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Part B Insider (Multispecialty) Coding Alert

E/M Coding: Get These 5 E/M Answers--Straight From the Source

Know who needs to sign incident to records�and who doesn't.

When it comes to E/M coding, the services often seem fairly straightforward but the coding requirements can take hours to interpret. If you get hung up on common E/M questions, check out the following answers provided directly from CMS and the MACs.

DNR Discussions May Not Impact Level

Question 1: If a physician talks with a patient about a do not resuscitate (DNR) order and documents the conversation, would this be a high-level risk management option under medical decision making even though the patient's prognosis may be fine?

Answer: No, said Part B MAC Palmetto GBA in a July 15 Q&A. "A high level of risk would only be indicated if the documentation states that the patient has a poor prognosis, or it can be inferred there is a poor prognosis from the content of the note."

Therefore, you should instead base your E/M level on the other elements of the visit.

You Certainly Can Bill Incident to for NPs

Question 2: Can a physician bill incident to for non-physician practitioners (e.g., certified nurse midwives, clinical psychologists, CSWs, PAs, NPs, and clinical nurse specialists) that are eligible to bill separately for their services?

Answer: Yes, as long as the services meet all of the requirements for incident to services specified in the CMS Internet-Only Manual (IOM) Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 60�60.1, says Part B payer NGS Medicare on its website.

"For example, the services must be an integral, although incidental, part of the physician's personal professional services, and they must be performed under the physician's direct supervision," the payer says.

This means "that there must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the non-physician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment. In addition, the physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary," NGS adds.

In addition, the payer clarifies, the supervising physician is not required to sign the chart, but "documentation should contain evidence that he or she was actively involved in the care of the patient and was present and available during the visit," NGS adds.

Classify New Vs. Established Patients

Question 3: What is the definition of "new patient" for billing EM billing purposes?

Answer: A new patient is one "who has not received any professional services, i.e., evaluation and management service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous three years," CMS says in a FAQ on its website.

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"For example, if a professional component of a previous procedure is billed in a 3-year time-period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit," CMS says. "An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient."

In addition, for Medicare E/M services, the same specialty is determined by the physician's or practitioner's primary specialty enrollment in Medicare. "Recognized Medicare specialties can be found in the Medicare Claims Processing Manual, chapter 26 (http://www.cms.gov/manuals/downloads/clm104c26.pdf)," CMS says. "You may contact your Medicare claims processing contractor to confirm your primary Medicare specialty designation."

Avoid Sending Documentation Without Request

Question 4: Can I send in documentation to be reviewed even if it was not requested?

Answer: You should only send in documentation when requested or with a valid Redetermination or Reopening request, says Part B payer Noridian Medicare on its website. "Documentation submitted without a valid request will be archived." In cases where you know the insurer will request the documentation, make copies and/or scan the files for submission so they'll be ready when the request arrives, but don't send them until you get that request.

Tally Your MDM Points Accurately

Question 5: If I order a diagnostic test in the office and I independently review the image, tracing or specimen do I receive three medical decision-making data points (one for ordering the test and two for independently reviewing)?

Answer: "If you ordered a diagnostic test and did not bill the professional component, three points would be given (one point for ordering and two points for independently reviewing)," Palmetto GBA says in a July 15 Q&A. "If you are billing the professional component, one point would be given for ordering the test."

Background: CMS guidelines allow you to get one data point for reviewing or ordering clinical lab or radiology tests. The medical decision-making table also gives you two points for independent reviews of images, tracings, or specimens. Hence, the three point total when calculating your medical decision-making in this example.

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