Codify
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Internal Medicine Coding Alert

Are You Ready for an Internal Chart Review? 4 Quick Tips

Why modifier -25 could be costing you deserved payment

If your office has been receiving many denials lately, it's probably time for an internal chart review. Here are expert solutions to what are most likely the top-four most error-prone areas in your practice: E/M and procedure code accuracy, consultations, and modifiers.

1. Support Your E/M Codes

When reporting office visits, make sure the documentation supports the level of E/M service you've billed or you could end up returning money to the insurer.

"Most practices are overcoding, and their documentation is lacking in the history component," says **Trish Bukauskas-Vollmer, CPC,** owner of TB Consulting in Myrtle Beach, S.C.

For instance, the appropriate history documentation for a detailed E/M service should include "extended history of present illness" and "pertinent past, family, and/or social history directly related to the patient's problems."

Also, the level of medical necessity is critical when you're determining the appropriate E/M code. "Many codes get downcoded because of medical necessity," says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS**, director and senior instructor for the CRN Institute, an online coding certification training center.

Why: "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code," the Medicare Carriers Manual (MCM) states. "It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted."

Scenario: The physician bills a level-four established patient visit for treating intrinsic asthma (ICD-9-CM 493.10) and diabetes mellitus without mention of complication, type I (ICD-9-CM 250.01). You code the visit as a 99214 (Office or other outpatient visit ... established patient). To justify billing 99214, the documentation should support the medical necessity (medical decision-making of moderate complexity) and at least a detailed history and/or a detailed examination, he adds. Also, the office visit should consist of 25 minutes of face-to-face contact with the patient and/or family, according to CPT guidelines.
If an auditor reviewed the above 99214 charge, would your documentation support the E/M level? A "No" answer could cost you the $85 that most carriers pay for 99214.

2. Double-Check Coverage for Procedures

Another source of denials may be inaccurate procedural coding, Bukauskas-Vollmer says. If you're inaccurately unbundling procedures or submitting codes that your carrier doesn't pay for, you can expect denials.

Example: A patient's insurance information and other forms take an unusual amount of time for your doctor and biller to complete, so you assign 99080 (Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form).

Problem: Nearly all private and government insurers will deny this code, because Medicare has not assigned 99080 any RVUs.

Solution: You should check the Medicare insurer or the commercial carrier's guidelines to determine which codes the payer will accept. Say you want to report 11400 (Excision, benign lesion including margins, except skin tag [unless listed elsewhere] trunk, arms or legs; excised diameter 0.5 cm or less) for the physician's removal of a benign lesion for cosmetic reasons to Medicare's Blue Cross Blue Shield of Arkansas. Checking that carrier's Local Medical Review Policy (LMRP) would inform you that Medicare never pays for cosmetic lesion removals.

3. Get the Three R's You Need for Consults

You should report consultation codes (99241-99275) when another physician requests a "medical opinion" from your internist, Bukauskas-Vollmer says.

Otherwise, if a physician asks your doctor to "evaluate and treat" a patient, then you should consider this a "referral" and assign new patient E/M codes (99201-99205), she says.

Coding challenge: When you're reviewing the consultation you've coded, check your physician's consult documentation to ensure it contains these three key elements:

1. **Reason:** The reason for the consult is always another physician's request for your internist's opinion, which your physician should document. "If they request the patient be treated, then it's a referral, not a consult," Jandroep says.
2. **Render:** When your internist diagnoses a condition, such as hypertension (401.x), he should document this in the medical notes. A consultation always involves a suspected problem and an unknown course of treatment.
3. **Report:** The last step is the internist providing the requesting physician with a report of his findings. In the report, the internist will typically suggest a treatment plan for the patient.

"The three R's are important because this is what distinguishes a consult from an office visit," says **Pat Larabee, CPC, CCP**, a coding specialist at InterMed, a multi-specialty healthcare network in South Portland, Maine. "Without documentation of the three items above, you will see insurance companies change the codes from consultations to new or established office visit codes."

If the medical documentation for your office's consultations is missing the three R's, you should educate your physician on the proper way to document these visits, or you should begin to report other appropriate E/M codes.

4. Don't Let Modifiers Wreck Your Claims

Even if you have solid documentation and your procedure coding is pristine, you'll face denials and trouble during audits if you're misusing modifiers.

"Modifier -25 is the most confusing and abused modifier" in most practices, Bukauskas-Vollmer says.

Tip #1: Be sure that you - and every coder and biller in your office - understand how to use the modifier. You can attach modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) only to E/M codes (for example, 99201-99215).

"Basically, anytime the physician provides an E/M service and a procedure, you should use modifier -25," Jandroep says.

Payers assume that any E/M you report on the same date as a procedure is included in the procedure, so the carrier won't pay separately for the E/M, she says.

Tip #2: Use modifier -25 for your internist's E/M services only when they are "significant" and "separate" from a procedure or service, Larabee says. "However, if there is no significant workup from the procedure, then charge for the procedure only," she says.

What to do: If during an office visit for hypertension management the patient complains of recent onset of elbow tenderness, and the physician determines that the patient should receive an injection, you may be able to report the injection and E/M code. For example, you could assign 20605 (Arthrocentesis, aspiration or injection; intermediate joint or bursa [e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]), and 99213-25 (Office or other outpatient visit) for the E/M.