Codify
BY AAPC

Internal Medicine Coding Alert

Are You Ready to End Your E/M-Guideline Confusion? We Can Help

Use CMS' responses to our questions to report correct E/M levels

Like many coders, you've probably had it up to here with trying to understand Medicare and CPT E/M guidelines. But now you can assign an office visits' elements with confidence if you follow this advice offered by CMS and our coding experts.

The scoop: The Coding Institute posed four questions about E/M guidelines to a CMS policy official who spoke with us on the condition of anonymity. Here's what we learned:

Diagnostics Impact Complexity Level

1. Question: Suppose a physician orders a diagnostic test, such as a colonoscopy, but the patient refuses to undergo the test. Should the physician still get credit for the order when determining the level of complexity associated with the encounter?

CMS response: You should factor the physician's order into the medical decision-making or care/treatment plan. Be sure you document that the physician ordered the test, the patient refused it and why he did so.

What you should know: Your physician's decision to order a diagnostic test can impact each of the complexity (medical decision-making) section's three elements, says **Jim Collins, CPC, ACS-CA, CHCC, CEO** of the Cardiology Coalition in Matthews, N.C. Physicians frequently recommend a test but the patient declines for various reasons (for example, financial concerns or reservations about risks).

Factoring in the physician's order makes sense because if the physician "went through the medical decision-making process to determine that the patient needed a particular test, even though the patient didn't follow through, the physician ... should receive credit for that, provided there is documentation of that thought process," says **Sherry Wilkerson, RHIT, CCS, CCS-P**, manager of coding and compliance for CHAN Healthcare Auditors in St. Louis, Mo.

Example: The physician performs a fecal-occult blood test (82270-82274) on a patient who complained of black tarry stools. When the test comes back positive, the physician orders a colonoscopy to determine the problem's source, but the patient refuses to take the test. "The physician needs to make note of this in the chart, not only as part of the medical decision-making," says **Linda Parks, MA, CPC, CMC, CCP**, of GI Diagnostic Endoscopy Center in Marietta, Ga.

2. Question: A patient presents with shortness of breath. The physician documents that "the patient's chief complaint is shortness of breath, which is not exacerbated with any specific activity and has no reported associated symptoms." Should the physician receive credit for documenting the HPI elements of "modifying factors" and "associated signs or symptoms," even though he reported that no activity exacerbates the condition and no associated signs or symptoms exist?

CMS response: The physician absolutely should receive credit. What you've provided is valuable information, which the physician should document.

Quick tip: Don't let the physician document that the patient's HPI is negative. Instead, if the patient has no exacerbating activities or associated symptoms, as in the above example, the physician should put that in the documentation.

For example, in the documentation, the physician writes, "The patient relays that her problems are not related to time of

CPT® 2023 American Medical Association. All rights reserved.

day, she relays no aggravating or alleviating factors, and there are no associated symptoms," Collins says.
The bottom line: With this simple sentence, the physician would document three of the required four HPI elements necessary to establish an "extended" HPI, Collins says.

When you also add in the documentation "an anatomic description of where the problem is (which should be possible for about every condition), you would firmly establish an extended level of HPI," he says.

Under the 1995 set of documentation guidelines, this level of history is necessary for any established-patient visits above level three and any new-patient visits or consultations above level two.

"This distinction pretty much eliminates any advantage the 1997 guidelines brought to the table for virtually all physicians," Collins says.

Get Awarded for Orders and Reviews

3. Question: The audit tool many carriers have used and made public awards credit for ordering/reviewing clinical lab tests or tests from the CPT manual's radiology or medicine sections. But if the physician orders/reviews a test from a different section of the CPT book, such as a colonoscopy, would the doctor receive the same amount of credit?

CMS response: CMS does not have an audit tool. Never did. Our medical staff reviewed the one developed by Marshfield Clinic that carriers often use. We neither adopted nor endorse the tool. We told carriers they could use it or modify it. I have the form and it also allows credit for review and/or order of test in the medicine section of CPT (examples: EEG, echocardiography, pulmonary function testing, endoscopy). These are just examples. Carriers should credit colonoscopy if the physician documents it.

Important point: "This clarification is a big one for many specialties, such as gastroenterology, that may not have been giving themselves credit for ordering or reviewing endoscopic procedures," Collins says.

Also, remember that carriers may use different audit tools, Wilkerson adds.

4. Question: The Marshfield Clinic's audit tool awards two credits for independent visualization of an image, tracing or specimen itself (not simply review of a report). The tool also awards one credit for ordering a diagnostic test. If the physician ordered a test (such as an electrocardiogram) and he personally reviewed the tracing on the same day, would he be awarded credit for both the order (1 credit) and the personal review (2 credits)?

CMS response: Yes. The order and personal review are two separate activities. If you order the electrocardiogram (EKG) you might not get to review it. If you do review it or look at it in a scope and make judgments, then documenting this activity should allow you to have credit for both ordering and reviewing it (not just reading a report).

What this means: "This clarification is huge for physicians who personally review their own diagnostic testing (x-ray, EKG, echo, endoscopic procedures, etc.)," Collins says.

Let's break it down: You should understand that, when it comes to the audit tool's complexity section, you only need four credits in the data section to achieve a "high" level of medical decision-making, assuming that at least one of the other complexity section elements (diagnoses/treatment options or table of risk) also supports this level of complexity.

CPT® 2023 American Medical Association. All rights reserved.