

Internal Medicine Coding Alert

E/M Coding Clinic: Using 99212 for Low-Level Physician Visits is Crucial to Reimbursement

Editors Note: This is the second installment of a continuing series on the individual CPT evaluation and management (E/M) codes for office/outpatient visits. Future articles will cover codes 99213-99215 and 99202-99205.

Code 99212, the Level 2 office/outpatient E/M code for established patients, is used in the internal medicine practice setting when a patient comes in with a minor illness or problem that requires the physician's input.

These are usually patients with conditions of low severity such as the flu, sore throat, fever or a headache. Often, they are conditions that would probably go away on their own, without medical attention, explains **Jim Stephenson**, billing manager for Premium Medical Management Inc., a multi-specialty practice in Elyria, OH. These are things that don't always need to be addressed by the physician so long as care is under his or her supervision.

The Level 2 codes do not require a significant amount of work or documentation and are not a problem to report in most practices, he adds. The Level 3 services (99213, established patient; 99203, new patient) are the most popular codes and, from my experience, the physician can usually achieve a legitimate Level 3 without too much trouble.

Brett Baker, the third-party relations specialist for the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) in Washington, DC, agrees that reporting Level 2 codes is typically not a problem for most physician offices. The only problem might occur when a non-physician provider sees the patient instead of the physician, he notes.

There is some question of whether a non-physician provider, particularly a nurse, can report a [code higher than 99211](#), which is the only code that specifically indicates that the physician's presence is not required, he says.

Higher codes are usually reported by NPPs (non-physician provider) under the incident to concept, meaning the service provided by the NPP is an incidental part of the overall physician service.

Most third-party payers including the Health Care Financing Administration (HCFA) contracted carriers that administer plans for Medicare patients recognize the incident to concept, although specific rules apply.

HCFA rules stipulate that, for a service to be considered incident to, the following conditions must apply:

the provider must be employed by the physician group;

the physician is on-site at the time of treatment;

the physician originally saw the patient for the first visit to the office or clinic, and established the diagnosis for the problem treated by the NPP; and

the physician sees the practice's established patients for any new medical problems.

Nurse practitioners (NPs) and physician assistants (PAs) can report higher-level E/M codes to Medicare under their own provider identification numbers (PINs) and be reimbursed at 85 percent of the physician fee schedule.

These services do not have to be incident to the physician services, but the services provided by the PAs and NPs must be consistent with the services that these providers are allowed to provide under their individual states medical licensure laws.

Note: Commercial (non-Medicare) payers may have different rules about what services can be provided by an NPP, as well as different rules about what constitutes incident to. It is important to check with your other payers about any specific requirements they have.

Requirements for Reporting 99212

According to CPT, code 99212 requires the performance of at least two of the three following components:

a problem-focused history;

a problem-focused examination; and

medical decision making of straightforward complexity.

According to the 1995 E/M documentation guidelines established by HCFA and the American Medical Association, a problem-focused history is comprised of a brief (1-3 documented elements) history of present illness (HPI). No review of systems (ROS) or PFSH (past, family, social history) is required.

A problem-focused examination is limited to the body area or organ system affected by the chief complaint or presenting problem. According to the guidelines, one to five elements of the affected organ system or body area must be documented.

Medical decision making (MDM) of straightforward complexity is the lowest level of MDM recognized in CPT. It is comprised of a minimal number of diagnoses or management options considered by the physician, minimal or no data reviewed, and minimal risk of complications and/or morbidity or mortality for the patient.

Quantifying the MDM

Because CPT does not specifically define the terms used for the components of medical decision making (minimal, limited, low, moderate, extensive, high), it can be difficult for coders to know what meets a particular level of MDM.

Many groups use the Medicare auditors method, which assigns point values for the different recognized elements of a physicians decision-making process to arrive at a score for each of the three components of MDM (number of diagnoses or treatment options, amount and/or complexity of data considered, and risk of complications or morbidity and/or mortality to the patient).

Note: Auditors score sheets can be obtained by calling your regional Medicare carrier or by contacting ACP-ASIM.

For example, in determining the number of diagnoses or treatment options, Medicare considers five categories:

problems that are self-limited or minor (stable, improved, or worsened) worth 1 point per problem to a maximum of 2 points, according to the carriers audit sheet;

established problems that are stable or improved worth 1 point per problem;

established problem that is worsening worth 2 points per problem;

new problem with no additional workup

plannedworth three points with a maximum of one problem; and

new problem with additional workup plannedworth 4 points per problem.

A minimal number of diagnoses or treatment options is considered a score of 1 or less.

When considering the amount and/or complexity of data reviewed, Medicare assigns points in the following categories:

review and/or order of clinical lab tests in the Pathology and Laboratory section of CPT, 80049-89399worth 1 point

review and/or order of tests in the Radiology section of CPT, 70010-79999worth 1 point;

review and/or order of test in the Medicine section of CPT, 90281-99199worth 1 point;

discussion of test results with performing physicianworth 1 point;

decision to obtain old records and/or obtain history from someone other than patientworth 1 point;

review and summarization of old records and/or obtaining history from someone other than patient and/or discussion with other healthcare providerworth 2 points; and

independent visualization of image, tracing or specimen (not simply review of report)worth 2 points.

Minimal review of data or review of data with minimal complexity is considered a score of 1 or less.

Calculating Risk

For Medicare carriers, the risk of complications or morbidity and/or mortality is determined by considering the degree of risk in three different areas: the presenting problem(s), the diagnostic procedures ordered, and the management options selected.

Minimal risk in all three areas would be a presenting problem that is self-limited or minor, lab tests that do not pose significant risk of complications or morbidity or mortality (these include venipuncture, chest x-rays, ECG/EEG, urinalysis, ultrasound, and KOH prep), and management options that do not exceed a recommendation to the patient to rest, gargle, apply elastic bandages, or superficial dressings.

However, the highest level of risk in any one of these areas determines the overall level of risk considered.

Determining Overall Level of MDM

When determining the overall level of medical decision making, Medicare auditors consider the three individual components of MDM. Again, these are: 1) number of diagnoses or management options considered; 2) the amount and/or complexity of data reviewed; and 3) the risk of complications and/or morbidity and mortality to the patient.

To reach a level of MDM consistent with an overall Level 2 E/M code, two of the three categories must meet or exceed Level 2. This means that, out of the three areas, at least two must meet the minimal requirements.

Since minimal is the lowest level of requirement, almost any visit requiring medical decision making and input by the physician would justify a Level 2; however, the appropriate history, physical exam, and medical decision making must be documented in order to report any E/M code.