Internal Medicine Coding Alert

Reader Question: Medical Necessity Drives E/M Code Choice

Question: Our physician documents office visits very thoroughly. Because he documents in his EMR so well, almost all of his cases qualify for 99214s and 99215s. Since the documentation supports his code selections, is this acceptable?

Nevada Subscriber

Answer: Not necessarily. The answer depends on the medical necessity of the encounters. Your electronic health record will most likely offer an E/M code suggestion at the end of each visit but that doesn't mean you can use that to justify all high-level codes.

Several practices state that their physicians "thoroughly document" the history and physical exam elements for all conditions, leading to high-level codes, even if the medical decision-making (MDM) doesn't support 99214 or 99215. They justify this by pointing out that established patient office visits only require two out of three criteria (history, exam, medical decision making).

Reality: CMS indicates in its Medicare Claims Processing Manual (Section 30.6.1.A of Chapter 12) that "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT® code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed." In addition, both the 1995 and 1997 E/M Documentation Guidelines state, "The documentation of each patient encounter should include: reason for the encounter and **relevant** history, physical examination findings and prior diagnostic test results."

You should use your EHR's code selection as a suggestion, but the final code choice should be up to the clinician, and should be based on medical necessity and the nature of the presenting problem as well as the key components (history, exam, and medical decision making) of the encounter.