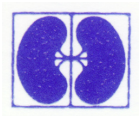
Compliance Manual
East Bay Nephrology Medical Group



Revised August 2008

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East Bay Nephrology Medical Group
Compliance Manual

The East Bay Nephrology Medical Group has developed the Compliance Program outlined in this manual to ensure that guidelines issued by providers (Medicare, Medi-Cal, etc.,) which delineate requirements for billing, are treated as an integral part of business practice of all board members, administrative staff, designated Compliance Officers, physicians, employees, and billing agents.

This Compliance Manual reiterates and clarifies the policies of EBNMG for professional billing and patient care services. It also functions as a guide and a good faith effort on behalf of East Bay Nephrology Medical Group to work cooperatively on voluntary compliance to, as requested by the OIG, "minimize errors and to prevent potential penalties for improper billings before they occur". All members of East Bay Nephrology Medical Group are encouraged to participate in a joint effort to ensure their commitment to fully understand the Compliance program instituted, and also, to make a joint effort to uphold the standards of practice which will support the Compliance program on a daily basis.

East Bay Nephrology Medical Group requests all physicians and staff to work together in a joint effort to provide the voluntary work effort necessary to prevent potential penalties from improper billings. This effort will be supported through the efforts of the Compliance Officer and ongoing periodic assessment of physician billing, documentation practices as set forth by the State, and Federal fraud and abuse laws.

Section I

The Compliance Program is intended to incorporate the following features:

- Commitment to uphold the standards and policies of all laws relating to patient care services and reimbursement.

- Authority and oversight by a designated official, functioning with the support of the East Bay Nephrology Medical Group Governing Board and Administration, to implement the Compliance Program.

- Training and education to all physicians, office managers, clinic staff, billing and coding personnel, and others whose actions impact the proper delivery of patient care, billing and documentation as set forth by government and commercial carriers. Training will include principles of reimbursement, improper referral patterns, appropriate selection of and sequence of diagnosis, submission of claims when rendered by a non-physician, i.e. the "Incident to" rule, proper documentation, signing a form on behalf of physician without prior consent, and duty to report misconduct.

- Standards of Procedures to assist in compliance. Physicians should have readily available to them, through ongoing training, regular staff meetings, comprehensive written policy on state and federal fraud and abuse laws; reimbursement principles involved with coding and a list of resources detailing proper coding; documentation requirements imposed by government and third party payers.

- Audits of billing and medical record documentation. To assess and identify compliance issues.

- A monitoring process which includes a committee of administrator(s), compliance officer(s), and physician(s), to review billing and coding audits of concern. The committee will refer to the EBNMG Board individuals who are unable to comply with the practice's standards.

- A mechanism for employees to raise questions regarding what is perceived to be inappropriate billing and coding practices. Also a prevention program, which includes a reasonable review of current employees to prevent employing or doing business with people who may have a propensity to engage in inappropriate activities.

Section II

Compliance Officer

The Compliance Officer is responsible for administering all aspects of the Compliance Program including periodic audits focusing on high-risk billing and coding issues. This person may have duties in addition to serving in this role. One or more persons may be designated with compliance monitoring responsibility.

The Compliance Officer shall ensure that all appropriate information regarding Compliance Standards and issues are made available to all individuals involved in the billing process. This person will maintain effective communication, both oral and written, with employees, physicians and carriers.

The Compliance Officer shall:

Review all billing, coding ,and training materials and through guidelines presented for in-house compliance training, ensure that all training materials presented at in-service training, at mandatory physician and staff seminar presentations, and at all daily memos and website updates reflect current billing and coding practice guidelines offered by Federal and State agencies.

Maintain responsibility for reviewing and approving the credentials of all outside billing and coding agents before they are engaged in employment. This function includes reviewing the OIG's list of excluded Individuals and Entities debarred from Federal Programs.

Ensure that all employees and physicians know and comply with Federal and State statutes, regulations and standards inpatient care, documentation and billing.

The Compliance Officer is responsible for conducting annual billing audits. At the direction of the compliance officer, other appointed staff will review selected samples of charges submitted for accuracy of CPT and ICD9 coding, as well as accuracy of data entry used in creating the billing document. The Compliance Officer will assist in developing face- to- face training sessions for Physicians whose audits indicate that more compliance education and training is required.

Prepare a periodic report to the administrator on the status of East Bay Nephrology Medical Groups billing and coding compliance activities formulated from annual audits of the top ten services billed, including unbilled claims. The review will include ten charts per physician and a review of the top 10 carrier claims denial used to determine why claims are denied, and how future claim submissions can be improved. [1] New Physician billing will be monitored for the first month.

[1] See Part B News (6/19/00)

In the case of the identification of a potential compliance problem, the Compliance Officer shall initiate the following actions:

The Compliance Officer responsibilities:

1. Develop full understanding of the problem identified.
2. Review the current policies/procedures
3. Determine means of correcting the problem.
4. Assess the financial impact on the organization.
5. Determine the corrective/educational action appropriate per Policies and Procedures.
6. Determine disclosure/reporting activities and repayment activities.

Section III

Written Policies and Procedures

Compliance Program standards and procedures that will be followed by the East Bay Nephrology Medical Group and the line of responsibility for implementing the Compliance Program are stated below. The standards and procedures have been set in place to reduce the prospect of the inappropriate activity and to also help identify any incorrect billing practices.

Code of Conduct

The mission of EBNMG Compliance Program is to ensure all billing for Patient Care services actually is rendered, coded accurately, documents medical necessity, is in compliance with applicable laws and regulations, and adheres to all payer contracts.

The code of conduct is a commitment to compliance. This commitment is established in the practice's written **Policies and Procedures**. The following elements should be incorporated to enable the compliance mission to be realized (1) maintain a written manual; (2) update clinical encounter forms to make sure they represent data required for all levels of coding; (3) develop an organizational structure for oversight of the program. (4) Maintain a system of communication that not only succinctly states a practice mission statement or code of conduct, but also puts into place a means of communicating changes to the compliance program standards and policies. This internal system also serves reporting of potential violations and supports responsible parties who ask questions or seek further clarification of compliance standards and policies.

Policy and Procedures:

East Bay Nephrology Medical Group shall bill for services actually rendered.

All services must be accurately documented and correctly coded to represent only those services deemed reasonable and necessary. Submitting claims for equipment, medical supplies and services that are not reasonable and necessary will not be tolerated.

EBNMG will not knowingly submit any claims to Governmental or Private Payors that represent Double Billing.[2] Double billing occurs when the physician bills for the same item or service more than once. This can also occur when another party bills the Federal Government for services also billed by an East Bay Nephrology Physician. Duplicate billing or repeated double billing can be monitored by claims denial. Repeated patterns of duplicate billing can create criminal, civil or administrative law liability.

Billing for non-covered services as if covered will not be tolerated. If questions arise concerning coverage, physicians should contact their Compliance Committee.

Rules governing the use of Provider Identification numbers, or suspected inappropriate use of these identifications, is available for review in Medicare Manual Carrier Manual 3060.10.

Unbundling practices are prohibited. Unbundling is the practice of billing separately for components of a service that should be billed as a single fee.

All claims submitted by EBNMG will be properly coded including the billing of appropriate modifiers. See Appendix A for current Modifiers. (page 14)

Upcoding, billing for a level of service not performed, or billing for a more expensive service than the one actually performed, will not be allowed.

The official coding guidelines are promulgated by HCFA, the National Center for Health Statistics, the American Medical Association and the American Health Information Management Association. See International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9 CM); 1998 Health Care Financing Administration Common Procedure Coding System (HCPCS); and Physicians' Current Procedural Terminology (CPT). [3]

Failure of physician practices to: (1) document items and services rendered; and (2) properly submit them for reimbursement is a major area of potential fraudulent or erroneous conduct involving Federal Health Care programs. [4]

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[2] Draft Compliance Program Guidance for Individual and Small Group Physician Practices. See page 36.
[3] Draft Compliance Program Guidance for Individual and Small Group Physician Practices. P36
[4] Same

Coding and Billing

The following risk areas associated with billing have been identified by the OIG as the subject of current investigations and audits.

- Billing for item or services not rendered or not provided as claimed
- Claims submitted for equipment, medical supplies and services that are not reasonable and necessary
- Double billing
- Billing for non-covered services as if covered
- Knowing misuse of provider identification numbers, which results in improper billing.[5]
- Billing for unbundled services
- Failure to properly use coding modifier
- Upcoding the level of service provided.[6]

[5] See 42 CFR 424.70-424-80. See also Medicare Carrier Manual 3060.10
[6] Health Insurance Portability and Accountability Act 1996. See 42 U.S.C. 1320a-7a(a)(1)(A)

Section IV

Medical Record Documentation

Medical record documentation pays particular attention to appropriate diagnosis codes and individual Medicare Part B claims (including documentation guidelines for evaluation and management services).

Physicians supplying services to Medicare Beneficiaries and Medicaid recipients are obliged to render services that are supported by evidence of Medical Necessity, including who provided the care, that the care is evidenced by documentation, and meets appropriate guidelines for diagnosis and procedure codes as set forth in the General Principles of Documentation.

General Principles of Medical Record Documentation

All departmental billing staff members, physicians and administrators are responsible for understanding and adhering to the principles of Medical Record Documentation as set forth in the guidelines for Evaluation and Management Services and other Federal guidelines for Physician billing.

Medical Record Documentation should comply with the following:

- Medical Record should be complete and legible. If notes are not legible, Auditor may not review, therefore documentation will not be accepted in audit. Repeated problems will be reported to the EBN Board.

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- Consults, History and Physicals and Discharge Summaries must be dictated.
- The documentation of each patient encounter should include the reason for the encounter; any relevant history; physical examination findings; prior diagnostic test results; assessment, clinical impression, or diagnosis; plan of care; and date and legible identity of the physician.
- When records are not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred by an independent reviewer or third party. Past and present diagnoses should be accessible in medical record documentation from the previous treating and/or current consulting physicians.
- Appropriate health risk factors should be identified. The patient's progress, his or her response to, and any changes in, treatment, and any revision in diagnosis, should be documented.[7]

[7] Draft Compliance Program Guidance for Individual and Small Group Physician Practices. See page 7.

Section V

Evaluation and Management Services

E/M codes are used to report services such as office visits, hospital visits, and consultations. E/M services are represented by varying levels of service determined by the extent of the History taken, the Physical exam performed and the Complexity of the Medical decision-making.

Any East Bay Nephrology physician may submit a claim for E/M services only if they have been present and directly involved in patient care.

The physician is responsible for determining the level of patient care. The seven components of this patient care are a) History b) Exam c) Medical decision-making e) Counseling f) Coordination of care g) Nature of presenting problem h) Time.

The physician must personally submit a hand-written, or dictated, signed note, that demonstrates his direct involvement in the key portion of the encounter. The key portions/components are 1) History, 2) Exam, 3) Medical decision making.

A detailed explanation of these components follows:
The levels of E/M service are based on four types of History. These designations are being constantly revised and updated by the Health Care Finance Administration and updates will be made to this section of the EBNMG Compliance manual on a regular basis, e.g., current draft is under review for 2001 E/M coding rules and regulations.

History :

a) Problem focused
b) Expanded problem focused
c) Detailed
d) Comprehensive

Each type of the above History, listed above, includes the following elements:

CC-Chief Compliant/ a concise statement describing the symptom, problem, condition, diagnosis, reason for the visit). This is often best stated in the patient's own words.

HPI- History of Present Illness/a chronological description of the patient's illness) includes: location, quality, severity, duration, timing, context, modifying factors, associated signs and symptoms.

ROS- Review of Systems is separated into the following 14 areas: which includes the following: constitutional symptoms, eyes, cardiovascular, ears/nose/mouth/throat, respiratory, gastrointestinal, genitourinary, musculoskeletal, integumentary, neurologic, psychiatric, endocrine, hematologic/ lymphatic/allergic/immunologic.

PFSH- Past, family and social history. Past items include: medications, illnesses, injuries, operations, hospitalizations, allergies, immunization status, health maintenance.

Family items: Health status and diseases of family members or cause of death. Social Items: Marital status, current employment/occupational history, environment, drugs, alcohol and tobacco use, sexual history.

The CC, ROS and PFSH may be listed separately or included in the description of the history of the present illness. Ancillary staff may record the elements of history, however this document must be reviewed and a notation made by the physician supplementing or confirming the information recorded by staff. This document must be a permanent document in the Medical Record.

Each level of E/M service is based on four types of Examination

a) **Problem focused-**a limited exam of the affected body area, organ system
b) **Expanded problem focused**- a limited exam of the affected body area or organ system and or other symptomatic or related organ systems.
c) **Detailed**-an extended exam of the affected body area (s) and other symptomatic or related organ systems
d) **Comprehensive**- a general multi-system examination or complete organ system.

Body areas	Head, including the face
	Neck
	Chest, including breasts and axillae
	Abdomen
	Genitalia, groin, buttock, back, including spine
	Each extremity
Organ Areas	Constitutional symptoms-fever-weight loss
	Eyes
	Ears, nose, mouth throat
	Cardiovascular
	Respiratory
	Gastrointestinal
	Genitourinary
	Musculoskeletal
	Skin
	Neurologic
	Psychiatric
	Hematologic/Lymphatic/Immunologic

The extent of the exam performed is dependant on the clinical nature of the presenting problem. Abnormal or relevant negative findings of the examination should be documented. A notation of abnormal without sufficient elaboration is not acceptable.

Documentation of Medical Decision Making

The levels of **E/M** service include four types of Medical Decision Making:

Straightforward
Low Complexity
Moderate Complexity
High Complexity

Medical Decision-Making refers to the complexity in establishing a patient's diagnosis and selecting a management option. The level of Medical Decision Making complexity is determined by the following:

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

Number of Diagnosis 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 physicians.

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 without an established diagnosis the assessment or clinical impression may be stated in the form of a differential diagnoses and/or possible or probable, rule-out diagnoses.

Initiation or changes in treatment should be documented. Treatment includes a wide range of management options including patient instructions, nursing instructions, therapies, and medications. If referrals are made, consultations requested or advice sought, the record should indicate to whom or where the referral consultation is made or from whom advice is requested.

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 and reviewed. Obtaining old medical records and/or obtaining history from sources other than the patient increases the amount and complexity of data to be reviewed.

The type of a diagnostic service (test or procedure) that is ordered, planned, scheduled and/or performed at the time of the encounter should be documented. The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented.

The review of lab, radiology and/or other diagnostic tests should be documented. Alternatively, the review may be documented by initialing and dating the report containing the test results. The results of discussion with laboratory, radiology, or other diagnostic tests with the physician who performed or interpreted the study should be documented. A decision to obtain old records or decision to obtain additional history from the family, or other source 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 a) presenting problem, b) diagnostic procedures, c) possible management options. The following must be documented.

- Co morbidities that increase the risk of complications, morbidity and/ or mortality
- Diagnostic procedures ordered, or scheduled at the time of the E/M encounter
- Referral for,or decision to, perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

The assessment of risk of the presenting problem is based on the risk related to the patient's health from the current encounter forward.

Risk Table

Level of Risk	Presenting Problem	Diagnostic Procedures	Management Options
Minimal	•One self-limited or minor problem, e.g. cold, insect bite.	Laboratory Tests requiring venipuncture Chest x-rays EKG/EEG Urinalysis Ultrasound, e.g. Echocardiography Koh prep	Rest Gargles Elastic bandages Superficial dressings
Low	• Two or more self-limited or minor problems •One stable chronic illness, e.g. well controlled hypertension or 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., pulmonary function tests 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 without additives

Level of Risk	Presenting Problem	Diagnostic Procedures	Management Options
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 complex 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 with contrast and no Identified risk factors, e.g., arteriogram,cardiac catheterization. Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis,culdocentesis.	Minor surgery with identified risk factors Elective major surgery with no risk factors. Prescription drug management Therapeutic nuclear medicine IV fluids w/additives closed treatment of fracture or dislocation without manipulation
High	•One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment •Acute or chronic illness or injuries that 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 contrast with identified risk factors cardiac electrophysiological tests Diagnostic endoscopies with identified risk factors Discography	Elective major surgery with risk factor identified. Emergency major surgery Parenteral controlled substances Drug therapy that requires intensive monitoring for toxicity Decision not to resuscitate or to de-escalate care because of poor prognosis.

Incident To Services

HCFA definition:

"Services furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment or an injury or illness"[8]

In order for a non-physician provider to bill under "incident to" rules, the following conditions must be met:

Services provided must be services most commonly performed by a physician

Service must be medically appropriate in the office setting,

Non-physician practitioner must be employee of the physician, physician group practice or a leased employee.

Physician must render the initial patient service and be involved in the management and course treatment.

Service must be rendered under physician's "direct personal supervision"

Direct personal supervision means that a physician must be on the premises and immediately available at all times to assist the non-physician practitioner who is providing services. Physician does not need to provide a patient service on the same day as non-physician provider.

Under "incident to" guidelines, Nurse Practitioners (NP), Physician Assistants (PA), Nurse Midwives (NM), and Clinical Nurse Specialists (CNS) may bill the appropriate E/M codes that their scope of practice will allow.

NPs, PAs, NMs, and CNSs can bill any level of E/M service, but should note that higher levels of E/M services require moderate or high medical decision-making.

For all other non-physician practitioners (e.g., Certified Registered Nurse Anesthetists, Clinical Psychologists, Clinical Social Workers), the only E/M code available is 99211, if the physician was not involved with the treatment of the patient that day.

Non-physician providers cannot base their selection of an E/M code on counseling and/or coordination of care; this is only available to physicians.

In billing "incident to," non-physician practitioners cannot:

Use E/M codes for New Patient Visits (CPT codes 99201-99205)
Carry their own case load.

[8] Medicare Carriers Manual Volume 3, Sections 3, Sections 2050, 2150,2152.

Section VI

East Bay Nephrology Medical Group Compliance Committee

The Compliance Committee will function as an advisory counsel to the Compliance Officer on all issues of documentation presented by the Audit Committee. The Audit committee will be responsible for reviewing all provisions of documentation or billing for medical and health care services to government and third party payors.

Committee Structure/*Key Functions*

The Compliance Officer will serve as the Chair of the Committee. The East Bay Nephrology Medical Group Chief Operating Officer will be responsible for appointing the members of the committee. The Chief Operating Officer will also appoint, in conjunction will the Compliance Officer, the members of the Audit Committee, who will serve in a liaison role to the compliance officer.

Quarterly meetings will be held by the Compliance Officer as needed, or upon recommendations from the compliance committee.

Key Functions

The Compliance Officer reports to the EBNMG Board. The Compliance Officer has the overall responsibility for providing an avenue to receive information pertaining to potential non-compliance. That responsibility includes investigating and resolving issues either alone or in conjunction with the appropriate physician. Any employee or physician of East Bay Nephrology Medical Group may call the EBNMG Hot Line number to report their concerns.

EBNMG Phone HotLine: (510)-841-0411 x120
Email Hotline: hwilliams@ebnmg.org

The Compliance Officer will review audit results and recommend actions for non-compliance as indicated by the compliance manual. The Compliance Officer will review and adopt new policies as appropriately identified by the EBN Board, which may include:

- Compliance Education Program for Physicians and Staff
- Review of regulatory/third party coding/documentation rule changes
- EBNMG Sanction Policy Updates
- Annual Compliance Program Appraisal

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Review #1

The Audit committee will periodically sample medical records for compliance standards. If the review #1 results in 100% compliance the physician member will be notified, thanking him with a reminder of yearly Compliance Training.

If **Review #1** shows less than 100% , an Audit Committee Member will meet with the physician for a *Focused Personal Coding Training Session*.

The Audit Committee Member will complete a follow-up review of 5 charts. If this review shows the identified problem has not improved, the Compliance Officer will contact the Physician to discuss the lack of compliance and the need for more personal coding training.

If **Review #2** is successful, the Physician will be reminded of the Annual Training requirements, and a letter will be sent to the EBN Board informing them of the successful completion of the Focused Personal Coding Training Session. If after further counseling no significant improvement occurs, physician will be reported to EBN Board for possible further appropriate actions.

During Review #1 or 2, if in opinion of the Compliance Officer, the deficiencies are significant, an additional five charts will be reviewed within 90 days. If after further counseling no significant improvement, occurs, physician will be reported to EBN Board for possible further appropriate actions.

Specific complaints directed to Compliance Officer may result in an impromptu audit. Compliance Officer will address results with physician involved and EBN Board as appropriate.

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Within 60 days of the second personal coding session, the Audit Committee Member will complete a follow-up review of 5 charts.¶
¶
Failure to achieve correct coding compliance during the Third Review will result in forwarding the matter to the Compliance Officer. Upon review the Compliance Officer will make a recommendation to the EBNMG Board regarding resolution. [9]

Appendix A Modifiers

Modifier 22-Unusual Procedural Service
This modifier indicates that a procedure was complicated, complex, difficult or took significantly more time than usually required by the provider to complete this procedure. Documentation should be contained in the operative report, attached to the claim form.

Modifier 24- Unrelated Evaluation and Management Service During a Postoperative Period.
This modifier should only be used with an E/M code. A diagnosis different from the surgical diagnosis is required.

Modifier 25- Significant, Separately Identifiable Evaluation and Management Service by the same Physician on the Same Day of the Procedure or Other Service. The E/M service may be prompted by symptom or condition for which the procedure and /or service was provided. As such, different diagnoses are not required for reporting of the E/M service on the same date.

Modifier 26-Professional Component
This modifier identifies the physician's component of a two component service, usually associated with radiology services. The technical component includes reimbursement for the facility, equipment, film processing and the technician. The professional component is usually reserved for the physician who interprets the procedure.

Modifier 32-Mandated Services
Modifier 32 identifies services mandated by insurance carriers, government agencies and private payers.

Modifier 50-Bilateral Procedures
This modifier identifies an independent procedure performed on the opposite side during a single operative session.

Modifier 51-Multiple Procedures
This modifier designates multiple procedures that are rendered at the same operative session on the same day.

Modifier 52-Reduced Services
Modifier 52 identifies when the physician has elected to reduce a portion of a service or procedure. Diagnosis reflects the reason for the reduced services.

Modifier 53-Discontinued Procedure
Modifier 53 is used to indicate where the procedure is terminated due to extenuating circumstances or those that threaten the well being of the patient. (not used to report an elective cancellation of a procedure).

Modifier 54-Surgical Care Only
This modifier is used to indicate when a physician performs a surgical procedure and another physician provides the pre/post operative management.

Modifier 55-Postoperative Management Only
This modifier is used when one physician provides postoperative management and another physician has performed the surgical procedure.

Modifier 57-Decision for Surgery
This modifier identifies an evaluation and management service that results in the initial decision to perform surgery. This modifier should only be reported with E/M services (used only prior for those procedures whose global days are 90 days).

Modifier 58-Staged Procedure or Service by the Same Physician During the Postoperative Period.
This modifier is used to indicate that the procedure or service was planned at the time or the original procedure or staged; was more extensive than the original procedure; or was for therapy following a diagnostic surgical procedure.

Modifier 59-Distinct Procedure Service
This modifier is used to identify a procedure or service as distinct or independent from other services performed on the same day; 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 not ordinarily encountered or performed on the same day by the same physician

Modifier 62-Two Surgeons (Co-Surgery)
This modifier is used to indicate that two surgeons, usually of different specialties, each complete an integral part of the procedure.

Modifier 66-Team Surgery
This modifier indicates that three or more surgeons worked together as primary surgeons to perform a specific procedure. Sufficient documentation must be submitted to establish that a team was medically necessary.

Modifier76-Repeat Procedure by the Same Physician
This modifier indicates that a basic procedure with no follow-up days had to be repeated by the same physician.

Modifier 77-Repeat Procedure by another Physician
This modifier indicates that a basic procedure with no follow-up days had to be repeated by another physician.

Modifier 78-Return to the Operating Room for Related Procedure During the Post operative Period
This modifier indicates that the complication arose to necessitate a return trip to the OR.

Modifier 79-Unrelated Procedure or Service by the Same Physician During the Post Operative Period.
This modifier indicates that there was a procedure done during the global period which was not related to any post-operative complication.

Modifier 80-Assistant At Surgery
This modifier indicates that a surgical assistant was utilized and is applied to the surgical procedure codes.

Modifier 81-Minianl Assistant At Surgery
This modifier indicates that a non-provider assisted at surgery.

Modifier82-Assistant Surgeon
This modifier indicates that a resident surgeon was not available and for that reason, an assistant surgeon was used.

Modifier 90-Reference Laboratory
This modifier indicates that Laboratory procedures were performed by a party other than the treating or reporting physician.

Modifier 91-Repeat Clinical Diagnostic Laboratory Test
Repeat laboratory on the same day.

Modifier 99-Multiple Modifiers
Modifier 90 identifies circumstances where two or more modifiers are necessary to delineate a service.

Addendum

Coding for Teaching Physicians

According to Health Care Financing Administration (HCFA) guidelines, payment can be made for Physician services furnished in teaching settings, under the physician fee schedule, under one of two circumstances:

> **The services are personally furnished by a physician who is not a resident.**
>
> **The services are furnished jointly by a teaching physician and resident, or by a resident in the presence of the teaching physician.**

Generally speaking, Medicare will pay only for direct patient services provided by the teaching physician to the patient. Services provided jointly by the teaching physician and resident must be coded and billed only to the extent that the teaching physcian documents his/her participation in the service. Some services, such as critical care and hospital discharge, are billed based on the time spent with the patient. Time exempted from billing includes:

> time the resident spends administering services in the absence of the teaching physician;
>
> time the teaching physician spends teaching the resident solely, rather than, administering also to the patient.

The type of service also dictates physician involvement and level of documentation. If, for example, a resident or fellow performs a surgery such as femoral hemodialysis catheter insertion, The attendant need not be present during the full procedure. The attendant must be present in the operating room during key components of the surgery, such as locating the vein and placing the catheter over the guide wire.

Time-dependant critical care services to a critically ill patient are administered solely by the teaching physician, although sometimes in the presence of a resident. When administering critical care it is essential that the physician be present throughout the critical care procedure. It is also important when billing to document the time spent and the extent of the physician participation. The physician can bill for the critical care time only when he was personally in attendance.

The physician must be fully present for the period of time for which the claim is made for time-dependent E/M services. In other E/M services, if more than half of the service is spent counseling the patient/family and or coordinating and managing care, then time is the key factor that qualifies the level of service. As with critical care, only the time the teaching physician spends administering to the patient, whether the resident is present or not, is billable. Services provided strictly by a resident without the teaching-physician presence or follow-up cannot be billed.

While documenting E/M services, a resident must document in his/her notes that the patient was seen and examined with teaching physician and that the assessment and plan were discussed with the teaching physician attending. The teaching physician also needs to corroborate that he was present. The attending physician should incorporate key elements of the examination in the resident's notes, including, in the history section specific complaints, indicating symptoms such as

lungs clear, shortness of breath. The attending also should make a short note in the assessment and plan, such as, acute renal failure, fluid status OK. Unlike critical care, when the physician's notes are separate from the resident's, the teaching physician can link his notes with the resident's, as long as the physician conducts and documents the key portion of the exam that determines the level of service. While review of systems and past, family, social history can be performed by ancillary personnel, including the resident, the physician must refer back to the resident's assessment and plan, confirming the key elements.[10]

[10] Nephrology Coding Alert, July 2000, page 49.

References

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Internet Resources

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www.hhs.gov/oig

Health Care Financing Administration
www. hcfa.gov

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