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BY AAPC

Part B Insider (Multispecialty) Coding Alert

E/M Coding: Can you Spot the Problem With This E/M Code Assignment?

A thorough read is all it takes to identify the most glaring issue.

Sometimes, we're so quick to review a physician's documentation that we can gloss over important facts within the records, which can lead to assigning the wrong code. Read through the following documentation example and see if you can identify the problems with the physician's code assignment.

Date of service: Dec. 8, 2014

Chief complaint: The patient presents today to assess the status of his left shoulder abscess, on which we performed an I&D on Dec. 1.

HPI: This 77-year-old male is improving with no further problems and there are no stitches that need to be removed. He is back to his normal activities of daily living and his urination and bowel movements are normal. He is not using pain medication and he reports that the incision is healing well. He has a visiting nurse that packs it each day to ensure that it remains sterile. He reports no unusual drainage or discomfort.

PMFSH: History of high cholesterol and hypertension and underwent a hernia repair in 1978. Smokes three cigars per week and occasionally drinks beer. Denies any other relevant social history. His brother died at 72 of bladder cancer. He denies any further contributory family history.

Physical Exam: The patient has a good general appearance, with no swelling, tenderness or warmth in the shoulder. Passive motion is limited and active motion is limited as well. Wound is clean and dry and neurovascular intact. The patient has previously limited left shoulder mobility due to prior trauma but has had a further decrease in mobility. He will need PT for increasing range of motion.

Wound packing was changed in the office today. There is excellent granulation as his nursing aide has done an excellent job taking care of the wound, which is approximately 85 percent healed at this point.

Assessment: Abscess (682.3). I will order physical therapy evaluation and treatment for his left shoulder's significantly decreased range of motion. Patient should continue packing the wound until flattening out, and then just use a plain dressing until it is completely healed. Return to the office as needed.

Code reported: 99213

Did You Spot the Problem?

Although 99213 would be the appropriate charge based on the history, exam and medical decision-making if this were a billable visit, the reality is that you can only report 99024 (Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason[s] related to the original procedure) with zero charge for this service because it is simply a postoperative visit following the incision and drainage surgery (23030), which has 10 global days assigned to it. Therefore, this visit on Dec. 8 as a follow-up to a Dec. 1 surgery is already included in the payment for the actual I&D surgery and is not going to net you any extra payment.

Tip: Many payers don't recognize 99024 for payment purposes, but the code is valid for tracking purposes. Although it has a zero charge, it's always a good idea to use 99024 to keep track of visits for risk management purposes to show that the patient did present for a follow-up visit within the surgical period. Keep in mind that each surgical code requires the surgeon to see the patient for all appropriate visits during the post-operative period. By using the 99024, you clearly

illustrate this.