Internal Medicine Coding Alert

Polish 3 Documentation Skills for Stellar Claims

Help your internist grasp key documentation elements to reduce repayments.

Documentation errors or omissions plague every coder sooner or later. Take a peek at three typical areas you can improve upon, and watch some of those rejections disappear.

Look for Nurse Visit's Medical Necessity, Order

Before reporting 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician. Usually, the presenting problem[s] are minimal. Typically, 5 minutes are spent performing or supervising these services), make sure that the encounter was medically necessary. "Documentation should clearly indicate the supervising physician's involvement," said **Bruce Rappoport, MD, CPC, CHCC,** at The Coding Institute's Coding and Reimbursement Conference in Orlando, Fla. For instance, 99211 is not appropriate for a "patient who's in and out the door for a blood pressure check. Something else has to be going on," Rappoport said. Just as important as medical necessity, for billing purposes, a 99211 visit must have been ordered by the physician. Without an order from a physician, it would not be medically necessary if the patient walked into the office requesting a blood pressure check, adds **Pat Larabee, CPC, CCP-P,** a coding specialist with InterMed PA in South Portland, Maine.

Show Critical Care Minutes

What is the most commonly missed element in timebased coding? Time, says Rappoport. When coding is based on time, auditors will look at having time in your documentation. "The official recommendation is that the documentation should clearly indicate the total time," Rappoport adds. However time is documented, it needs to be in the medical record. Don't put all your eggs on a time stamp. While some EMR (electronic medical record) programs include time stamps, without seeing how a system's time stamp works, it's hard to say if the "start" time indicates the time the physician entered the examination room or the time that the patient came into the room. It's better for the physician to record that information, Rappoport recommends.

Example: Critical care code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes) requires at least 30 minutes. If your documentation doesn't mention the amount of time spent providing critical care, an auditor will disallow use of this CPT code. Time needs to be there in the documentation because if the provider spent less than 30 minutes providing critical care, the definition for 99291 is not met and another evaluation and management code would be needed, Rappoport stressed. Tally all the day's medically necessary critical care time. The Medicare Claims Processing Manual, Chapter 12, Section 30.6.12E, states that critical care codes 99291 and 99292 "are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient." That's even if the time spent by your physician on that date is not continuous. Critical care, by definition, requires a physician's presence. If you're doing audits, look at what took place above and below the critical care note. Your physician may have checked the boxes for critical care and time, but an auditor wants to know what was going on surrounding it.

Be Stingy With E/M-25

When using modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service), the E/M service must be significant and separately identifiable from the same-day service or other procedure.

Example 1: If documentation states that the patient is only present for his synvisc injection (J7322, Hyaluronan or

derivative, Synvisc, for intra-articular injection, per dose) you should not additionally bill for the E/M. If the physician is just asking if the patient has had any complications since her last shot, and saying "Here's another shot," there's no significant, separately identifiable evaluation and management service and thus no modifier 25.

Example 2: On the other hand, "If the patient is complaining of another joint being painful and it warrants obtaining history, doing an exam, and then providing medical decision making, this would be an example where modifier 25 would be appropriate," Larabee says.