Internal Medicine Coding Alert

E/M Coding: Remain Vigilant When Coding 4th and 5th Digit E/M Codes

OIG is watching on usage of these high-level codes.

A recent OIG report found that family physicians were among the groups of doctors who increased their billing of higher-level E/M codes across all categories (inpatient, outpatient, etc.) between 2001 and 2010. Reporting high-level E/M codes doesn't automatically point to fraud, but you want to ensure those higher codes are justified. Read on for expert advice on how to stay above board with E/M codes.

Determine the Physical Exam Level

One step in successful E/M coding is to determine the physical examination key component for the encounter. E/M coding guidelines help you determine which of the following four levels of examination the physician completes during an encounter:

- Problem-focused
- Expanded problem-focused
- Detailed
- Comprehensive.

The level of exam is a factor in determining which code you can report. In the office or other outpatient setting, you'll choose from 99201-99205 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components ...) for new patients or 99212-99215 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components ...) for established patients.

Caution: "The biggest issue I see in internal medicine is that now, with electronic medical records, the physicians are merely 'clicking and pasting' to populate fields in the Exam section of the encounter, but not actually doing the work," says **Terry A. Fletcher, BS, CPC, CCS-P, CCS, CEMC, CCC, CMSCS, CMC,** of Terry Fletcher Consulting, Inc. in Laguna Beach, Calif. "The records start to look like 'cloned' records."

High-Level Codes Don't Necessarily Equal Fraud

As stated above, a practice with high-level E/M codes doesn't always mean a problem. "Practices need to recognize that higher-level coding is often legitimate, but needs to be carefully documented to pass muster," says **Kent J. Moore,** manager of healthcare financing and delivery systems for the American Academy of Family Physicians (AAFP) in Leawood, Kan.

Many reasons exist that could cause a practice to legitimately begin coding more high-level E/M services than in the past. Consider these examples from Moore and Fletcher.

Example 1: Your practice might have begun seeing a more complex patient population who has more chronic problems that require intense management. For example, if the practice has an influx of older patients with multiple comorbid, chronic conditions such as diabetes, congestive heart failure, hypertension, and arthritis, higher level E/M services may become more common, especially if those comorbid, chronic conditions are not well controlled. Similarly, if the practice begins to care for more patients with special needs (such as patients with disabilities or HIV/AIDS), the incidence of higher level E/M services may legitimately increase.

Example 2: Your practice might have been audited and discovered the physicians were downcoding claims. Now the physicians are correctly coding based on the documentation, which warrants more 99214s and 99215s.

Example 3: "Patients often want to discuss head-to-toe issues, not just focus on a specialty physician area or one complaint," Fletcher says. "This would, in effect, be a multiple system review. Internist physicians also spend more time counseling patients on issues than the specialty physicians do." More comprehensive encounters can lead to higher levels of E/M service based on more extensive history, exam, and medical decision making. More time spent counseling can lead to encounters dominated by counseling or coordination of care, which allows the visit to be coded on the basis of time, which can also lead to higher levels of E/M service, depending on the amount of time involved.

Conclusion: If you fit into one of the legitimate billing categories such as these, you shouldn't fret the new OIG study. If, however, you aren't sure how your physicians arrive at their E/M codes, the OIG recommends coding education as the top priority following the report. The OIG also encourages MACs to review physicians' E/M billing patterns to avoid improper payments. "CMS should conduct additional reviews of physicians who consistently bill higher level E/M codes to ensure that their claims are appropriate," the OIG recommends.

To read the complete report, visit http://oig.hhs.gov/oei/reports/oei-04-10-00180.pdf.