Medicare Risk Adjustment
RAF 101

Presenter:
Renee White, LPN, CCS, CPC, CPCI, CPMA, CRC
Disclaimer

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Abbreviations

- RAF: Risk Adjustment Factor
- MRA: Medicare Risk Adjustment
- CMS: Centers for Medicare & Medicaid Services
- RA: Risk Adjustment
- MA: Medicare Advantage
- HCC: Hierarchical Condition Categories
- MEAT: Monitor, Evaluate, Address, Treatment
Objectives

- Provide Overview of Medicare Risk Adjustment (MRA)
- Identify the role of Health Care Providers in the Medicare Risk Adjustment process
- Provide medical record documentation guidelines
Purpose

• MRA is intended to **redirect** money away from MAO that would cherry-pick the healthier enrollees

• MRA is a way to provide MAO that care for the sickest patients the resources to do so
Reimbursement Model RAF-HCC

• RAF-HCC is a **predictive** model CMS uses diagnosis data submitted from the previous year to establish capitation payments to the MA plan
HCC’s are disease categories which are mapped to certain Diagnosis Codes for chronic conditions:

- 79 HCC’s and over 8830 ICD-10-CM diagnosis codes out of ~70,000
I’m Cured

CMS wipes the slate clean every January 1, so MA plans must recapture all chronic conditions in order to receive reimbursement
How it Works

The average CMS FFS patient has the score of 1.00

- RAF is a numeric value assigned by CMS to identify the health status of a patient
- RAF scores are made up of the following criteria for each member:
  - Demographic information e.g. age and sex
  - Medicaid status and Medicare eligibility due to a disability
  - Chronic conditions and disease interactions
How it Works

• RAF-HCC is a **predictive** model using diagnosis submitted from the previous year to establish capitation payments to the MA plan

• Each diagnostic code falls into one Diagnosis Group and codes are grouped into Condition Categories
Disease Interaction

- DM and CHF
- DM and CVD
- CHF and COPD
- COPD, CVD and CAD
- RF and CHF
- RF, CHF and DM
<table>
<thead>
<tr>
<th>Low level of specificity</th>
<th>Moderate level of specificity</th>
<th>High level of specificity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>76 year old female</strong></td>
<td><strong>76 year old female</strong></td>
<td><strong>76 year old female</strong></td>
</tr>
<tr>
<td>0.426</td>
<td>0.426</td>
<td>0.426</td>
</tr>
<tr>
<td>Medicaid eligible (aged female 65+)</td>
<td>Medicaid eligible (aged female 65+)</td>
<td>Medicaid eligible (aged female 65+)</td>
</tr>
<tr>
<td>0.202</td>
<td>0.202</td>
<td>0.202</td>
</tr>
<tr>
<td>No Type 2 diabetes coded</td>
<td>Type 2 Diabetes w/o complications E11.9 (HCC 19)</td>
<td>Type 2 Diabetes with diabetic peripheral angiopathy w/o gangrene E11.51 (HCC 18)</td>
</tr>
<tr>
<td>X</td>
<td>0.118</td>
<td>0.368</td>
</tr>
<tr>
<td>No vascular disease coded</td>
<td>Vascular disease w/o complications PVD, unspecified I73.9 (HCC 108)</td>
<td>Vascular disease w/ Atherosclerosis of native arteries of left leg with ulceration of ankle I70.243(HCC 106)</td>
</tr>
<tr>
<td>X</td>
<td>0.299</td>
<td>1.143</td>
</tr>
<tr>
<td>Chronic diastolic (congestive) heart failure not coded</td>
<td>Chronic diastolic (congestive) heart failure not coded</td>
<td>Chronic diastolic (congestive) heart failure I50.32 (HCC 85)</td>
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<tr>
<td>X</td>
<td>X</td>
<td>0.368</td>
</tr>
<tr>
<td>No Disease Interaction</td>
<td>No Disease Interaction</td>
<td>Disease Interaction (DM + CHF)</td>
</tr>
<tr>
<td>X</td>
<td>X</td>
<td>0.182</td>
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<tr>
<td>Total RAF</td>
<td>Total RAF</td>
<td>Total RAF</td>
</tr>
<tr>
<td>0.628</td>
<td>1.057</td>
<td>2.089</td>
</tr>
<tr>
<td>Total RAF, With FFS Normalization¹ &amp; Coding</td>
<td>Total RAF, With FFS Normalization¹ &amp; Coding Intensity Adj²</td>
<td>Total RAF, With FFS Normalization¹ &amp; Coding Intensity Adj²</td>
</tr>
<tr>
<td>0.590</td>
<td>0.993</td>
<td>1.963</td>
</tr>
<tr>
<td>Estimated Average County Rate</td>
<td>Estimated Average County Rate</td>
<td>Estimated Average County Rate</td>
</tr>
<tr>
<td>$821</td>
<td>$821</td>
<td>$821</td>
</tr>
<tr>
<td>Estimated Dollars PMPM</td>
<td>Estimated Dollars PMPM</td>
<td>Estimated Dollars PM</td>
</tr>
<tr>
<td>$484</td>
<td>$815</td>
<td>$1,611</td>
</tr>
<tr>
<td><strong>Estimated Dollars PMPY</strong></td>
<td><strong>Estimated Dollars PMPY</strong></td>
<td><strong>Estimated Dollars PMPY</strong></td>
</tr>
<tr>
<td><strong>$5,812</strong></td>
<td><strong>$9,782</strong></td>
<td><strong>$19,333</strong></td>
</tr>
</tbody>
</table>
ICD-10-CM Official Guidelines for Coding & Reporting

• Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment or management
• Do not code conditions that were previously treated and no longer exist
• However, history codes (Z codes) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment
Why is complete documentation important?

- **B19.20** Hepatitis C, unspecified *(No HCC)*

- **B17.10** Hepatitis C, acute *(No HCC)*

- **B18.2** Hepatitis C, chronic *(HCC-29)*
Why is complete documentation important?

- If the patient is actively receiving medication for cancer treatment (AHA Coding Clinic 10/2008). Assign the following codes:
  - Active cancer code e.g. breast cancer C50.919
  - Long-term (current) use of medications Z79.81

- History of code should only be assigned if the drug is being used prophylactically.
Where’s the M.E.A.T

A diagnosis will **not** pass a RADV audit without the M.E.A.T
The Road to Success Starts and Ends with M.E.A.T.

• A variety of downfalls beset Providers and MA plans when confronted with a RADV audit

• Simply listing a diagnosis in the medical record without M.E.A.T. will not support a reportable HCC code and is unacceptable

• Remember when the Provider follows the M.E.A.T. guidelines the documentation is basically audit-proof
Definition of M.E.A.T.

- **Monitor**—signs, symptoms, disease progression, disease regression
- **Evaluate**—test results, medication effectiveness, response to treatment
- **Assess/Address**—ordering tests, discussion, review records, counseling
- **Treat**—medications, therapies, other modalities
Example M.E.A.T.

- **Monitor**: B/P reading 120/80; HgbA1c 5.5; last lipid panel was within normal limits
- **Evaluate**: stump well healed, ostomy site w/o infection appears clean & dry
- **Address**: stable; controlled, worsening; unchanged, uncontrolled
- **Treatment**: taking Fosamax for osteoporosis; taking tamoxifen for breast cancer “treatment”, DM controlled on insulin
Why Would You Fail a RADV Audit?

• Failure to ensure the diagnosis codes being billed and the medical record documentation match
• Failure to document according to the M.E.A.T. principles (i.e. monitor, evaluate, addressed, and/or treatment)
• Failure to link the causal relationship for manifestation codes
Key to Success

• At the end of the day, providing timely and accurate documentation and submitting HCC codes allows proper reimbursement

• Accurate documentation and coding allows the plans to provide better benefits to members and improve premiums per member per month (PMPM)
Conclusion

MRA supports achievement of “Triple Aim”

• Cost effective Care
• Quality Outcomes
• Patient Satisfaction
Resources

- [http://www.hcpro.com/content.cfm?content_id=302031](http://www.hcpro.com/content.cfm?content_id=302031)
- [https://www.cartoonstock.com/directory/c/cured_ham.asp](https://www.cartoonstock.com/directory/c/cured_ham.asp)
Evaluation & Management Services (E&M)

Presenter:

Thomasina L Young, CPC, CPCO, CPMA, CRC
What are E & M Services

• A section of codes in the AMA CPT Manual that are used to report the *professional fee* services performed by physicians and other qualified healthcare providers.

The “bread and butter” of many professional fee services
Why Is Documentation So Important?

- Supports the medical necessity of the service
- Reduces risk to audit exposure
- Supports billing services to payers
- Demonstrates the quality of care rendered
- Serves as a legal document in malpractice cases
- Provides continuity of care across disciplines
# Outpatient E/M Services

<table>
<thead>
<tr>
<th>CPT Code New</th>
<th>Time</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>10</td>
<td>Problem Focused</td>
<td>Problem Focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99202</td>
<td>20</td>
<td>Expanded Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99203</td>
<td>30</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Low</td>
</tr>
<tr>
<td>99204</td>
<td>45</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate</td>
</tr>
<tr>
<td>99205</td>
<td>60</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT Code Established</th>
<th>Time</th>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>10</td>
<td>Problem Focused</td>
<td>Problem Focused</td>
<td>Straightforward</td>
</tr>
<tr>
<td>99213</td>
<td>15</td>
<td>Expanded Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Low</td>
</tr>
<tr>
<td>99214</td>
<td>25</td>
<td>Detailed</td>
<td>Detailed</td>
<td>Moderate</td>
</tr>
<tr>
<td>99215</td>
<td>40</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
</tr>
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# Inpatient Hospital E/M Services

<table>
<thead>
<tr>
<th>CPT Code Initial</th>
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<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>99221</td>
<td>30</td>
<td>Detailed or Comprehensive</td>
<td>Detailed or Comprehensive</td>
<td>Straightforward/ Low</td>
</tr>
<tr>
<td>99222</td>
<td>50</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate</td>
</tr>
<tr>
<td>99223</td>
<td>70</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
</tr>
<tr>
<td><strong>Subsequent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99231</td>
<td>15</td>
<td>Problem Focused</td>
<td>Problem Focused</td>
<td>Low</td>
</tr>
<tr>
<td>99232</td>
<td>25</td>
<td>Expanded Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Moderate</td>
</tr>
<tr>
<td>99233</td>
<td>35</td>
<td>Detailed</td>
<td>Detailed</td>
<td>High</td>
</tr>
<tr>
<td>CPT Code Initial</td>
<td>Time</td>
<td>History</td>
<td>Exam</td>
<td>MDM</td>
</tr>
<tr>
<td>------------------</td>
<td>------</td>
<td>--------------------------</td>
<td>--------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>99218</td>
<td>30</td>
<td>Detailed or Comprehensive</td>
<td>Detailed or Comprehensive</td>
<td>Straightforward/ Low</td>
</tr>
<tr>
<td>99219</td>
<td>50</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>Moderate</td>
</tr>
<tr>
<td>99220</td>
<td>70</td>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
</tr>
<tr>
<td><strong>Subsequent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99224</td>
<td>15</td>
<td>Problem Focused</td>
<td>Problem Focused</td>
<td>Low</td>
</tr>
<tr>
<td>99225</td>
<td>25</td>
<td>Expanded Problem Focused</td>
<td>Expanded Problem Focused</td>
<td>Moderate</td>
</tr>
<tr>
<td>99226</td>
<td>35</td>
<td>Detailed</td>
<td>Detailed</td>
<td>High</td>
</tr>
</tbody>
</table>
Consultations

Medical Record Documentation requirements:

- **Request** for consultation
- **Rendering** of consultant’s opinion
- **Report** sent back to the requesting physician

Example: I saw this patient in consultation at the request of Dr._
CMS Preventive Visits

There are 3 types of “wellness visits/preventive visits”, each has different reporting requirements.

- Initial Preventive Physical Examination (IPPE)
- Initial Medicare Annual Wellness Visit (AWV)
- Subsequent AWV
Care Management Services

99487: Complex chronic care management 60 minutes of clinical staff time

99489: Complex chronic care management EACH additional 30 minutes of clinical staff time

99490: Chronic care management service at least 20 minutes of clinical staff time

99495: Transitional care management (TCM) moderate complexity; face-to-face within 14 days

99496: Transitional care management high complexity; face-to-face within 7 days
Medical Necessity

• Medicare defines "medical necessity" as services or items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member

• Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code
Components of Medical Necessity

Medical necessity cannot be quantified using a points system. Determining the medically necessary LOS is multi-factorial and is not the same from patient to patient and day to day. Medical necessity is determined through a culmination of factors, including, but not limited to:

- Clinical judgment
- Standards of practice
- Why patient needs to be seen (chief complaint)
- Any acute exacerbations/onsets of medical conditions or injuries
- Stability/acuity of patient
- Multiple medical co-morbidities
- Management of patient for that specific DOS
Medical Necessity Criteria

• Consistent with the symptoms and diagnoses or treatment of the patient’s condition, illness, disease or injury
• In accordance with accepted professional medical standards
• Not primarily for the convenience of the patient or provider
• Furnished at the most appropriate level that can be safely provided to the patient
Evaluation & Management (E/M)

E/M services recognize 7 components which are used in defining the levels of E/M services

Key Components
• History
• Examination
• Medical Decision Making

Contributory Components
• Counseling
• Coordination of care
• Nature of presenting problem
• Time
Chief Complaint (CC)

• The CC is a concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter.

• Is required for every E&M service.

• If there is no chief complaint, the service can be deemed not billable.
History of Present illness (HPI)

A chronological description of the development of the patient's present illness with elements of:

Two types of HPI:
- Brief – 1-3 elements
- Extended – 4 elements
- OR
  - the Status of 3 chronic conditions

<table>
<thead>
<tr>
<th>Location</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity- pain scale</td>
<td>Duration</td>
</tr>
<tr>
<td>(peds 0-4; adults 8-10)</td>
<td></td>
</tr>
<tr>
<td>Timing</td>
<td>Context</td>
</tr>
<tr>
<td>Modifying factors</td>
<td>Associated signs and symptoms</td>
</tr>
</tbody>
</table>
Past Medical, Family, Social History

- **Past Medical history** (the patient's past experiences with illnesses, operations, injuries and treatments). For Infants/newborns may include mother’s pregnancy and the birth of the child.

- **Family history** - a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk.

- **Social history** - an age appropriate review of past and current activities, i.e., Military Status, living arrangements and education.
Review of Systems (ROS)
14 Systems Are Recognized

Three types of ROS:
1. Problem Pertinent – inquires about organ system directly related to the presenting problem
2. Extended – inquires about 2-9 organ systems
3. Complete – Requires documentation of at least 10 organs systems individually OR some pertinent +/- of some organs systems with a statement “all other systems were reviewed and are negative”
## Examination Guidelines

<table>
<thead>
<tr>
<th>Exam level</th>
<th>Problem Focused</th>
<th>Expanded Problem Focused</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1995 &amp; 1997 Exam Guidelines</strong></td>
<td>99201;99212;99241;99251;99231</td>
<td>99202;99213;99242;99252;99232</td>
<td>99203;99214;99243;99253;99221</td>
<td>99204-99205;99215;99244-99245;99254-99255;99222-99223</td>
</tr>
<tr>
<td><strong>1995 Body Areas/Organ Systems</strong></td>
<td>Affected area</td>
<td>2 – 4 body area/organ systems</td>
<td>5 - 7 body areas/organ systems</td>
<td>8+ organ systems</td>
</tr>
<tr>
<td><strong>1997</strong></td>
<td>1 - 5 bullets in 1+ systems/areas</td>
<td>6 - 11 bullets in 1+ system/areas</td>
<td>12+ bullets in 2+ systems/areas</td>
<td>2+ bullets for each of 9+ systems/areas</td>
</tr>
</tbody>
</table>
Medical Decision Making (MDM)

There are 4 levels of MDM:

1. Straightforward
2. Low
3. Moderate
4. High

MDM is:

A. The number of diagnoses or management options
B. Amount and/or complexity of data to be reviewed
C. Risk of complications and/or morbidity or mortality
OBSERVATION SERVICES (OBS)

- There must be a physician’s order specifying “Placement for Observation” or simply “Observation” including the reason and medical necessity for OBS care.

- A physician order for observation services should NOT read “Admit to (or for) Observation”.

- All OBS services must be ordered by a physician.

- OBS starts at the documented time that observation care is initiated.

- All other physicians who furnish evaluations or services while the patient is receiving OBS must bill the appropriate outpatient service codes.
The Teaching Physician must personally document:

- That they performed the service or were physically present during the critical or key portions of the service furnished by the resident; and
- His or her participation in the management of the patient.

Documentation by the resident of the presence and participation of the TP is NOT sufficient.
Medical Students

• TP can only use the ROS and PFSH from a Medical Students documentation

• TP MUST re-document the HPI, Exam and MDM

• TP MUST be present during the entire encounter
Medicare Administrative Contractors (MACs)

Banner Health is located in seven states:

- Arizona – Corporate Headquarters
- Alaska
- California
- Colorado
- Wyoming
- Nebraska
- Nevada
## Variances Encountered

<table>
<thead>
<tr>
<th>MAC’s</th>
<th>Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Noridian</td>
<td>• Review of Systems</td>
</tr>
<tr>
<td>• Novitas</td>
<td>• Exam</td>
</tr>
<tr>
<td>• WPS</td>
<td>• PFSH</td>
</tr>
<tr>
<td></td>
<td>• Medical decision making (MDM)</td>
</tr>
</tbody>
</table>
The documentation may be worded:
• Exactly the same as another DOS
• Similar to a previous DOS
• The same for all patients

Cloned documentation methods include:
• Templates
• Handwritten
• EHR
Medical Record Cloning

• Cloned documentation may be handwritten, but generally occurs when using a preprinted template or an Electronic Health Record (EHR). While these methods of documenting are acceptable, it would not be expected the same patient had the same exact problem, symptoms, and required the exact same treatment or the same patient had the same problem/situation on every encounter.

• Cloned documentation does not meet medical necessity requirements for coverage of services.

• Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.
Common Errors

• Insufficient Documentation
• Incorrect Coding
• Medical Necessity Not Supported
• Documentation Doesn’t Support Level Billed
• Prolonged Services
• Time-based Services
• Duplicate submissions
• Other Issues
Documentation Doesn’t Support Level Billed

• Each encounter must tell a complete story

• Prior encounters cannot be considered unless referenced by date in the encounter being audited

• All three components (history, exam and medical decision making) must be present when billing initial/new patient visits
Documentation Doesn’t Support Level Billed

• Should be able to find a correlation between chief complaint/HPI/exam findings and what is documented for medical decision making

• It would not be medically necessary or appropriate to bill a higher level E/M when a lower level of service is warranted
## CERT Findings Improper Payments

<table>
<thead>
<tr>
<th>Part B Service</th>
<th>$ Amounts</th>
<th>No Doc</th>
<th>Insufficient Doc</th>
<th>Medical Necessity</th>
<th>Incorrect coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits - new</td>
<td>$490,841,942</td>
<td>0.7%</td>
<td>18.2%</td>
<td>0.9%</td>
<td>77.1%</td>
</tr>
<tr>
<td>Office visits - established</td>
<td>$1,141,913,178</td>
<td>4.8%</td>
<td>4.8%</td>
<td>0.0%</td>
<td>59.7%</td>
</tr>
<tr>
<td>Hospital visit - initial</td>
<td>$888,882,432</td>
<td>3.7%</td>
<td>29.1%</td>
<td>0.0%</td>
<td>66.2%</td>
</tr>
<tr>
<td>Hospital visit - subsequent</td>
<td>1,048,419,405</td>
<td>4.3%</td>
<td>55.9%</td>
<td>0.4%</td>
<td>38.3%</td>
</tr>
<tr>
<td>Emergency room visit</td>
<td>$292,397,866</td>
<td>0.0%</td>
<td>9.7%</td>
<td>0.6%</td>
<td>89.7%</td>
</tr>
<tr>
<td>Nursing home visit</td>
<td>$362,260,716</td>
<td>9.9%</td>
<td>40.8%</td>
<td>0.0%</td>
<td>49.3%</td>
</tr>
</tbody>
</table>
Key Points to Remember

• Professional fee service and facility fee services are reported differently but support the total care rendered to patients.

• Providers should have ongoing CDI education and taught how to “think in ink.”

• Coders should have ongoing education and given the tools necessary to ensure their success.
WHAT’S NEW FOR 2017
UPCOMING UPDATES

Global periods:

• Instituting GXXX global period codes for data gathering; time based 10 min; based on complexity of the visit; by setting inpt/outpt

New Codes for Telehealth:

• Critical Care – G Codes; 1 per day;

Complex Chronic Care Management Services 99497/99498

• Payable 1/12017

BHI CoCOM – Psychiatric Collaborative Care Model

• G codes for initial and subsequent; all are time based
SPECIFICITY

Each health care encounter should be coded to the level of certainty known for that encounter.

**NOTE:** Check with commercial payers regarding reporting unspecified ICD-10-CM.
The End of Grace Period

October 1\textsuperscript{st}, 2016 will mark the end of a 1-year grace period that Centers for Medicare and Medicaid Services (CMS) established for the ICD-10-CM diagnosis codes. CMS will no longer accept unspecified ICD-10-CM codes on Medicare fee-for-service (FFS) claims when a specific one is warranted by the medical record.

- Avoid unspecified ICD-10-CM codes \textit{whenever documentation supports a more detailed code}. Check the coding on each claim to make sure that it aligns with the clinical documentation.
Unspecified Codes

- Rheumatoid Arthritis
  - Juvenile, seronegative, seropositive, site
- Crohn’s disease
  - Enteritis, regional: colon, duodenum, ileum, jejunum, large bowel, intestine
- Ulcerative Colitis
  - Enterocolitis, ileocolitis, proctitis, pseudopolyposis, psychogenic, rectosigmoiditis, complications
- Asthma
  - Intermittent (mild)
    - Exacerbation or status asthmaticus
  - Persistent: mild, moderate, severe
    - Exacerbation or status asthmaticus
Unspecified Codes

• Osteoporosis
  o Age related, disuse, drug-induced, idiopathic, involutional, localized, postmenopausal, post-traumatic, senile, etc
• Osteopenia
  o Site: ankle, foot, forearm, hand, leg, rib, shoulder, etc
• Lung CA
  o Type: primary, secondary, benign, in-situ, malignant,
  o Laterality: right, left, bilateral, upper, lower, middle lobe
• Breast CA
  o Type: primary, secondary, benign, in-situ, malignant,
  o Laterality: right, left, bilateral, lower, upper, inner, outer
References

CMS Claims Processing Manual; Chapter 12; sec 30.6.1; pgs. 40-41
CMS 1995 & 1997 Examination Guidelines
BH Pol 12411; Incident To
BH Position Statement: Review of Systems; Formal P&P upcoming
BH Policy #678
BMG Compliance Newsletter June 2012 “Cloning of Medical Notes”
CMS IOM 100-04, Chp.12, Section 30.6.13-H,
Novitas Web Article, “Split/Shared E/M’s
WPS Web Article, “Inpatient Split/Shared/E./M Services”

• AMA CPT Manual 2016
• Federal Register:
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/physicianfeesched/