Internal Medicine Coding Alert

Don't Use the 'Loophole' to Bill All Visits as 99215

Surprise! CPT and CMS require medical necessity for all E/M visits

If you are a victim of the "E/M loophole" myth, you could be severely miscoding your E/M levels and collecting thousands more in payment than you are entitled to collect.

A physician recently wrote to The Coding Institute with the following comment: "The rules as I interpret them say that I can bill a level 99215 based on history and examination if I can substantiate in the record that I performed a comprehensive history and examination on this patient, even though the medical decision-making is low risk and there is no data to review ... Nowhere does it say I must 'justify' the code after meeting the criteria."

Therefore, the physician feels she is entitled to bill 99215 for any E/M visits during which she performs a comprehensive physical and exam, even if the visit is simply to treat a runny nose.

So the question is: Do the E/M guidelines offer physicians a legal "loophole" by allowing them to ignore medical necessity?

"Absolutely not," says **Stephen R. Levinson, MD,** author of the AMA's Practical E/M: Documentation and Coding Solutions for Quality Health Care. "CMS indicates in its Carriers Manual that 'Medical necessity is the overarching criterion for payment in addition to the individual requirements of a CPT code.' "

"The nature of the presenting problem is CPT's measure of medical necessity for E/M services," Levinson says, "and this important contributory factor is included for every level of every type of service that measures care using the three key components. Additionally, the Clinical Examples in Appendix C of CPT have been developed and approved by our own specialty societies to illustrate the level of care warranted by representative patient problems, and CPT directly tells us that the clinical examples 'are provided to assist physicians in understanding the meaning of the descriptors and selecting the correct code.' "

Explore the Origins of This 'Loophole'

Some coders may wonder why their internists try to use what they consider to be a loophole. "It's not really a loophole as much as it is a code definition," says **Suzan Hvizdash, BS, CPC, CPC-EMS, CPC-EDS,** physician education specialist for the department of surgery UPMC Presbyterian-Shadyside in Pittsburgh. "In CPT it says that on established patients, only two out of the three components need to be met in order to code the service. However, there is a big overriding factor -- medical necessity.

"If medical necessity is not evident in the documentation," Hvizdash says, "the charge could be downcoded and would be considered abusive behavior."

In addition, you should consider the amount of time that CPT suggests for billing a 99214 or 99215. CPT states that these codes normally require 25 and 40 minutes of physician time, respectively. Most physicians are not spending this kind of time treating a runny nose or other presenting problems that are self-limited, minor, or of low severity.

You should also look at how frequently you need to take a comprehensive history. "If a patient comes in, say, three times a year for frequent earaches, how can you document medical necessity or risk for all complete histories and physicals?" asks **Merrilee Severino, CPC,** a coder in Florida.

History Must Be Relevant to Presenting Problem

If your physician still balks at coding simple, uninvolved runny noses using 99212 or 99213, refer him to the E/M documentation guidelines, which make several references to medical necessity, says **Erica D. Schwalm, CPC-GSS, CMRS,** billing and coding educator in Springfield, Mass. Schwalm refers to the following references from the 1995 E/M Guidelines:

Page 2: "The documentation of each patient encounter should include: reason for the encounter and relevant history, physical examination findings, and prior diagnostic test results."

"The key word here is 'relevant,' " Schwalm says. "If the patient presented with a runny nose, a comprehensive history and exam would not be relevant to the reason for the encounter."

Page 10: "The extent of examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s)."

"The clear message here is that the history, exam, and medical decision-making performed should correlate with the presenting problem(s)," Schwalm says.

Learn How Insurers ID Red Flags

If your physician bills all 99214s and 99215s, "you could set off a 'red flag' to your insurer, not to mention the complaints you will get from your patients, which could also hurt your bottom line in the long run," Schwalm says.

"Local carriers use 'bell curves' or utilization data by specialty to target practices for audits," she says. "If you start billing out a majority of your E/M services at higher levels, your utilization data will be well above what is considered the norm, which could make you a target for an audit."

And remember that an auditor will look at the E/M services against the medical necessity, so your documentation will have to speak for itself, Severino says. If it doesn't, you could be in trouble.

What Should You Do?

If your physician tries to code to the "loophole," you should sit down with him and show him CPT's clinical examples of which visits warrant which E/M codes. Also show him the E/M guidelines and explain that medical necessity must help drive the code choice. "I approach my physicians with documentation and let them know that I work at keeping their money in their pockets, unlike an auditor who will not come in and look at the records and say, 'I know what you meant when you failed to document this ...' " Severino says.

In addition, you can use the opportunity to explain that although coding at higher levels may increase your income inappropriately, it can bring on a whole slew of new problems that you don't want to deal with. Instead, you should examine other ways you can increase your accounts receivable.

"When you review an office's EOBs and you find a lot of visits not meeting medical necessity, it opens the door to discussion on how and where they can improve," says **Christine Goans** of Coding Smarter Office Support Plus. "When a physician complains that his accounts receivable is poor, it is the opportunity to take the discussion further."

Look to Other Areas for A/R Boosts

While many physicians can empathize with doctors who feel they are collecting inadequate payment, "committing fraud or abuse is not the solution," Levinson says. "The solution is to not participate in contracts that provide insufficient reimbursement."

Bright side: The good news is that this year you can expect an increase in some of your E/M payments. CMS has increased the relative value of 99213 and other E/M services for 2007 claims, offering physicians more money for the

intermediate code and other E/M services. Internal Medicine Coding Alert will keep you posted on the payment changes when the official 2007 Fee Schedule is issued.