Internal Medicine Coding Alert

Earn $35 More per Visit With Better Medical Decision-Making

If youve been downcoding to a level-four office visit or lower just to play it safe, you may be missing out on some well-deserved reimbursement. Assuming your physicians services adequately qualify for a higher-level E/M code, it could mean the difference of about $30 or $35 as you move up the scale from 99213 to 99215.

Facing CMS scrutiny of high-level office visit coding and complicated coding guidelines, many practices shy away from reporting 99215 for physician services to escape possible audits. You can avoid this problem by learning some clear-cut rules regarding the criteria for high-level E/M visits.

E/M Level Takes Two Out of Three

You use three components to determine what level of E/M service to report. These include the history taken at the time of visit, the physical examination, and medical decision-making (MDM). For office or other outpatient visits for established patients, you must meet two of the three criteria to bill for a specific level of care.

Most coders find the MDM piece of the puzzle the hardest to fit into place. Determining the difference between straightforward (S), low (L), moderate (M) and high (H) MDM can be an arduous task. You determine the level of MDM by looking at three aspects of the visit:

1. number of possible diagnoses and/or management options

2. amount and/or complexity of medical records, diagnostic tests and/or other information that the physician reviews and analyzes

3. risk of significant complications, morbidity and/or mortality including co-morbidities associated with the patients presenting problem(s), diagnostic procedure(s) and/or the possible management options.

Unlock Reimbursement With Key Element of Risk

Determining the level of risk can be the hardest of the three components because it requires more than just counting diagnosis options or lab tests the physician ordered. This category includes risks associated with the presenting problems, the diagnostic procedures and the possible management options. The highest level of risk in any of these areas determines the overall risk, says **Catherine Brink, CMM, CPC**, president of Healthcare Resource Management of Spring Lake, N.J. Take the four levels of risk as examples:

Minimal One minor problem. For instance, an internist might order diagnostic procedures such as laboratory tests requiring venipuncture, x-rays, urinalysis or ultrasounds. Management options include rest and simple bandages.

Low Two or more minor problems, one stable chronic illness, or an acute uncomplicated illness. The internist might order diagnostic procedures such as superficial needle biopsies, laboratory tests requiring arterial puncture, non-cardiovascular imaging studies such as barium enema, and physiologic tests not under stress. Management options include over-the-counter drugs, minor surgery with no risk factors, therapy, and IV fluids without additives.

Moderate One or more chronic illnesses with mild exacerbation, two or more stable chronic illnesses, an undiagnosed problem, acute illness with systematic symptoms, or an acute complicated injury. Diagnostic procedures an internist may order include physiologic tests under stress, diagnostic endoscopies with no risk factors, deep needle or incisional biopsy, cardiovascular imaging studies with contrast and no risk factors, and obtaining fluid from the body. Management

options include minor surgery with identified risk factors, elective major surgery with no risk factors, prescription-drug management, therapeutic nuclear medicine, and IV fluid with additives.

High One or more chronic illnesses with severe exacerbation or progression, acute or chronic illnesses or injuries that may pose a threat to life or bodily function or an abrupt change in neurologic status. The internist may order diagnostic procedures that include imaging studies with contrast and identified risk factors, cardiac electrophysiological tests, and diagnostic endoscopies with risk factors. Management options include elective major surgery with risk factors, emergency major surgery, parenteral controlled substances, drug therapy requiring intensive monitoring for toxicity, and the decision not to resuscitate or to de-escalate care because of poor prognosis.

Add Diagnostic Options to the Mix

Although you may find determining the level of risk to be the most difficult, you shouldnt overlook the number of diagnoses and treatment options. According to CMS guidelines, the number of possible diagnoses and management options is based on the number and types of problems the physician addresses during the encounter, the complexity of establishing a diagnosis, and the physicians management decisions.

You must document an assessment, clinical impression, or diagnosis for each encounter, along with the initiation or change in treatment and any consultations or referrals initiated. For each established diagnosis, document whether the problem is (1) improved, well controlled, resolving, or resolved or (2) inadequately controlled, worsening, or failing to change as expected. You can use the number and type of diagnostic tests employed as an indicator of the number of possible diagnoses.

Document Complexity of Data

The physician should document what he reviewed, tests performed, tests reviewed, and past medical records reviewed, Brink says. If this information is not documented, you cannot count it toward the complexity-of-data category of MDM. According to CMS, the amount and complexity of data is based on the types of diagnostic testing the physician ordered and reviewed. The decision to obtain and review old medical records and the discussion of unexpected test results with the physician who performed or interpreted the tests is one indicator of the complexity of data.

Clear Up the Confusion With Case Studies

Considering the vast amount of information you must assimilate to determine the level of MDM, you should take a look at the following examples for established patients provided by **Bruce Rappoport, MD, CPC**, a board-certified internist who works with physicians on compliance, documentation, coding and quality issues for RCH Healthcare Advisors LLC, a Fort Lauderdale, Fla.-based healthcare consulting company:

Scenario #1: Straightforward MDM. A patient presents with a potential infected insect bite. The physician recommends over-the-counter ointment.

Scenario #2: Low-Complexity MDM. A patient presents for follow-up of well-controlled diabetes. The physician recommends continuation of dietary counseling.

Scenario #3: Moderate MDM. A patient presents with intermittent RUQ abdominal pain and discomfort. After taking the patients history and performing an exam, the physician is unable to determine the etiology of the problem. Therefore, the physician orders lab work and an abdominal ultrasound. The physician gives a differential diagnosis of GERD (530.81) versus cholelithiasis (574.xx).

Scenario #4: High MDM. A patient presents with recent onset of syncopal attacks.

Scenario #5: Nurse Visit. A 52-year-old established patient with known hypertension (401.1) and recent fluctuating blood pressures presents to the office for a blood pressure check performed by the nurse.

Putting all of these components together to come up with a level of medical decision-making can be quite a task, so use

the chart on page 52 to clear up your coding difficulties. You should remember this section from the Medicare Carriers Manual, 15501A: Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. 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. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.