Internal Medicine Coding Alert

HelpYour Doc Code Dementia E/M Encounters for More Accurate Claims

Determine HPI or ROS during assessment for geriatric patients.

Your internist is a pro at assessing and treating medical issues, but youre the pro at getting him paid for his work. Helping him brush up on how he reports E/M services for geriatric dementia can improve the accuracy of your claims, and therefore reduce denials.

Expect Combination Problems toYield Higher-Level E/M

Many geriatric patients have health problems like vascular disease, diabetes, hypertension, or a history of stroke or heart attack. Your internist must consider these health issues when assessing patients for dementia.

Your internist should document signs, symptoms, and reasons for the workup using the appropriate office/outpatient E/M code. The level you select depends on what the patients problems are. If the patients only health problem is forgetfulness, you will likely use a lower-level code.

When a patient has multiple problems, your doctor will typically spend additional time completing the assessment. The visits complexity may substantiate billing the highest-level E/M for an office visit (99205 for new patients or 99215 for established patients), says **John E. Morley, MD,** director of the Division of Geriatric Medicine at Saint Louis University School of Medicine.

At this initial visit, the doctor performs a battery of tests such as a mini-mental status exam and a gait and balance assessment, in addition to the history, physical, and family interview, Morley says. Because these tests do not have their own CPT codes, we roll all of that into the E/M, he says.

Recognize that a review of systems (ROS) will be more in-depth at initial visits.

Your provider, or in some cases a patients caretaker, must complete the history of present illness (HPI). The ROS is recorded by ancillary staff or on a form completed by the patient. Your physician must include a notation that he reviewed the information collected with an ROS.

ROS elements typically reference signs and symptoms, of which both positive and negative responses are considered, says **Stephanie Jones, CPC, CEMC,** vice president of product management with the American Academy of Professional Coders (AAPC) in Salt Lake City.

Although you should only count ROS that is medically necessary, you can expect more ROS at certain visits.When a patient presents as an initial new patient, the physician may consider obtaining a complete ROS medically necessary. It may not be considered necessary to repeat a complete review on every follow-up.

Watch for Variations Between HPI and ROS

Pinpointing ROS versus HPI statements can prove tricky. There is a fine line between the signs and symptoms that a patient shares in the HPI and those obtained via an ROS, says Jones.

Example: HPI documentation could read, Patient states that her hip has been painful since her fall last week. If, on the other hand, the documentation reads, Patient states that her hip has been painful since her fall last week, and there is swelling at the joint; there is no other stiffness or redness present, then there is a distinct documentation that shows the HPI and also a separate musculoskeletal ROS occurred.

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Check Out How ROS Can Raise E/M Level

To see if your ROS meets a level three or fours requirements, look for statements on two to nine body areas/systems. An extended ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

An extended ROS (inquiry of 2-9 systems) may support up to a level-three new-patient E/M (99203, ... a detailed history; a detailed examination; medical decision making of low complexity ... or a level-four established-patient E/M (99214, ... a detailed history; a detailed examination; medical decision making of moderate complexity ...)

Caution: Do not select a code solely based on the ROS. The patients HPI, past, family, and social medical history, physical examination, medical decision making, and the amount of time your physician spends with the patient -- such as discussion of counseling and coordination of care -- can all contribute to the correct E/M code.

Also, do not report a higher level of E/M service when a lower level of service is warranted simply due to documentation volume. Medical necessity of a service is the primary criterion for payment in addition to the individual requirements of a CPT code. Documentation should support the level of service reported.

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