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Internal Medicine Coding Alert

You Be the Coder: Reporting Established E/M is Possible Without One Key Component

Question: I have newly joined into internal medicine coding. Recently, when reporting an E/M encounter for a follow up patient, I noticed that our internal medicine specialist had not performed a physical examination for the patient. He had documented history and recorded the vitals. He had also detailed out the treatment plan for the patient. Can I report an E/M code for this encounter even though our clinician did not perform a physical examination?

Vermont Subscriber

Answer: If you look at the descriptors for "new" patient E/M codes and "established" patient E/M codes, you will notice that established patient E/M codes 99212-99215 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components ...) needs only two of the three components of history, examination and medical decision making while new patient codes 99201-99205 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components ...) need all three elements to be performed by your clinician.

Since your clinician has recorded history and documented the treatment plan (medical decision making) and the patient is an established patient, you won't need your clinician to perform a physical examination for you to report an E/M code for the visit.

That said, both the 1995 and 1997 versions of the documentation guidelines for E/M services maintained by the Centers for Medicare & Medicaid Services consider recording vital signs to be part of the physical examination.

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