Billing Provider Training

Documentation, Coding, and Billing Compliance

CPMP Compliance & Privacy Department
2025

Every reasonable effort has been made to ensure the accuracy of the information within these slides at the time of presentation.

Stony Brook Medicine

The CPMP Compliance & Privacy Department operates the corporate compliance and privacy program for Stony Brook Medicine's Clinical Practice Management Plan (CPMP).

Learning topics:

1. The importance of an effective compliance program
2. Diagnosis coding accuracy, RAF, and HCC
3. Selecting the correct level of an Evaluation and Management (E/M) service using either Medical Decision Making or Time
4. Documenting and billing under the Teaching Physician Guidelines
5. Incident To and Split/Shared services
6. Timely documentation and the risks of copy/paste

CPMP Compliance & Privacy Department

The CPMP Compliance & Privacy Department operates the corporate compliance and privacy program for Stony Brook Medicine's Clinical Practice Management Plan (CPMP).

We support all professional fee billing providers (UFPC, SBCM, and MHLMP) and workforce members (RF, StaffCo/CPMP, SBAS, and MHLMP), per the CPMP Compliance Code of Conduct.

What is Compliance?

- ✓ Following the rules
  - Federal and state laws, rules, and regulations
  - SBM, CPMP/UFPC Policies and Procedures
- ✓ Safeguarding Patient's Protected Health Information (PHI)
- ✓ Promoting ethical behavior
- ✓ Encouraging a "Speak Up" culture
- ✓ Protecting the organization

Elements of an Effective Compliance Program

Come to Us for Questions/Concerns Relating to:

- **Billing Integrity**
- **Regulatory Rules and Guidelines**
- **HIPAA Privacy**

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Retaliation and/or intimidation against anyone who seeks advice, raises a concern, or reports a compliance issue in good faith will not be tolerated and may result in discipline.

The Golden Rule

Document what you do, code what you document!

The Medicare Claims Processing Manual (Chapter 12) explains that **payment is primarily based on the medical necessity of a service and the specific requirements of the CPT code.**

It is not appropriate to bill for a higher level of evaluation and management service if a lower level is warranted.

Documentation should accurately support the level of service reported.

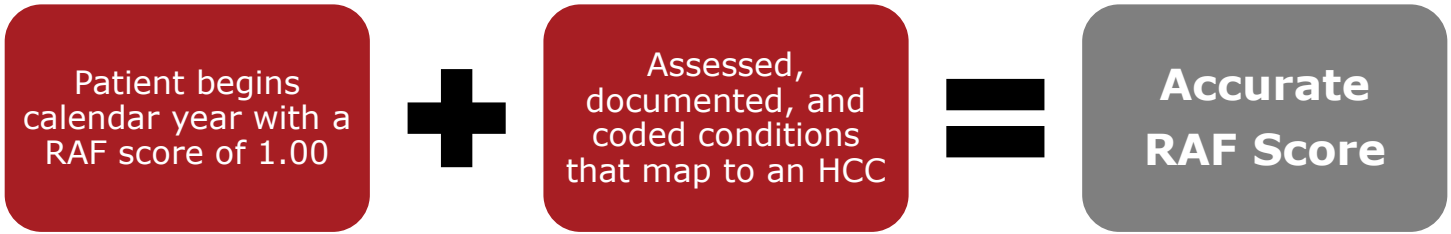
IMPORTANT: The Medicare contractors perform medical review audits to ensure Medicare is paying providers for appropriately covered services. Their reviewers examine documentation from providers to validate that the documentation supports the services and level of service billed by the provider and the documentation adheres to all Medicare coverage guidelines.

Diagnosis Coding Accuracy

HCCs and RAF Scores

Hierarchical Condition Categories (HCCs) are groups of clinically similar diagnoses, with each group consuming similar resources, known as clinical disease burdens.

- HCCs help communicate the current conditions and complexity of each patient.
- HCCs are linked to a Risk Adjustment Factor (RAF) Score, which is a numeric value assigned to a beneficiary based on their disease burden in addition to demographic information.
- RAF scores are a reflection of the probable cost to meet the beneficiary's yearly healthcare needs.
- RAF scores are reset every year on January 1. HCC conditions will need to be reported again each year.



Considerations for Accurate Diagnosis Coding

1. **Identify the reason for the visit or encounter** - Choose the primary ICD-10 code that best describes the reason for the service provided. If there is no definitive diagnosis, code signs and symptoms until a diagnosis is established.
2. **Code to the highest level of detail** – Avoid unspecified codes if a more specific code is available.
3. **Acute vs Chronic Conditions** - Conditions must be accurately documented to reflect the status of the condition.
4. **Laterality –** Some ICD-10 codes specify whether the condition occurs on the left, right, or bilaterally.
5. **Code for social determinants of health (SDoH)** - Examples of SDoH would include problems related to the physical environment, housing or economic circumstances, psychosocial circumstances, or social environment.

Summary

You must document accurately, thoroughly, and to the highest level of specificity.

The M.E.A.T. Acronym

Monitored

- Signs/symptoms
- Disease regression or progression

Evaluated

- Test Reviewed
- Response to treatment

Assessed

- Tests Ordered
- Records Reviewed
- Counseling
- Discussion

Treated

- Medications
- Therapies
- Other Modalities

If you are MEAT-ing a condition, capture that work by reporting the diagnosis code.

Key Components of Evaluation & Management (E/M) Services

Elements of History and Exam

A **chief complaint** is always required to be documented on all E/M notes

History of Present Illness (HPI)	
1. Location	5. Duration
2. Severity	6. Timing
3. Context	7. Modifying Factors
4. Quality	8. Associated Signs & Symptoms

Review of Systems (ROS)	
1. Constitutional	8. Musculos
2. Eyes	9.
3. ENMT	gical
4. Cardi	. Psychiatric
	12. Endocrine
intestinal	13. Hematologic/Lymph
7. Genitourinary	14. Allergy/Immunology

Histories (PFSH)
Past Medical, Family and Social

CMS Recognized Organ systems:	
1. Constitutional	
2. Eyes	
3. Ears/ Nose/ M	
4. Cardi	
	estinal
	Genitourinary
8. Musculoskeletal	
9. Integumentary	
10. Neurological	
11. Psychiatric	
12. Hem/Lymph/Immunology	
And Body Areas:	4. Abdomen
1. Head and Face	5. Genitals
2. Neck	6. Back, Spine
3. Chest, Breast, Axillae	7. Extremities

Requirements prior to 2021/2023 E/M changes

Current Requirements

Documentation of a medically appropriate history and/or physical examination is always required.

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KEY COMPONENT: MEDICAL DECISION MAKING

Level of MDM*	COLUMN 1 Number and Complexity of Problems Addressed	COLUMN 2 Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	COLUMN 3 Risk of Complications and/or Morbidity or Mortality of Patient Management
Straight-forward	**1** self-limited or **minor** problem	Minimal or None	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**2** or more self-limited or **minor** problems; or **1 stable chronic** illness; or **1 acute, uncomplicated** illness or injury **1 stable, acute** illness; or **1 acute, uncomplicated** illness or injury requiring hospital inpatient or observation level of care	**Must meet the requirements of at least 1 of the 2 categories** **Category 1:** Tests and documents: Any combination of 2 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* or **Category 2:** Assessment requiring an **independent historian(s)** (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	**Low risk of morbidity from additional diagnostic testing or treatment** **Examples:** **OTC drugs, PT, OT**, Decision regarding **minor** surgery w/out identified risk factors, IV fluids w/out additives
Moderate	**1** or more chronic illnesses with **exacerbation**, progression, or side effects of treatment; or **2** or more **stable chronic** illnesses; or **1 undiagnosed** new problem with uncertain prognosis; or **1 acute** illness with systemic symptoms; or **1** acute, complicated injury	**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)	**Moderate risk of morbidity from additional diagnostic testing or treatment** **Examples only:** Prescription **drug management** Decision regarding **minor surgery** with identified patient or procedure risk factors Decision regarding elective **major surgery** without identified patient or procedure risk factors Diagnosis or treatment significantly limited by social determinants of health
High ***Based on 2 out of 3 Columns of MDM*** ***Source: AMA***	**1** or more chronic illnesses with **severe exacerbation**, progression, or side effects of treatment; or **1 acute or chronic** illness or injury that poses **a threat to life or bodily function**	**Must meet the requirements of at least 2 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)	**High risk of morbidity from additional diagnostic testing or treatment** **Examples only:** Drug therapy requiring **intensive monitoring** for toxicity Decision regarding **elective major surgery** with identified patient or procedure risk factors Decision regarding **emergency major surgery** Decision regarding **hospitalization or escalation of hospital level care** **Decision not to resuscitate** or to de-escalate care because of poor prognosis Parenteral **controlled substances**

Let's pause for some questions!

Selecting Levels of Service Based on Time

Time-Based E/M Coding

Time is defined as the total time spent in Evaluation and Management of the patient on the date of the encounter.

It includes:

- Both the face-to-face time with the patient and/or family/caregiver and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter.
- Time spent in activities for the patient regardless of the location of the physician or other qualified health care professional.

It does not include:

- Time in activities normally performed by clinical staff.
- Any time spent in the performance of other separately reported services(s).

Sample Time Statement:
"XX minutes was spent in the evaluation and management of this patient today."

Levels of Service with Corresponding CPT Codes

Office/Outpatient Levels of Service

	CPT	Medical Decision Making		Total Time
New Patient	99202	Straightforward	OR	15
	99203	Low		30
	99204	Moderate		45
	99205	High		60

	CPT	Medical Decision Making		Total Time
Established Patient	99212	Straightforward	OR	10
	99213	Low		20
	99214	Moderate		30
	99215	High		40

Hospital Inpatient or Observation Levels of Service

	CPT	Medical Decision Making		Total Time
Initial Visit	99221	Straightforward or Low	**OR**	40
	99222	Moderate		55
	99223	High		75

	CPT	Medical Decision Making		Total Time
Subsequent Visit	99231	Straightforward or Low	**OR**	25
	99232	Moderate		35
	99233	High		50

Hospital Inpatient or Observation Discharge Management Services

CPT	Description
99238	**30 minutes or less** on the date of the encounter
99239	**More than 30 minutes** on the date of the encounter

Documentation for discharge services must include:

1. A final examination.
2. Discussion of the hospital stay.
3. Instructions for continuing care.
4. Preparation of discharge records, prescriptions, and referral forms.

Keep in Mind: Time must be documented to support 99239.

G2211: Office/Outpatient E/M Add-On Code

When can G2211 be reported?

- When the patient has a single, serious, or complex condition.
- You are serving as the continuing focal point of care for that condition.

What are the documentation requirements?

According to NGS, *"medical necessity is the primary factor in considering the use of this code; the medical record must support the key elements of the code's definition and requirements."*

What E/M codes can G2211 be added to?

- G2211 can be reported in addition to CPT codes 99202-99205,99211-99215.
- It can also be reported when an E/M is performed along with preventative services such as Annual Wellness Visits (AWV), vaccine administration, or any other Medicare Part B preventative service (including Initial Preventive Physical Examination, or IPPEs).

Before adding G2211 to your Office/Outpatient E/M, ask yourself:

1) Are your MEAT-ing a single-serious and/or complex condition(s)?
2) Do you already have or plan to have a long-term relationship with the patient to care for that condition(s)?

Teaching Physician Guidelines

Teaching Physician Guidelines

Evaluation and Management Services	
The Teaching Physician Must:	**If these components are missing, the resident's contribution and documentation cannot be used as part of the billable service!**
1. Personally attest to their physical presence during all key and critical portions of the E/M service.	
2. Specifically document that they reviewed the resident's progress note.	
3. Document that they participated in the management and plan as documented by the resident.	
4. Agree to the document or revise it, if needed, and sign.	

Teaching Physician Attestations

Specific auto-texts must be used when supervising a resident and co-signing a note to bill for that service.

Use Cerner's auto-text feature when adding an attending addendum

	Auto Text Phrase
Abbreviation zaAttestationAttendingPhysician **Description** Attending Attestation of Resident Supervision	**Attending Note** I was physically present during the service to the patient and/or personally examined the patient and I was directly involved in the management plan and recommendations of the care provided to the patient. I reviewed the history and the physical exam as documented by the resident/fellow. I have discussed my plans with the resident/fellow. I confirm/revise the resident/fellow's note as follows:
Abbreviation zalLAttestationAttendingPhysician **Description** Late Attestation	**Attending Note** The date of service is ___ The time of service is ___ I was physically present during the service to the patient and/or personally examined the patient and I was directly involved in the management plan and recommendations of the care provided to the patient. I reviewed the history and the physical exam as documented by the resident/fellow. I have discussed my plans with the resident/fellow. I confirm/revise the resident/fellow's note as follows:

Let's pause for some questions!

Incident To and Split/Shared Services

Incident To Services

Incident To services are reported when a plan of care is established by a physician and followed by an Advanced Practice Provider (APP) at future visits.

- Occurs in the Office/Outpatient setting (POS 11).
- Follows a plan of care that has been established by a supervising physician.
- Is supervised by a physician who is present in the office suite while care is provided.
  NOTE: The supervising physician is not required to sign the medical record, but they must be readily available with their presence documented by the APP.

If the patient presents with a new problem, the visit would no longer qualify as an Incident To service. The treating provider (physician or APP) would then bill for that service.

When to Report Incident To

Physician establishes a plan of care

+

APP follows the plan of care and a supervising physician is in the office suite at the time of services

=

Incident To service

Physician establishes a plan of care

+

Patient presents with a new problem or there is no supervising physician in the office suite

≠

Service is reported under the treating provider

Split/Shared Services

Split/Shared services occur when a physician and Advanced Practice Provider (APP) act as a team in providing care for the patient during a single E/M service on the same date of service.

- Occur in settings such as hospital inpatient care, observation care, or nursing facility care.
- Performed by a physician and APP in the same group practice (i.e., same Tax ID Number).
- Include the –FS modifier.
- Documentation must reflect the identity of both providers and each provider's involvement in the service.
- Whoever performs and documents the substantive portion is the provider who reports that service.

What is the substantive portion?

Either the greater amount of total time **OR** making or approving the management plan and taking responsibility for that plan of care.

Split/Shared Services

NEW!!! Attestations are now in Cerner

When Using Medical Decision Making (MDM):

zzsplitsharedmdm "I saw and evaluated the patient with (physician or APP). I performed the substantive portion of care for this patient by making or approving the management plan for the number and complexity of problems addressed and taking responsibility for that plan with its inherent risk of complication and/or morbidity or mortality of patient management. I have reviewed and verified this documentation, which accurately reflects the care provided."

When Using Time:

zzsplitsharedtime "I saw and evaluated the patient with (physician or APP). The combined total time spent performing services for this patient was _____ minutes. I spent _____ minutes, which is the majority of the face-to-face and non-face-to-face time performing this service. I have reviewed and verified this documentation, and it accurately reflects the care provided."

REMINDER

(Medical Necessity) + (Supporting Documentation) + (Attestation) + (FS Modifier)
= Split/Shared Service

Documentation in the Medical Record

Importance of Timely Documentation

"All services provided to beneficiaries are expected to be documented in the medical record at the time they were rendered."

Medicare Program Integrity Manual

"The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record."

Medicare Claims Processing Manual

The best practice for timely documentation is to have it completed as soon as possible after the encounter.

Risks of Copy/Paste & Copy/Forward

Definitions

- **Copy/Paste:** Selecting data from an original or previous source to reproduce in another location. For example; nursing spreadsheet, progress note or narrative reports from diagnostic imaging studies
- **Copy/Forward:** A function that copies a significant section or entire prior note. For example; past medical history, review of systems, physical exam
- **Data Linking:** Using shortcuts to insert data from another part of the patient record into a progress note. For example; past medical/family and/or social history, medication list, problem list, lab data, flowsheet data

Risks

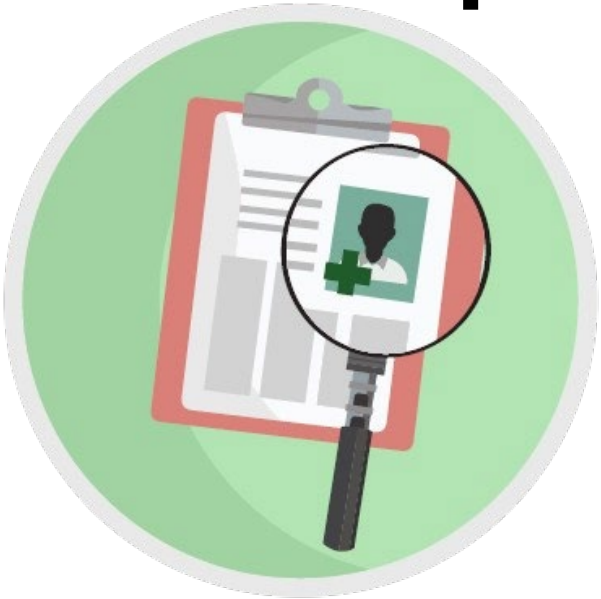
Patient Safety

- Information may be placed in the wrong encounter date or patient record
- Be repetitive, identical, old or bloated which increases the risk that they will be ignored by clinical staff leading to important information being missed
- May create challenges relating to establishing medical necessity in cases where no additional information is documented

Improper Billing

- Copied content may appear to document a service that was not performed at that particular visit and result in up-coding
- Content may be old, outdated, conflicting, incomplete, or inaccurate deeming a note un-useable
- Repetitive or identical notes may raise questions about what was relevant to that encounter date and can affect medical necessity

Next Steps

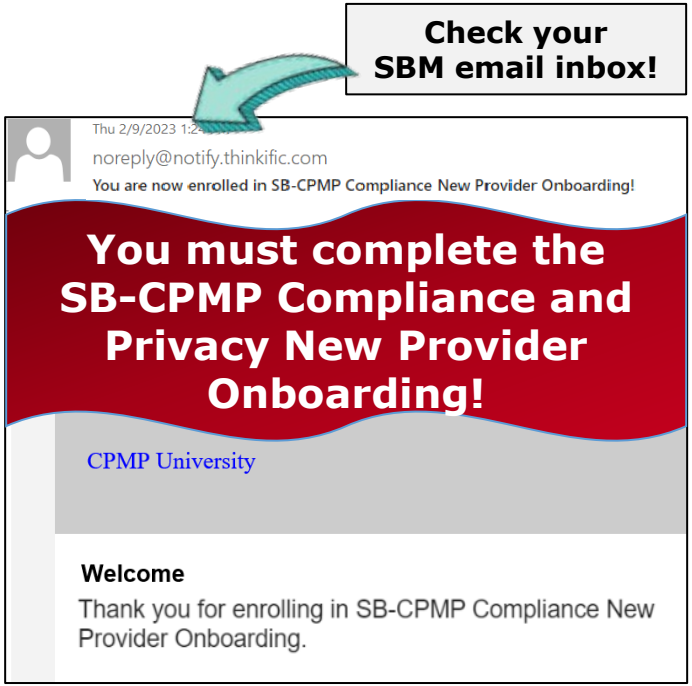


CPMP Compliance & Privacy Mandatory Training

All new providers must review and complete:

1. The CPMP Code of Conduct
2. Regulatory Compliance Fraud, Waste, and Abuse Prevention Education
3. HIPAA Privacy Training
4. NY DHHS "Think Cultural Health" Cultural Competency Training

Be on the lookout for an email from CPMP University notifying you of your enrollment.
Check your junk folder!



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Note: This training is assigned upon hire and annually thereafter.

Compliance Documentation Reviews

Billing Compliance Documentation Reviews are performed to ensure appropriate documentation and billing of services.

- All providers are notified of the results.
- Based on the review findings, further action may be required, which could include remedial training and/or re-audit of documentation to ensure compliance.

Never hesitate to contact us if you have questions or need assistance.

We are your business partners, and we are here to help!

We Are Here To Help!

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Additional Resources:
CMS CY 2025 Final Rule Evaluation & Management Changes
CMS Teaching Physician MLN
CMS Evaluation and Management Services MLN

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CPMP/UFPC's/ACO Compliance & Privacy Helpline – 24/7, Confidential, Anonymous Reporting
Telephone: 844-241-6856 and Web: http://cpmp-ufpcs.alertline.com

Visit our SB webpage or CPMP SharePoint for other compliance & privacy-related guidance, and more.