Internal Medicine Coding Alert

HCFA Suspends a Large Portion of the CCI 6.3 Edits

In an extraordinary about-face, HCFA has suspended edits of evaluation and management (E/M) services with diagnostic tests. The edits, published in version 6.3 of the national Correct Coding Initiative, bundled 66 E/M codes with more than 800 diagnostic tests and procedures listed in the Medicare fee schedule as having no global surgical period (XXX global days).

When the edits went into effect on Oct. 30, 2000, HCFA specified that an E/M service would be payable on the same day as the bundled procedures only if it was significant and separately identifiable. In such cases, coders were required to append the E/M service with modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) when submitting a claim.

HCFA gave no official reason for the suspension when it was announced on Jan. 26, 2001. However, it is believed the agency was responding to widespread objections from physicians and coders who had an increase in claim denials after billing for E/M services in addition to routine tests like x-rays, spirometry and EKGs, even when modifier -25 was attached.

HCFAs apparent motivation for introducing the edits and its determination to pay only for E/M services deemed significant and separate is due, at least in part, to chronic double-dipping by some physicians when diagnostic tests are performed, says **Susan Callaway, CPC, CCS-P,** an independent coding and reimbursement specialist and educator in North Augusta, S.C.

HCFA stated that the edits were designed to prevent the practice of physicians reporting an E/M service code for the inherent evaluative component of the procedure itself. Because every procedure has an inherent E/M component, for an E/M service to be paid separately, a significant, separately identifiable service would need to be documented in the medical record.

But this really isnt a scenario that lends itself to abuse by internists, says Callaway. In most situations in internal medicine the patient does not come in just for a test. They come in presenting with a problem, and the test is part of determining what the problem is.

When an internist examines a patient, ordering tests and reviewing the results are part of the decision-making component of the visit. But when it comes to providing the test itself, thats a separate procedure and it should be paid separately.

Suspension of the edits is retroactive to Oct. 30, but it does not affect any edits involving services that were in effect prior to then. HCFA says it will review the suspended edits and that a number of them may be re-implemented no earlier than July 1, 2001. Although HCFA says that any denied claims involving E/M services and diagnostic tests after Oct. 30 should be resubmitted, it recommends that physicians continue to attach modifier -25 to the E/M service when refiling the claim. That being the case, internists should still be certain to indicate in the patients medical record that the E/M service was significant and separately identifiable.

E/M services are separately payable only if the documentation clearly indicates that the visit led to the decision to perform a test, such as an EKG, or a procedure, such as a nebulizer treatment.

Callaway gives the example of a new patient presenting to an internist complaining of difficulty breathing. The internist performs a full E/M workup, including history, examination and medical decision-making, and then orders a nebulizer treatment (94640) to help open the airway. Its something internists do regularly, she says.

In this case, the appropriate level of E/M with modifier -25 attached (i.e., 99203-25) can be billed in addition to the nebulizer treatment, says Callaway.

Similarly, if the results of a diagnostic test prompt the internist to perform an examination, modifier-25 should also be appended to the E/M.

A note of caution comes from **Gaye Boughton-Barnes, CPC, MPC, CCS-P,** senior medical compliance specialist at the University of Oklahoma Medical College in Tulsa. She advises that to be billed at the same time as a diagnostic test, an E/M service must also be significant, meaning it should be more than a level-two encounter. Significance relates to the purpose of the patient encounter, including the context of the visit and the medical decision-making involved, Boughton-Barnes says. All the components taken into account when determining the level of the visit time, effort, complexity and treatment options need to be documented to indicate a significant visit.

This requirement is especially important for E/M services provided at the same time as a diagnostic test because the pretest evaluation built into the tests relative value is typically not substantial. Documentation indicating that a significant service was provided offers additional evidence that double-dipping has not occurred.

HCFA says that before it reintroduces any of the edits, it will strengthen efforts to educate physicians and its own carriers about the appropriate use of modifier -25 and what constitutes a significant, separately identifiable E/M service.