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Internal Medicine Coding Alert

Use 1995 or 1997 Guidelines to Get E/M Reimbursement

Just when many internists had gotten accustomed to performing the more detailed examination requirements of the Health Care Financing Administrations (HCFA) 1997 evaluation and management (E/M) documentation guidelines, the agencys recently issued proposal for new guidelines indicates that a less restrictive examination system is being considered for adoption in January 2002. In the meantime, internists should continue to follow either the 1997 or 1995 guidelines issued by HCFA and make sure that they are properly documenting the examination component of the E/M service.

Three Tips for Better Exam Documentation

What the internist does to document the examination will probably be the same for both the 1997 and the June 2000 guidelines, according to **Martin Gottlieb,** president of Martin Gottlieb & Associates Inc., a medical billing company in Jacksonville, Fla. What the internist documents will remain the same, he says. The new guidelines look like they will require fewer elements for an examination, and internists may be able to bill a higher level of service than under the 1997 standards.

The following three tips on documenting examinations will apply to whatever set of standards (1995, 1997 and June 2000) are in effect:

1. Patients appearance counts as an element. The constitutional part of the exam contains two bullet elements. According to Brink, most internists (or a member of their staff) document the first element, the measurement of any three of the following vital signs: a) sitting or standing blood pressure, b) supine blood pressure, c) pulse rate and regularity, d) respiration e) temperature, f) height and g) weight. But they often miss the second element: patients appearance.

The internist can make a statement in the patients medical record about his or her appearance, such as patient appears to be in good health or patient appears to be disoriented, Brink explains. Most internists notice how the patient looks, but often fail to document it.

2. Documenting patient history helps justify exam. Brink cautions internists who skimp on the history portion of the E/M service with an established patient and focus solely on the exam portion. An internist only needs to document two out of three components (history, examination, medical decision-making) for an established patient visit, she says. However, the information obtained by the internist in the history, and history of present illness (HPI) or in the interval history is what necessitates performing the examination. If theres no history, HPI or interval history, then what is the medical necessity to perform the exam?

Brink suggests that internists always document the chief complaint or reason for the visit with every patient E/M service. Because most internists also review the patients original medical health history form during the course of the visit, she advises them to note in the patients medical record that the form was re-reviewed, and note the date of the original history form, as well as noting any changes to the original history.

3. Abnormal findings must be explained. HCFA has stated that a brief notation indicating negative or normal is enough to document normal findings. Internists can just write normal or check it off a form if they use a checklist or template, Brink notes.

Commonly used shorthand abbreviations are also acceptable. The notes in the patients medical record can read HEENT normal, instead of writing out heart, eyes, ears, nose and throat, adds Haynes.

But notation of abnormal without further explanation is not sufficient documentation. If theres an abnormal finding during the examination it is not enough just to write the word abnormal in the patients record, Brink says. You have to include a statement such as abdomen is tender or mass in abdomen.

Copies of the 1995, 1997 and proposed June 2000 E/M documentation guidelines can be downloaded from HCFAs Web site at www.hcfa.gov/audience/planprov.htm.

Analysis of the proposed June 2000 E/M documentation guidelines can be found at the Martin Gottlieb & Associates Web site at www.gottlieb.com/documentation.htm.

Both 1995 and 1997 Guidelines Are Acceptable

In an attempt to distinguish between different levels of service, HCFA issued E/M documentation guidelines in both 1995 and 1997 with the section on examinations being the main difference between the two. The 1995 guidelines allowed physicians to conduct either a general multisystem or single system exam, and defined the levels of examination in a basic way.

There was no specific guidance, however, on what constituted the difference between the various levels of examination for coding and reimbursement purposes, which caused concern among physicians. In the 1995 guidelines, an expanded problem-focused exam was defined as a limited examination of affected body systems, says **Catherine Brink, CMM, CPC,** president of Healthcare Resource Management Inc., a physician practice management consulting firm in Spring Lake, N.J.

To provide further guidance for physicians and to create specific audit criteria, HCFAs 1997 guidelines, while continuing to use the 1995 definitions for the various levels of bullets (elements of examination), included the number of elements that must be performed and documented for each level. The 1997 guidelines also outlined the elements of the multisystem general examination and 10 single organ-system examinations (cardiovascular, ear/nose/throat, eye, genitourinary, hematologic/lymphatic/immunologic, musculoskeletal, neurological, psychiatric, respiratory and skin).

Although emphasis on bullet elements and counting added clarity to the 1997 guidelines, some specialists found it difficult to perform the required number of elements to qualify for upper-level E/M visits. The 1997 guidelines are clearly spelled out and easier to format into checklists, says Brink. For some specialties, following the 1997 guidelines can make it difficult for the physician to perform and document the required elements that constitute a level-four or five E/M service. In cardiology, for example, it may be very difficult to perform and document all the elements needed for a comprehensive exam.

Because there was significant resistance to the new guidelines from physician groups, HCFA announced that physicians could choose to use either the set of guidelines and that the agency would continue to develop a set of documentation standards that would meet with wider acceptance from the medical community. So for the past several years, physical examinations during E/M services could be measured by the following standards:

A problem-focused examination is defined in the 1995 guidelines as a limited examination of the affected body area or organ system. The 1997 guidelines stated that this consists of performing and documenting one to five elements identified by a bullet.

This is a component of the following office, inpatient, and consultation E/M codes: 99201 (new patient office visit), 99212 (established patient office visit), 99231 (subsequent hospital care), 99241 (office consultation), 99251 (initial inpatient consultation), 99261 (follow-up inpatient consultation), 99271 (confirmatory consultation) and 99281 (emergency department visit). It is also a component of nursing facility and home visit E/M codes.

An expanded problem-focused examination is defined by the 1995 guidelines as a limited examination of the affected body area or organ system and other symptomatic or related organ system(s). The 1997 guidelines state that this consists of performing and documenting at least six elements identified by a bullet.

This is a component of the following office, inpatient and consultation E/M codes: 99202 (new patient office visit), 99213 (established patient office visit), 99232 (subsequent hospital care), 99242 (office consultation), 99252 (initial inpatient consultation), 99262 (follow-up inpatient consultation), 99272 (confirmatory consultation) and 99282-99283 (emergency department visit). It also is a component of nursing facility and home visit E/M codes.

A detailed examination as defined by the 1995 guidelines is an extended examination of the affected body area(s) and other symptomatic or related organ system(s). The 1997 guidelines state this consists of performing and documenting at least two elements identified by a bullet from each of six areas/systems or at least 12 elements identified by a bullet in two or more areas/systems for the general multisystem exam.

It is a component of the following office, inpatient and consultation E/M codes: 99203 (new patient office visit), 99214 (established patient office visit), 99218 (initial observation care), 99221 (initial hospital care), 99233 (subsequent hospital care), 99234 (observation or inpatient care services), 99243 (office consultation), 99253 (initial inpatient consultation), 99263 (follow-up inpatient consultation), 99273 (confirmatory consultation), 99284 (emergency department visit). It also is a component of nursing facility and home visit E/M codes.

A comprehensive examination as defined by the 1995 guidelines is a complete examination of the general multisystem examination or of a single organ system. The 1997 guidelines state that this consists of performing all elements identified by a bullet in at least nine organ systems or body areas and documenting at least two elements identified by a bullet from each of nine areas/systems for the general multisystem exam.

It is a component of the following office, inpatient and consultation E/M codes: 99204/99205 (new patient office visit), 99215 (established patient office visit), 99219/99220 (initial observation care), 99222/99223 (initial hospital care), 99235/99236 (observation or inpatient care services), 99244/99245 (office consultation), 99254/99255 (initial inpatient consultation), 99274/99275 (confirmatory consultation) and 99285 (emergency department visit). It is also a component of nursing facility and home visit E/M codes.

New June 2000 Standards Proposed

On June 22, HCFA released its latest documentation proposal, referred to as June 2000. The proposal, which has a planned implementation date of January 2002, surprised many in the medical coding community because there was far less emphasis on counting elements than in the 1997 guidelines. The proposed levels of a multisystem examination are defined as follows:

A brief examination should include findings from one or two body areas or organ systems.

A detailed examination should include findings from three to eight body areas or organ systems.

A comprehensive examination should include findings from nine or more of the seven body areas or 13 organ systems, or at least three constitutional findings that are comparable to one body area or organ system.

HCFA is in the process of creating specialty-specific vignettes for multisystem exams and single organ system exams for physicians to use as a guide to determine the appropriate levels of E/M services and documentation to support the level of service.

Continue Coding for Existing Guidelines

The June 2000 guidelines would require a change in the definition of the E/M service codes, which currently are based on four levels of examination. In addition, HCFA will be spending the next year testing its June 2000 guidelines and making revisions, which means that significant changes still may be made to the final proposal.

Until a new set of guidelines has been adopted, internists need to use either the 1995 or 1997 guidelines in their practices. The consensus among coding experts seems to be that the general multisystem exam described in the 1997 guidelines is what most internists are or should be using in their practices. Even before standards were issued by

Medicare, we did something similar to the general multisystem examination, but we just didnt do all the detailed documentation, says **Michael Haynes MD, FACP,** an internist and pulmonologist, who also is the compliance director at University Medical Associates, a multispecialty, multiphysician medical practice in Augusta, Ga. In reality, its hard for any internist to do an exam with fewer than 12 elements.

If the patient has a simple case of sinusitis, the internist will probably do only an expanded problem-focused exam that mainly focuses on the ear, nose and throat, Haynes continues. But what we so commonly see in internal medicine are patients with a combination of ailments, such as diabetes, hypertension and heart disease, which will usually require at least a moderate level of medical decision-making and a moderate level of examination.