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Internal Medicine Coding Alert

Coding Question Roundup

Editors Note: Answers to this issues coding questions were provided by Garnet Dunston, CPC, MPC, National Secretary, American Academy of Procedural Coders Advisory Board and Gregory Schnitzer, RN, CPC, CPC-H, CCS-P, Audit Specialist in the Office of Audit and Compliance at the University of Pennsylvania in Philadelphia.

Correct E/M Documentation

Question: In the medical-decision making process, evaluating the amount and complexity of data involved, how would you document that you have read an EKG or chest x-ray during that visit rather than just reviewing the report? Example: Should you document specifically chest x-ray or EKG reviewed by me and negative or can you simply put chest x-ray negative.

-Subscriber

Answer: This is a good point, states Schnitzer. Reviewing an EKG or chest x-ray oneself rather than relying on the interpretation supplied by someone else indicates a substantially different level of involvement. Indicating your work with reviewed by me helps to give credit where credit is due and helps to more clearly reflect your participation in the medical decision-making process.

Question: In documenting the amount and complexity of data involved, is it appropriate to document discussed with husband or must you document specifically patients history discussed or reviewed with husband?

-Subscriber

Answer: Discussed with husband would probably be acceptable (since there is little you would be discussing besides the patients history or condition). Contrary to popular belief, auditors are not generally black-hearted, soulless creatures, says Schnitzer. They are generally looking for ways to give you the benefit of the doubt.

Question: You see a patient on June 1st and dictate a note with the history of present illness to include all of the appropriate elements for that visit. On June 9, you see the patient again and your HPI (history of present illness) includes two elements. However, you also document in your note: refer to my dictation on June 1. Do the elements in the June 1 dictation for the history of present illness (i.e., location, quality, severity, etc.) carry over to the June 9 visit when supporting the level of service for the June 9 visit?

-Subscriber

Answer: Its important to realize that the HPI is actually dynamic and can change from encounter to encounter, advises Schnitzer. HCFAs Documentation Guidelines ask the physician to describe the patients present illness from the first sign and/or symptom or [most importantly for this situation] from the previous encounter to the present. The HPI should be thought of as an evolving trend. So, rather than simply documenting refer to my dictation of June 1, perhaps patients condition is unchanged since my June 1 dictation would be a somewhat better way to describe your involvement in assessing the patients condition. What your documentation should be trying to reflect is that some amount of thought and assessment went into the HPI for the day. Try to convince the reader (auditor) that you are actually doing something to assess the eight elements of the HPI: location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms.

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Billing for Test for Occult Blood

Question: How can I get paid to do a guaiac test for occult blood when examining a patient?

-Office of Warren Stanton, MD
Floral Park, NY

Answer: If the test is performed in the office during the patients examination, it is included in the evaluation and management (E/M) service and cannot be coded separately, says Garnet Dunston. However, if the physician gives the patient the card to take home and collect the specimens himself or herself and the specimens are brought to the lab for evaluation, then the practice (if they have their own lab and are reading the test) can bill 82270 (blood, occult; feces, 1-3 simultaneous determinations). If the specimens are sent to an outside laboratory, the lab would bill for the test unless it bills the physician for its services. If it does, then the practice should bill for the test.

Charging for Critical Care and Hospital Admission on the Same Day

Question: Doctor sees a patient at 8 a.m. in the hospital. The patient is being treated for diabetes mellitus type II and spinal stenosis. The doctor bills 99232 (subsequent hospital care, level 2). Then, at approximately 10 p.m., the patient goes into respiratory failure. The doctor bills an additional critical care code 99291 x 1 for the time spent attending to the crisis. Medicare never pays, under any circumstances it seems, although they used to.

-Office of Marc Shapiro, MD
Clearlake, CA

Answer: Your carrier should definitely be paying for the critical care code in addition to the hospital care code, says Dunston. Unless the claims were submitted incorrectlywithout a separate diagnosis code for the critical care, for exampleshe recommends appealing the denial. With the documentation of the care provided, you might also want to attach copies of the pages of the 1998 CPT (or 1999 edition if the claim was for this year) that contain the critical care codes.

It is clear that these codes can be used in addition to other codes on the same day, Dunston notes.

In addition, American Medical Association members might want to take advantage of that organizations CPT Information Services program, she notes. CPT-IS is a fee-based telephone information line for coding questions. Fax queries are also received.

If you submit your question via fax, the return reply would have the AMA letterhead and probably carry some weight with the carrier, notes Dunston.

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