

Internal Medicine Coding Alert

E/M Coding: 4 Handy E/M Coding Tips For Accurate Reporting

Watch out to avoid down-coding the encounter.

When reporting E/M encounters, you might end up raising red flags if you are always reporting the same E/M code for every patient. You could also get audited if you are reporting a higher level code when your documentation does not support it. On the other hand, your practice's profits might suffer if you end up reporting a lower level code when you should have actually reported a higher code.

Use these four tips to get on top of your E/M coding each time.

Tip 1: Don't Report One E/M Code Repeatedly

When reporting E/M services, if you are constantly reporting the same E/M code (such as 99214, Office or other outpatient visit for the evaluation and management of an established patient...) for every E/M encounter that your clinician performs, then you will be inviting trouble. You might soon end up facing an unnecessary audit and other problems if you just report the same E/M code for every E/M encounter.

Even though you might find that most of your clinician's E/M encounters are pointing towards one of the E/M codes, you should not automatically reach out to the same code each time your clinician performs an E/M service. Instead of just blindly reaching for the most convenient E/M code, look through the patient's documentation, properly account for all the components of the E/M service, and then arrive at the proper code for the encounter.

"It would be a very rare situation in which the history, exam, and medical decision making of every patient seen by a physician led to the same E/M code," says a coding expert. "A review of the documentation should generally reveal some variation in the level of service provided to different patients."

Though you might have to spend more time in identifying the appropriate code for the encounter, you will save your practice precious time and money in the long run by avoiding the risk of an audit.

Tip 2: Check All the Documented Components

When your clinician performs an E/M service, check through patient documentation to see if your clinician has captured all the pertinent components of history, examination, and medical decision making (MDM).

If your clinician fails to properly document any of the components, you might have to report a lower level of E/M service even though your clinician actually performed a higher level. As the old adage goes, 'If it wasn't documented, it didn't happen.'

For instance, when your clinician is recording the history, you should check if he has documented all the necessary elements of the history associated with the selected code. This includes history of present illness, review of systems (ROS), and past, family, and social history (PFSH). While a brief HPI, wherein your clinician recorded only one to three elements of the HPI, can support 99213, you may be able to report a higher level code if your clinician documents an extended HPI with four or more elements. "99213 requires 1-3 HPI elements and the 99214 requires 4 or more if the history is going to be counted toward the service level," says **Suzan (Berman) Hauptman, MPM, CPC, CEMC, CEDC**, senior principal of ACE Med, a medical auditing, coding and education organization in Pittsburgh, Pa.

Similarly, when reporting PFSH, if your clinician is not noting down any changes in the PFSH or if he is not making a note saying, "PFSH not changed from previous visit," you might end up having to report a lower level code. So, if your clinician is not in the habit of making this note in the documentation, you might want to inform your physician that such notations

and proper documentation can help support a higher level E/M code.

When weighing the review of systems, you will need to see how many systems your clinician reviewed as this can help support a higher level of code if adequate systems have been reviewed. "The clinician should review the number of systems applicable to the current condition," Hauptman adds. "If billing a 99213 the ROS must include at least one system. When a 99214 is billed and the history is one of the two key components used toward the service level, at least 2 systems must be reviewed." When considering the medical decision making component, you should check documentation to find these elements:

- number of diagnoses and management options
- amount and/or complexity of the data reviewed
- risk of complications and/or morbidity or mortality.

These elements of MDM will help you understand the level of the MDM and the E/M code that it supports. "Medical Decision-Making reflects the intensity of the cognitive labor performed by the physician," says **Mary I. Falbo, MBA, CPC**, CEO of Millennium Healthcare Consulting, Inc. in Lansdale, PA. "The official rules for interpreting the MDM are identical for both the 1995 and 1997 E/M guidelines." The elements of MDM will also help in identifying the severity of the patient's problem (e.g. self-limited/minor, low, moderate or high), which may also help in assessing the level of E/M code to report for the encounter.

"With established patients, only 2 of the 3 key components are required. Thus, if the MDM is one of them, then in order to bill a 99213 there must be 2 points in diagnoses/management options, 2 points in data, and a low risk," says Hauptman. If one of these is higher or lower, the level would be decided on based on the other two. The same would be said for the 99214. Here, 3 points for diagnoses/management options is necessary as is 3 points for data. The level of risk is moderate.

Tip 3: Time-Based E/M Reporting May Give Higher Level Code

Although, in most situations, you will base your E/M code selection on the components of history, examination, and medical decision making, in some scenarios, you can choose the code based on time. You can choose the E/M code based on time if more than 50 percent of the encounter was spent on counseling and/or coordination of care. CPT®'s E/M guidelines state, "the extent of counseling and/or coordination of care must be documented in the medical record." Medicare's 1995 and 1997 E/M documentation guidelines add that the physician should document the total length of the encounter and "describe the counseling and/or activities to coordinate care" in these situations.

So, if your clinician spends about 15 minutes (total duration of the encounter was 25 minutes) discussing test results or the prognosis of a particular procedure with the patient, you could report 99214 for the visit based on time. The reason is, more than 50 percent of the time was spent in coordination of care, and 25 minutes is the typical time associated with 99214 in CPT®.

Tip 4: Get Into the Safety Net of an Auditing Tool

Sometimes, you might be in situations wherein you feel that you can report a higher level of code, such as 99214, but you are not sure. So, in order to be safe, you might just opt for a lesser level of code, such as 99213. In this process, you might end up losing out on deserved pay and your practice might unnecessarily suffer.

In order to avoid such situations, you could possibly take the help of an auditing tool. "An auditing tool is helpful but knowledge of auditing is important to understand what diagnoses codes are included in the overall MDM; particularly in the outpatient setting," Falbo says. "The auditor needs have knowledge and experience in how to apply the tool."

You have many such auditing tools available, and you might even find some of these tools that your payer might use on the Internet. "An audit tool is a must for helping to select the best level of service for the documentation written," Hauptman adds. So, if you are in doubt, you can take help of these tools and avoid losses to your practice.

