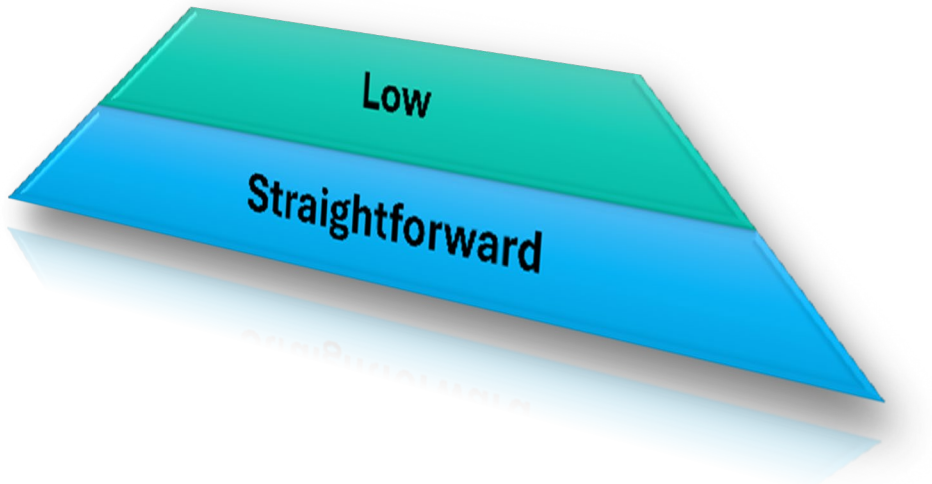


Risk – Straightforward

- Minimal risk of morbidity
- May be no risk

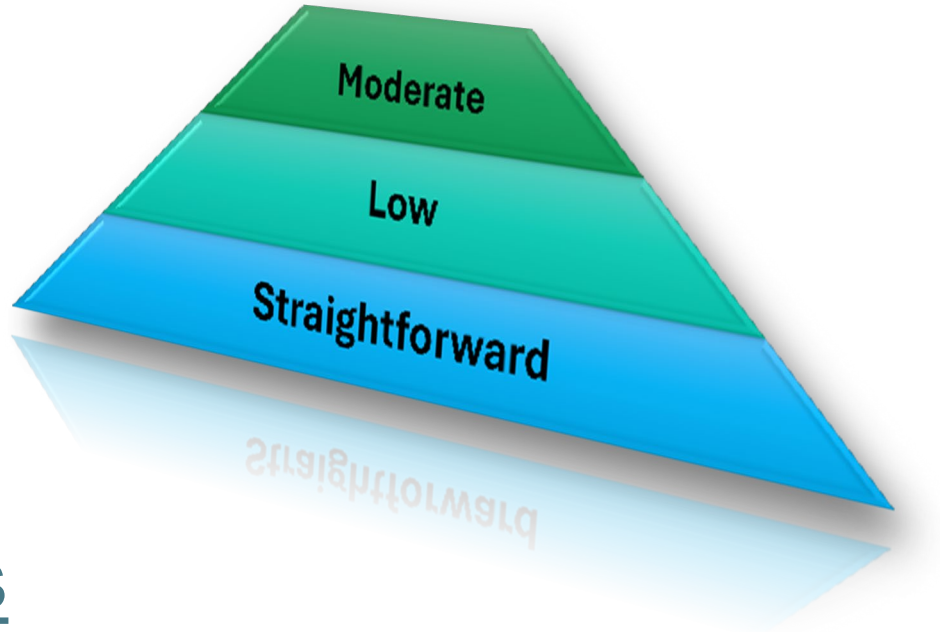
Risk – Low

- Low risk from
  - Additional diagnostic testing
  - Additional treatment



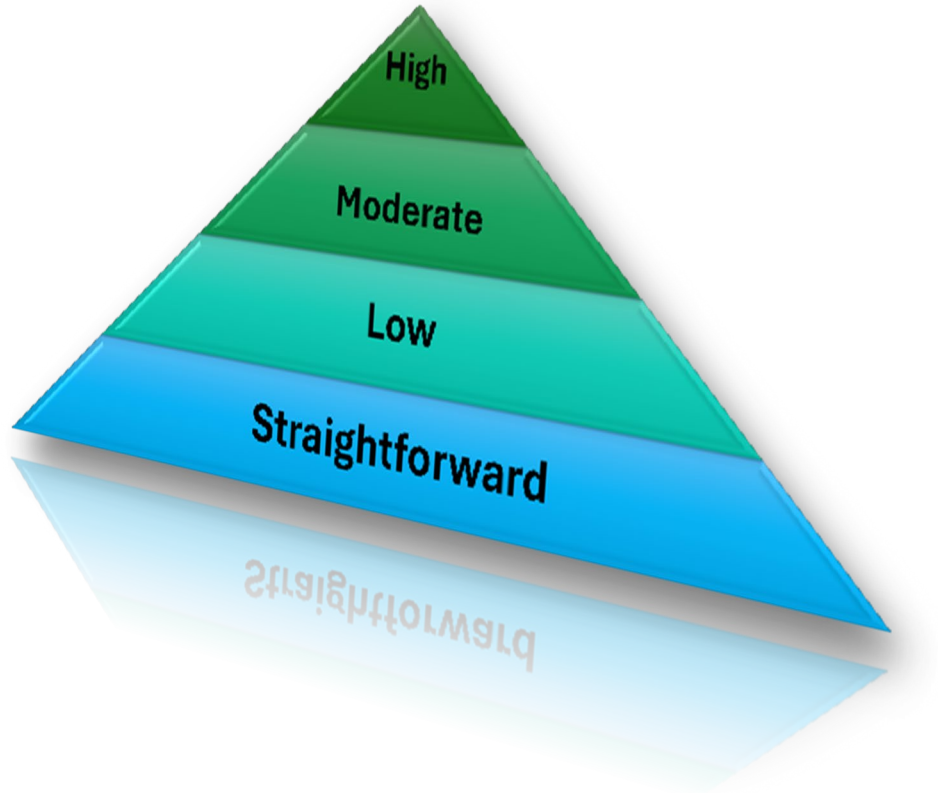
Risk – Moderate

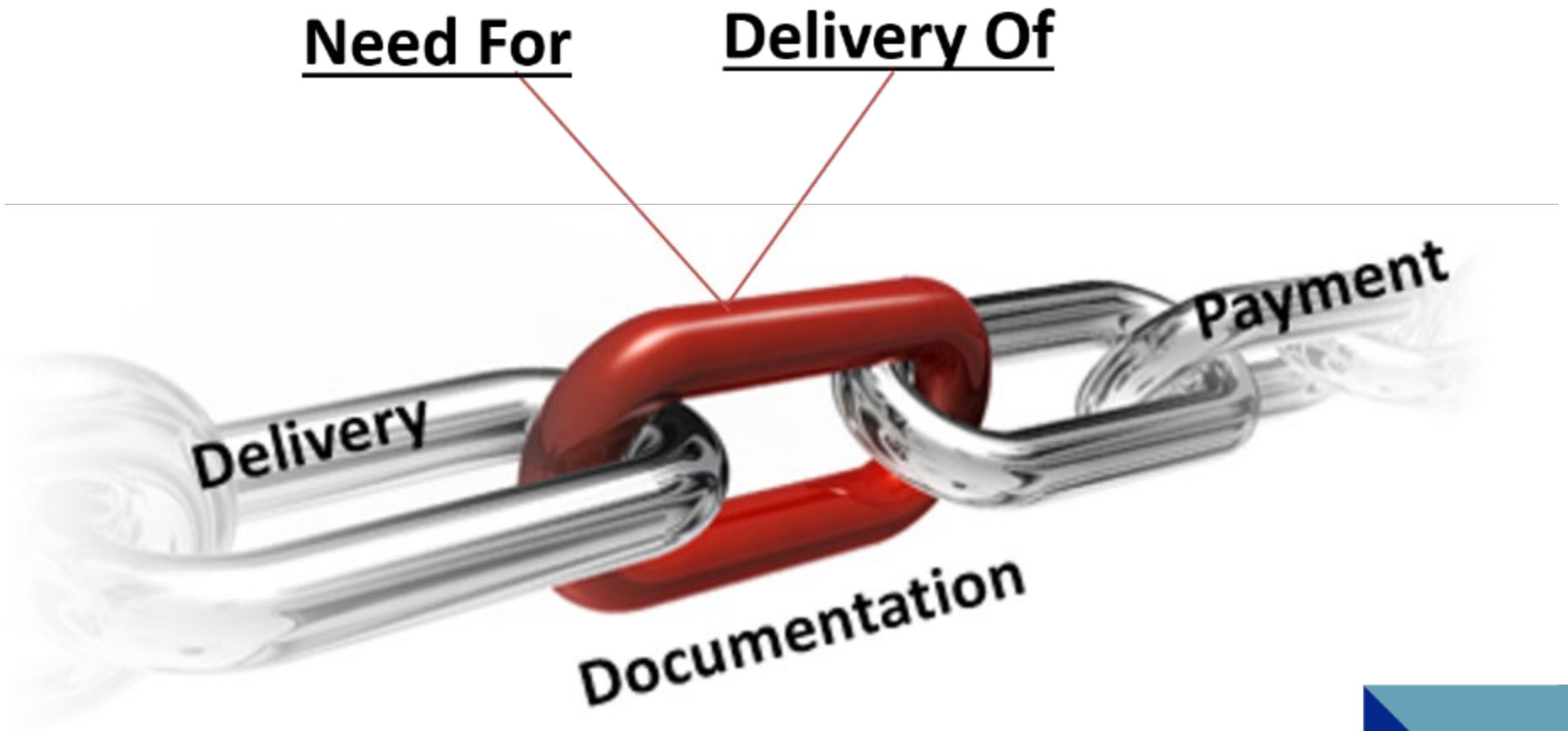
- Examples
  - Decision for minor surgery
  - Prescription drug management
    - Risk to the patient
    - Not blanket guidance
  - SDOH
- AMA Advancing landmark updates across more settings of care



Risk – High

- Examples
  - Intensive toxicity monitoring
  - Decision for major surgery
    - Emergency
    - Elective
  - Decision for hospitalization
  - Escalation of hospital care





Documentation Requirements

Documentation Overview

- Medical necessity
- Proof of thought
- Elements
  - Evaluation
  - History
  - Assessment
  - Care plan
  - Services provided

What does Medicare Expect?

- Accurate reflection of practitioner time
- Proof of thought for MDM
  - Problems addressed
  - Data analyzed
  - Risk to patient
- Reviews
  - Evaluate patient's needs versus the time spent
  - Activities documented
  - Does it make sense?

Example 1 Office Problem

- Chief complaint
  - Establish care
  - Patient here for right knee pain
  - Replacement and femur rod in 2016
- Patient presenting for hip pain
- Patient tried
  - Over-the-counter medication
  - Activity modification for greater than three months

Example 1 Office History

- Current hip pain is moderate
- Located at the lateral hip
- Aching with intermittent share pains
- Better at rest, worsening with activity
- Present greater than 6 months and getting worse
- Does not radiate
- Not associated with numbness or tingling around the hip

Example 1 Office History cont'd

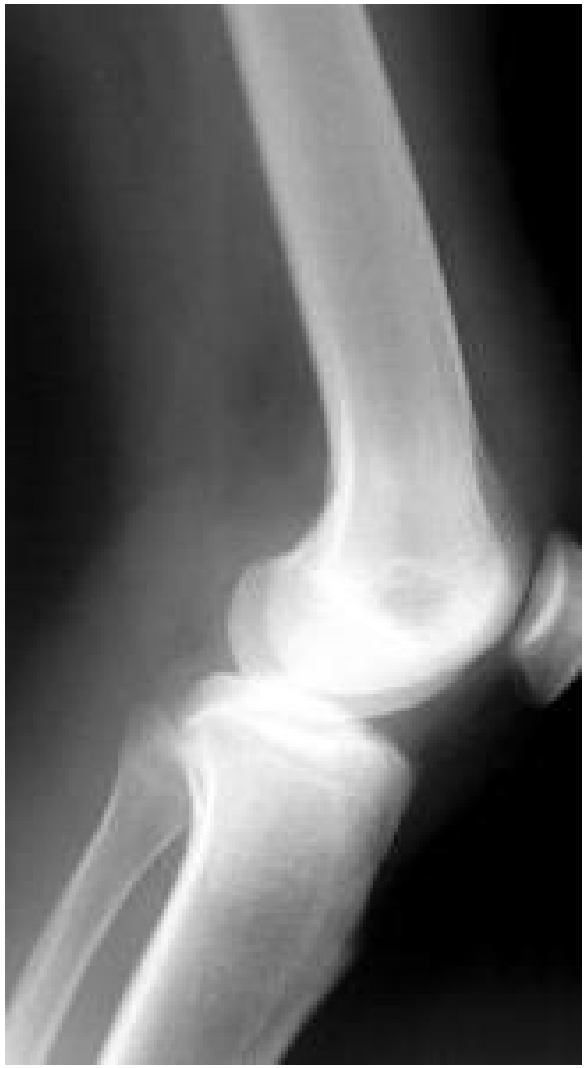
- Right total knee arthroplasty in 2003
- Patient had fall in 2006 and had ORIF (open reduction internal fixation) periprosthetic with plates and screws
- Provider documents 30 to 44 minutes

Example 1 Office Exam

- Hip range of motion 0-90
- No hip pain with flexion, abduction and internal rotation
- No groin pain with leg roll
- Exquisite TTP over great trochanter
- Positive OBER
- Range of motion smooth and painless
- Mild crepitus notes

Example 1 Office Data

- Order 3-view right knee x-ray
- Reviewed results of x-ray



Example 1 Office Plan

- Patient has ITB syndrome
- External referral to physical therapy
- Meloxicam 7.5 mg tablet
- Patient wants to continue conservative therapy
- Shown ITB stretches
- Discussed risks/benefits of joint injection
- Prescription for physical therapy if conservative therapy not effective

Example 1 Office Findings

Using MDM:

- Problem level – Low
- Data level – Limited
- Risk level – Low
- 99203

Using Time:

- Provider reported time as 30 – 44 minutes
- 99203

Example 2 Inpatient Resident Service

- Author: Resident
- Creation time: 04/11/2023 1600
- Signatures:
  - Physician 04/12/2023 0711
  - Resident 04/11/2023 1603

Example 2 Inpatient Medical Record

- MRI reviewed consistent with disc herniation L3-4
- Plan for L3-4 laminectomy and discectomy 4/12/2023
- Diagnosis, clinical and radiographic finding discussed
  - Discussed risks and benefits,
  - All questions answered
- Patient expressed understanding and wants to proceed with L3-4 laminectomy and discectomy
- Informed surgical consent signed

Example 2 Inpatient Findings

- Non-payable
  - Medicare does not reimburse for services provided by a resident unless documentation supports teaching physician guidelines
  - No indication by resident or physician that the physician was present during the key and critical portions of the service

Example 3 Inpatient Admit/Discharge

- Admit 04/19/2024
- Discharge 04/20/2024
- History and physical 04/20/2024 10:20 EDT
- Chief complaint
  - SOB with exertion
  - PE
  - Covid – 1 month ago
- Admission Criteria – I have spent __ minutes from the hours of __ to __ admitting this patient

Example 3 Inpatient History

History of Present Illness

Pt is a 82 year old female who presents to the hospital for SOB, DOE, and generalized weakness. Pt was discharged from this facility on 2/19, had IVC filter placed for acute DVT, pt was not anticoagulated at that time secondary to her anemia. Pt states since this discharge has had progressively worsening SOB, DOE, fatigue, and generalized weakness. Pt states + DOE even when ambulating short distances, can no longer walk to her barn without having to stop to rest. Pt SOB became so significant yesterday she called EMS, EMS did administer breathing treatment and pt was brought to the ED for further evaluation. Pt admits to associated dizziness, cough, BL LE edema, and fatigue. Admits to chronic BL LE neuropathy. Denies chest pain, vision changes, headache, abdominal pain, N/V/D, melena, or hematochezia. Pt does admit to dark stools she relates to supplemental iron. CXR shows tiny BL pleural effusions. Pt was transfused 3 units of PRBC by the ED. Repeat Hg=7.7 now up from 3.7. Pt denies any overt bleeding history. Pt is noted to have anemia in the past, has in the past been on B12 shots as well as Aranesp injections, is not currently on these. Pt states she spoke with [redacted] after her discharge in Feb, was told to restart her Eliquis at that time which she has been taking, pt was recently started on Dyazide which she stopped citing dizziness. Echo in 2/23 showing pr EF.

Example 3 Inpatient History cont'd

Pt. well known to me from recent admission. Agree w/ HPI as stated above. Pt. states she is feeling much better after receiving blood and lasix. She states she had severe palpitations prior to admission which have since stopped. She has been up ambulating without SOB or lightheadedness and is very eager for discharge. She states she has an outpatient appointment scheduled with [redacted] in May and can see [redacted] in the office. She has declined BMB in the past. She denies bruising. Her main complaint currently is how bad the ER food is.

Example 3 Inpatient More Information

- Practitioner completed a medically appropriate exam
- Order multiple clinical lab tests
- Ordered and reviewed chest x-ray 1 view portable
  - Interstitial prominence may represent COPD and/or fluid overload
  - Tiny bilateral pleural effusion

Example 3 Inpatient Assessment and Plan

- Symptomatic anemia
  - Acute/chronic anemia
  - Inconsistent follow-up with heme
  - Patient declined bone marrow biopsy in past
  - S/p 3 units
  - Stop Eliquis
- Respiratory insufficiency
  - Due to anemia and COPD
  - Improved
- Generalized weakness
  - Improved
- Protein calorie malnutrition, severe
- Tobacco use
- Anemia in chronic illness
- COPD with emphysema

Example 3 Inpatient Discharge

Discharge Disposition
home

"I have spent 50____ minutes on the patient's care unit involving any needed patient evaluation, preparation of discharge records including any needed prescriptions and forms, and coordination of care instructions with relevant caregivers."

Electronically Signed on 04/20/23 10:31 AM

Example 3 Inpatient Findings

- Submitted as 99236
- Incorrect
  - Documentation shows admit on 04/19/23 by another physician
  - Documentation shows discharge on 04/20/23
  - Does not indicate time of admission and discharge
  - Documentation shows admission and discharge by two providers
- Can submit the 99239 for the discharge management

Example 4 Inpatient

Date of evaluation: 10/7/2023

Reason for visit: Sepsis, colitis

Physical examination:
Gen: Alert, responsive
Skin: No generalized rash
ENT: no visible thrush , intubated
Lungs : Coarse vent sounds
Coronary: NSR on monitor
Abdomen: distended, benign
MSK: IV site without evidence of phlebitis.

Reason for visit: Sepsis, colitis

Subjective/Interval history:
No remarkable fever, hemodynamics holding.

Visit Vitals

BP	121/62
Pulse	85
Temp	99.3 °F (37.4 °C)
Resp	**(!) 27**
Ht	5' 5"
Wt	150 lb 4.8 oz (68.2 kg)
SpO2	97%
BMI	25.01 kg/m²
OB Status	Partial Hysterectomy
Smoking Status	Former
BSA	1.77 m²

Example 4 Inpatient Problem List

Patient Active Problem List

Diagnosis	Code
• Diabetic neuropathy associated with type 1 diabetes mellitus (HCC)	E10.40
• Herpes simplex	B00.9
• Insomnia	G47.00
• Chest pain	R07.9
• CAD (coronary artery disease) S/P CABG	I25.10
• Left ovarian cyst	N83.202
• Anxiety and depression	F41.9, F32.A
• Chronic abdominal pain	R10.9, G89.29
• DKA (diabetic ketoacidosis) (HCC)	E11.10
• Pain of upper abdomen	R10.10
• NASH (nonalcoholic steatohepatitis)	K75.81
• Elevated transaminase level	R74.01
• Neuropathy	G62.9
• Mild obstructive sleep apnea	G47.33
• Hyperlipidemia	E78.5
• Calculus of kidney	N20.0
• Bipolar disorder, in partial remission, most recent episode depressed (HCC)	F31.75
• Atherosclerosis of abdominal aorta (HCC)	I70.0
• Lumbar pain	M54.50
• Peripheral vascular disease (HCC)	I73.9
• Platelet disorder (HCC)	D69.1
• S/P CABG (coronary artery bypass graft)	Z95.1
• Gastroparesis	K31.84
• Bilateral lower extremity pain	M79.604, M79.605
• Type 1 diabetes mellitus with diabetic autonomic neuropathy (HCC)	E10.43
• Livedo reticularis	R23.1
• Toxic metabolic encephalopathy	G92.8
• Essential hypertension	I10
• Anxiety	F41.9
• Closed fracture of transverse process of lumbar vertebra (HCC)	S32.009A
• Frequent falls	R29.6
• Muscle weakness (generalized)	M62.81
• Presence of aortocoronary bypass graft	Z95.1
• Presence of insulin pump (external) (internal)	Z96.41
• Low back pain, unspecified back pain laterality, unspecified chronicity, unspecified whether sciatica present	M54.50

Example 4 Inpatient More Problems

• Debility	R53.81
• Polypharmacy	Z79.899
• Chest pain, unspecified type	R07.9
• Fall	W19.XXXA
• Ketosis (HCC)	E88.89
• Acute dehydration	E86.0

Example 4 Inpatient Lab Results

Recent laboratory and culture data reviewed.

Culture Result

Date	Value	Ref Range	Status
09/29/2023	NO GROWTH 7 DAYS		Final
09/29/2023	OROPHARYNGEAL MICROBIAL FLORA DIMINISHED		Final

Component	Value	Date
WBC	16.9 (H)	10/07/2023
HGB	9.5 (L)	10/07/2023
HCT	29.3 (L)	10/07/2023
MCV	90.4	10/07/2023
PLT	360	10/07/2023
AST	49 (H)	10/07/2023
ALKPHOS	111	10/07/2023
CREATININE	0.4	10/07/2023

Example 4 Inpatient Medication

CURRENT ANTIMICROBIALS:

Current Anti-infectives (From admission, onward)

Start	
09/29/23 1145	**meropenem (MERREM) 1000 mg/NS 100 mL mini-bag** EVERY 8 HOURS

Example 4 Inpatient Summary

Brief Summary:
Patient is a 54 y.o. female who was referred for consultation for sepsis and colitis. Patient with CAD, anxiety, chronic back pain, MDD, T1DM, HTN, NASH, presented to ED on 9/28 with acute onset severe nausea and vomiting. She was tachycardic, afebrile, BP 141/70 in triage and CT showed fluid distention and mild wall thickening involving the colon. She became confused and agitated, septic and labs this morning showed wbc 1.7, 32% bands, lactate 4.7 and was transferred to the ICU and got intubated. Had a bronch/BAL and removed mucus plug from RLL. CT 09/29 showed diffuse abnormal thickening of the walls of the colon consistent with colitis.

Example 4 Inpatient Impressions

Impression:
-Septic shock
-Acute hypoxic respiratory failure. Intubated 09/29.
-Colitis. Cdiff negative. Flex sig 10/03 findings not consistent with pseudomembranous colitis.
-Pneumococcal urine Ag positive 09/29 (extensive bilateral infiltrates on imaging).
-Type 1 DM: A1C 10/1 7.4
-NASH cirrhosis

Recommendations:
- patient had flexible sigmoidoscopy 10/03. Findings was not consistent with pseudomembranous colitis, Colon edema likely from WBC decreased to 16.9 hypoalbuminemia.
- BAL cultures neg..
- Continue treating for HAP, Meropenem outlined through 10/8, will then observe.
- Continue nutrition and supportive care.
- status discussed with patient and ICU staff.
- service will continue to follow and advise.

Example 4 Inpatient Findings

- Problem – Moderate
- Data – Moderate
- Risk – Low
- Procedure code – 99232

Example 5 Critical Care Problems

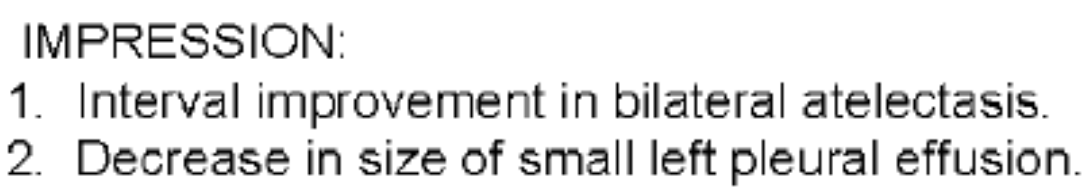
Principal Problem:
CAD in native artery
Active Problems:
RLS (restless legs syndrome)
RBD (REM behavioral disorder)
Sensory polyneuropathy
Moderate COPD (chronic obstructive pulmonary disease) (HCC)
Atrial fibrillation (HCC)
Chronic anticoagulation
Diabetes (HCC)
Parkinson disease (HCC)
Pulmonary embolism (HCC)
History of tobacco use
Dementia (HCC)
Acute on chronic diastolic congestive heart failure, NYHA class 2 (HCC)
Vasogenic shock (HCC)

Example 5 Critical Care Plan

Neuro – Pain controlled. Continue low dose oxycodone with scheduled Tylenol & Lidoderm patch. Continue PTA gabapentin. Resume PRN clonazepam at bedtime. H/O Parkinson's, continue PTA Carbidopa/Levodopa, donepezil and pramipexole.
CV – paroxysmal AF, currently AF rates 90s-110s. Completed digoxin load 9/2. Continue PTA amio dose (100mg daily). NE titrated off. BP 104/66, MAP 79. Add low dose BB for rate control and monitor BP, consider increasing BB frequency to TID over increased dose if needed. Continue ASA and statin. Intra op TEE LVEF 55-60%.
Resp – Daily CXR – bedside interpretation: low lung volumes, small bilateral pleural effusions, atelectasis; will review radiology report. Hx of COPD, FEV1 53%. Continue Duonebs Q4. Wean O2 for SpO2 goal > 88%. Continue guaifenesin and 7% NS nebulizer. Cont IS, aggressive pulm toilet. Chest tubes plan: remove remaining pleurals 9/2
Renal – Baseline sCr. 1.08. UOP: 2.2 mL/24hrs, net -1.4 L/24hrs. Continue furosemide 20mg orally BID. Hx of TURP, foley placed by urology. Continue tamsulosin. Keep foley x 3 days - consider removal 9/3.
GI - Nausea improved, given Parkinson's hx, will use only PRN Zofran or decadron for antiemetic. Continue post op bowel regimen.
ID – Afebrile.
Heme – Hgb 8.5. Pt on coumadin PTA for hx of PE and afib. INR 2.4 (has not received warfain in > 1 week) - continue to hold warfarin. Continue mechanical DVT prophylaxis.
FEN – replace Mg and K to minimize the risk of cardiac arrhythmias. A1c 6.1, continue MDCF.
Activity – OOBTC, advance activity as tolerated. Should ambulate in halls with nursing and cardiac rehab TID.

Example 5 Critical Care Data

- Glucose results
  - 172 at 310
  - 154 at 611
  - 147 at 1009
  - 144 at 1608
- Protime INR result 2.1
- Chest x-ray


IMPRESSION:
1. Interval improvement in bilateral atelectasis.
2. Decrease in size of small left pleural effusion.

Example 5 Critical Care Attestation

I have seen, personally fully evaluated, and discussed patient with critical care attending [redacted] and the cardiothoracic surgeon. The patient is critically ill and at risk for life threatening deterioration. I spent 51 minutes (excluding time spent performing or supervising any procedures) providing and personally directing critical care services including hemodynamic monitoring and management, lab and radiology review, medication review and management, fluid and electrolyte management and coordination of care.

Example 5 Critical Care Findings

- Submitted as 99291
- CERT down coded to 99233
- Problem – High
- Data – High
- Risk – Moderate

Resources

- CMS
  - *Medicare Claims Processing Manual*, Chapter 12, Section 30.6
  - Evaluation and Management Services Guide
- WPS
  - Documentation to Support an Evaluation and Management Service under TPE Review

Questions and Answers

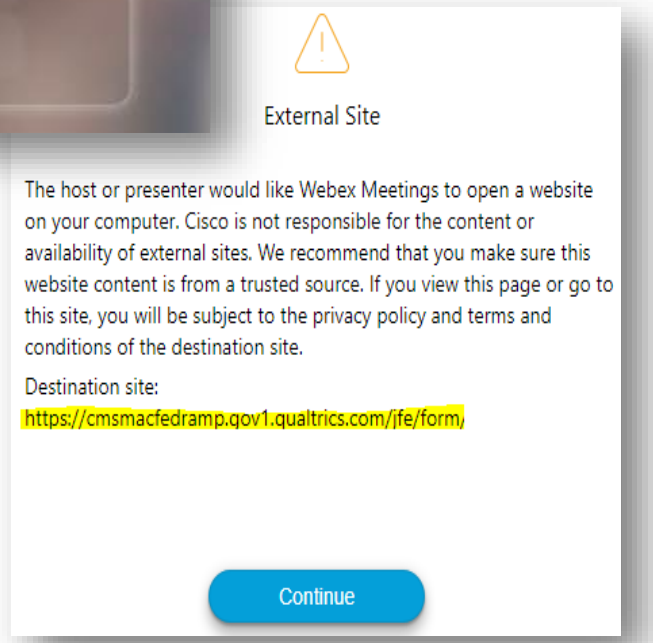
Follow-up Questions

Send your questions by 12:00 PM CT for seven days following the training

- Email wps.gha.education@wpsic.com
- Subject Line: Lakeland Medical Association

Send claim specific questions to Customer Service

Survey



Let us know what you think!

Take time to complete the survey now.

- Survey link in chat
- Redirect after closing webinar

Thanks for attending!

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