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Internal Medicine Coding Alert

E/M: Refrain Getting Caught in These 3 Common Evaluation& Management Traps

Incident to, critical care must meet certain criteria.

As a coder, you're accustomed to reporting office/outpatient E/M codes (99201-99215) on an everyday basis. Some Part B providers are falling prey to several common E/M myths, however, so read on to be sure you know the facts.

Myth 1: Report Supervising Physician for "Incident to"

Some coders believe that when you report 99211 "incident to" a physician, you should bill under the name of the physician on record for that patient.

Reality: Always file "incident to" claims under the supervising physician's name, including nurse visits reported with 99211 (Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of the physician). The Office of Inspector General (OIG) recently found that many practices were billing "incident to" services under the name of a physician who was not on the premises during the encounter.

"Incident to" requires that your nurse or other non-physician provider sees the patient for a follow-up exam instead of a new complaint and that the physician is around in the office suite, according to **Charles Scott, MD, FAAP,** a pediatrician with Medford Pediatric and Adolescent Medicine in southern New Jersey.

Practice management systems might automatically use the physician of record when billing services, rather than the supervising physician. That arrangement makes allotting finances between physicians easier, but it gives the appearance that "incident to" criteria are unmet. Reporting an encounter as "incident to" requires that the supervising physician is directly available, which is generally considered to be in or immediately adjacent to the office suite.

Myth 2: You Can Mark Illness Symptoms Twice

You see that a patient has symptoms of a particular illness. Can't you count that information toward both the history of present illness (HPI) and review of systems (ROS)?

Reality: No, you can't "double dip" and count the same information about the patient's symptoms toward two separate elements.

For example, if the patient suffered a sprain or fracture, the physician would typically address the musculoskeletal system during the ROS. The review might include questions about symptoms such as poor range of motion, joint pain, joint swelling, dislocation, muscle stiffness, or others. You can count the answers to these questions as elements of HPI or ROS, but you should not double count the same symptoms to support both elements.

Myth 3: ICU Visit Equals Critical Care

Physicians sometimes think that seeing a patient in the intensive care unit (ICU) automatically leads to reporting his services with critical care codes 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) and 99292 (... each additional 30 minutes [List separately in addition to code for primary service]).

Reality: You cannot bill the critical care codes simply because the place of service is the ICU. Critical care is not location based -- the term describes a type of care. The physician must meet three criteria before billing for critical care:

- The patient must have a critical illness or injury (usuallydefined as a critical organ system failure or a shock-like syndrome with a high probability of imminent or life threatening deterioration in the patient's condition)
- The physician must document at least 30 minutes of time spent directly with the patient or in the hospital unit, limited only to that patient
- The physician must document highly complex decision making to assess, manipulate, and support vital system function(s) to treat the critical illness or to prevent further deterioration of the patient's condition.

Better option: If your physician evaluates a patient in the ICU but does not perform critical care services, you'll report an initial hospital care code such as 99221 (Initial hospital care, per day, for the evaluation and management of a patient ...) or an appropriate subsequent hospital care code (99231-99233).