Internal Medicine Coding Alert

Five Tips for Improving E/M Reimbursement

No codes are more common for internal medicine practices than those for office/outpatient evaluation and management (E/M) services (99201-99205, new patient; 99211-99215, established patient). So, getting the maximum allowable payment for these services is vital to your groups survival.

Here are five tips for improving E/M coding, documentation and reimbursement:

1. Clarify the difference between a preventive-medicine service and an office sick visit. Physicians either report preventive physicals the same way they report problem-oriented visits, or they report almost all visits as annual physicals when the patients actually are evaluated for a problem. But there is a big difference between the two services.

A patients annual physical is a screening examination designed to check the patients health status to find out whether something is wrong and to make sure the patient is still healthy or still doing well with existing treatments. These visits should be reported with the CPT preventive-medicine services codes (99381-99387, new patient; 99391-99397, established patient). Select the code appropriate to the patients age. Reimbursement for these codes varies according to payer. Private payers who cover preventive exams will limit payment to once per year. Medicare, in fact, does not cover these visits at all. The patient is responsible for paying. In that case, you should have the patient sign an advance beneficiary notice (ABN) before the service is provided. (For more information on ABNs, see the reader question Medicare Waivers on page 23.)

Some physicians tend to report preventive services as regular office/outpatient visits and assign a level of E/M code, which is covered by the patients insurance. Physicians often ask me about this, says **Deborah Lief, CPC,** manager of coding compliance for ProMedCo, a medical services company based in Fort Worth, Texas. I try to keep it simple. I tell them, if the patient comes in with a chief complaint, that is an office visit. If they come in for a scheduled exam, use the preventive-medicine codes. If I am doing chart audits, I always look through Medicares eyes. If I open up a chart and it says, annual physical, I close it and dont need to read anymore. I mark it 99397 (periodic preventive medicine reevaluation and management of an individual . . . 65 years and over) and move on. That is what a Medicare auditor is going to do.

Some physicians get used to writing physical or annual physical for almost every patient, says **Deborah Ice-Turner, CPC,** billing supervisor for Internal Medicine Group, a multiphysician practice in Lawrence, Kan. And many patients wait to be evaluated for most of their health problems until they have the annual scheduled visit. CPT indicates that, for patients who present for an annual physical and have an additional health problem requiring a significant separate workupphysicians should report the appropriate preventivemedicine code and an office/outpatient E/M code with a -25 modifier (significant separately identifiable evaluation and management service by the same physician on the same day) attached.

A lot of times physicians will forget, Ice-Turner says. They will write the code for the physicaloften it is a Medicare patient we have seen for years and yearsand they probably were seen for something else. You will go back and pull the dictation from the patients file and find out that, yes, they did see them for something other than a physical. You have to look for a chief complaint.

Be careful, warns **Cindy Headley,** reimbursement educator for the Order of the Sisters of St. Francis (OSF) Medical Group in Peoria, Ill. Just because the physician finds a health problem at the physical, does not mean the visit warrants two codes. The health complaint must require a significant, separate workup.

What I see a lot of is both the preventive medicine and an illness on the same day, she relates. They can do that with a

-25 modifier, but they need a really significant illness in order to bill the other exam.

The documentation of the workup for the complaint must independently support the additional code reported, she adds.

Note: For more information on billing preventive services and problem visits on the same day, see the related box on page 19.

2. Prompt physicians to improve documentation of the patients medical history. Physician documentation of the chief complaint and the review of systems (ROS) for E/M visits are particularly problematic.

Leif points out that a lot of physicians dont document the chief complaint, and that causes problems when billers are auditing. To select the correct code, they need to know the medical decision-making involved. It can be confusing if the patient came in for the flu but all that was done was a workup for their blood pressure and their chief complaint wasnt documented. Failure to appropriately document the ROS performed when taking the patients history may force coders to downcode the chart.

Where most physicians are weak is review of systems, Lief says. The patient comes in, they get the history of present illness, then write, patient has headache. So you get headache times two weeks, plus nausea and vomiting, that is the history of present illness. The physician doesnt do a review of systems. They jump right to the exam. I know they are thinking about it, or maybe are even doing it, but not writing it down.

Coders should alert the physician when documentation of the patient history is lacking in a particular chart. Although the documentation cannot be changed retroactively for that patient, it will make the physician aware that this is an area to which he or she needs to pay attention.

3. Dont overuse code 99211. Medicare and other payers are restricting payments for code 99211, says Ice-Turner.

Many offices report this code whenever the patient comes into the office, but does not see the physicianfor example, for blood pressure checks and drawing blood for tests. Medicare, however, usually wants to see a definite, documented service provided to the patient.

In years past, we were able to bill 99211 pretty openly when the doctor did not see the patient,
Ice-Turner says. But, I know [from the experiences of other physician offices] that Medicare has been cracking down on the guidelines for that. Our policy is, unless you have spent a pretty significant amount of time with the patient, gotten their vital signs and everything, and there is a note in the chart by the nurse, we stay away from that code.

She acknowledges that many offices report the code more frequently, but she advises against it. In years past, we were able to code an injection, and we would report the 99211 in addition to the injection. Medicare is really starting to frown on that, she believes. We have stayed away from that particular code unless someone is actually coming in for, say a blood pressure check, and in addition, he visits with the nurse and she gives advice on how he should take medications or on diet counseling, diabetes, things like that. That is about the only time we use 99211, if the nurse dictates the note and takes the vitals.

4. Use the 1997 E/M documentation guidelines. Headley recommends requiring the use of the 1997 version of the CPT E/M documentation guidelines. They are more strict and if you were to be audited, you could be sure that the additional documentation is there to support the code.

For example, those guidelines are more specific about the requirements for the physical examination, she says. In an audit we would come out on top because we are using more strict guidelines, particularly with the exam portion.

5. Make sure the correct ICD-9 code is used on the claim to payers. In post-payment reviews, Lief often has seen office visits with the wrong diagnosis code listed. When I am auditing charts, nine times out of 10, the patient came in with influenza, and it is billed as osteoporosis, she says. It is one of the patients chronic and underlying illnesses, and the coder just chose that one.

Be sure to report an ICD-9 code that indicates the reason the patient was seen in the office on that day. Not only do some payers audit for accurate ICD-9/CPT linkage, but the World Health Organization uses ICD-9 data to track diseases and calculate health statistics, Lief says.