Internal Medicine Coding Alert

Accurately Code E/M Services to Avoid Audits

Internal medicine providers who think that the Health Care Financing Administrations (HCFA) decision to postpone enforcement of the 1997 E/M guidelines has given them license to abandon E/M documentation altogether should definitely think again, says **David Blecker, MD, MPH, FACP**, an Atlantic City, NJ-based practice management consultant who specializes in the use and implementation of the guidelines.

Blecker was recently dismayed when, shortly before he was to deliver a lecture on the guidelines before a large group of physicians, the moderator began his introduction by saying: Its a shame you came all the way here, Dr. Blecker; since the guidelines dont apply anymore, there is really no reason for you to lecture.
Blecker has since run across several internists and other specialists who also believe the E/M guidelines no longer apply, and nothing could be further from the truth, he states.

The 1997 guidelines were not postponed, Blecker emphasizes. Forcing you to use them was postponed. But, you must either use the old ones or the new ones.

Failure to choose a version of the E/M guidelines and adhere to its requirements significantly increases the chances that the practice will face a poor outcome in the event of a Medicare audit.

HCFA will continue to randomly audit between 1% and 3% of Medicare charts each year, Blecker adds. They have stated that physicians must continue to meet documentation
guidelines.

If doctors fail to do so, they may be forced to refund overpayments and pay penalties.

HCFA will also perform chart audits on claims submitted from practices that seem to be operating differently from the norm, Blecker notes. If an internal medicine practice is billing more Level 5s than other similar practices of a like size in the same geographic region, then thats a red flag.

Which Version Should IM Offices Use?

Internal medicine experts are divided over whether practices should continue using the 1997 version of the guidelines (if they already were) or use the 1995 guidelines until the final revisions are made to the 1997 edition. Here are some issues to consider:

1. Using the 1997 guidelines. Blecker favors using the new guidelines because they are more specific and allow less room for auditor bias, he says. The requirements for the physical examination and history are more specific than the 1995 guidelines and many physicians dont like that, he says. However, if an auditor disagrees with the level of service billed, there is less documentation to fall back on if you want to argue the point and you are using the older version of the guidelines.

In terms of the physical examination portion, it may be easier for internal medicine practices to get paid using the 95 guidelines, concedes Blecker.

However, with the history portion of the exam, it is easier to document a higher level of service under the new version, he states. For example, under the new E/M rules it is easier to document the extended history of present illness and that allows you to code a higher level.

Under the 95 guidelines, an extended history of present illness required four items of information that described the chief complaint. Under the 1997 version, the extended history of present illness can include information about three other diseases present in the same patient.

For example, if a patient came in with hypertension, under the old guidelines, you could only go to hypertension under the history of present illness, he explains. Now, if I talk to the patient about his arthritis, or a stomach problem, or an old surgical scar, that counts toward the history of present illness, and the level that can be coded.

2. Using the 1995 version. Still, many internal medicine practices are finding it too difficult to achieve the required number of elements in the physical examination portion to justify the level of service they feel theyve provided.

The 1997 E/M guidelines state that the comprehensive examination (the highest level) for a general multi-system exam, the exam most commonly used by internists, should include at least nine organ systems or body areas and, for each system selected, all elements of the examination identified with a bullet should be performed. For each area or system, documentation of at least two of the bulleted elements is required.

This has been very difficult for practices to achieve. I think that most internal medicine offices would find the 94-95 guidelines more applicable to their practice, says **Glenn D. Littenberg, MD**, chairman of the physician reimbursement committee of the American Society of Internal Medicine (ASIM) and an advisor on the societys AMA CPT Editorial Panel. The extent of the detail required in the physician examination portion [of the 97 guidelines] might be more applicable in some specialties, but it is not generally how internists have been practicing.

For the majority of internists, the most common exam would be a general multi-system examination, whereas some specialty areas might use the criteria for the single-organ-system examinations to be more applicable, he says.
Ive seen practices doing it both ways, either still using the 95 guidelines or, because some had already trained their physicians and staff to use the 97 [version], they are continuing to use it, states **Kathryn L. Cianciolo, MA, RRA, CCS, CCS-P**, chair of the Society for Clinical Coding and a reimbursement and coding consultant with the American Health Information Management Association in Waukesha, WI. Im in the middle of the road. I would say use whichever one pays better.

But, she has seen many practices have problems getting paid
using the 1997 guidelines.

The physicians were almost never able to document the required number of body systems, or to perform as many of the bulleted items needed to justify billing for a physical exam at his or her level of service, she explains. In the practices that Ive audited using the 1997 guidelines, when theyve coded a 99215, it was usually getting brought down to a 99214 or 99213.

You Must Choose Between 95 and 97 Version

The take-home message is that internal medicine practices must meet the requirements stipulated in either the 1995 version of the E/M guidelines or the 1997 edition. Practices that choose to use the original version will not be penalized for doing so, our experts emphasize.

HCFA auditors have been instructed to use both versions when auditing charts and to evaluate the practice using whichever version is most beneficial to the physician.

However, once a date for enforcement of the 97 guidelines is set (though most consultants agree that this date is anyones guess) the offices using the 1995 version may find themselves behind the eight ball.