Part B Insider (Multispecialty) Coding Alert

E/M Coding Quiz: Arm Yourself With Accurate E/M Knowledge

Determine whether your E/M coding skills are top-notch with this quick quiz.

It's time again to determine whether you're a Medicare coding ace or if you still need some assistance with your skills.

Almost every Part B practice codes an E/M chart from time to time, but ample questions exist about how to properly report these services. Today we're putting you to the test with a few questions that will help you understand Medicare's complicated E/M billing and coding rules.

Do Different Specialties Count?

Question 1: I work for a large hospital with multiple groups of physicians of different specialties. Lately we have started seeing rejections for new patient visits from Medicare when the patient is indeed a new patient for a practice (such as hand surgery) because Medicare is saying the patient had been seen before at another practice of the same specialty (hand surgery), related to the hospital. The two practices are totally different entities and do not share the patient database or records. Could this have anything to do with taxonomy codes and how they are matched to provider numbers?

Answer 1: The answer depends on whether the two hand surgery practices share a tax ID number. CMS specifically states that the patient is a new patient when seen under the same tax ID number by a doctor of a new specialty, not a doctor who does not share a chart.

If the physicians do not share the same tax ID number, then you may have a case worth appealing. You should contact your MAC to explain the situation and determine what caused the mix-up.

Can You Report Family Visits?

Question 2: My surgeon met with an elderly patient's family to discuss treatment options and the patient's plan of care. The patient was not present for this in-office meeting. Can I still bill Medicare for an E/M service based on the time spent with the family? What about if a patient is there with the family but due to cognitive issues is not mentally "present" or participating?

Answer 2: In most cases, Medicare will only pay for an office visit if the patient is present.

Medicare requirements specify that the physician must meet face-to-face with the patient to report an established patient E/M visit (99211-99215). The only exception is if the physician must contact another individual (such as a spouse, parent, child, or other family member) to "secure background information to assist in diagnosis and treatment planning," according to the Medicare National Coverage Determinations Manual, Chapter 1, Part 1, Section 70.1 (available at www.cms.hhs.gov/manuals/downloads/ncd103c1_Part1.pdf).

The manual further states, "In certain types of medical conditions, including when a patient is withdrawn and uncommunicative due to a mental disorder or comatose, the physician may contact relatives and close associates to secure background information to assist in diagnosis and treatment planning. When a physician contacts his patient's relatives or associates for this purpose, expenses of such interviews are properly chargeable as physician's services to the patient on whose behalf the information was secured. If the beneficiary is not an inpatient of a hospital, Part B reimbursement for such an interview is subject to the special limitation on payments for physicians' services in connection with mental, psychoneurotic, and personality disorders."

Key: The patient must be unable to provide the information himself. In this case, you may be able to report a low-level

visit, but expect Medicare to reject the claim unless your documentation is especially clear as to the reason that contact with the family member was necessary.

What Constitutes 'Face to Face?'

Question 3: A patient recently reported to our physician for an E/M service. The patient's record indicates that the doctor read the results of the patient's lab test on May 5, 2010. Can we report a new patient office visit for this most recent E/M visit, or does the lab test reading preclude us from doing that?

Answer 3: You should report a new patient office visit (99201-99205). Interpret the phrase "new patient" to mean a patient who has not received any professional services -- in other words, an E/M service or other face-to-face service -- from the physician or physician group practice within the previous three years.

This means that you might be able to report a patient as new if the doctor provided services for the patient less than three years ago -- provided it was not a face-to-face-service.

Explanation: When the physician reads an X-ray, EKG, etc., in the absence of an E/M service or other face-to-face service with the patient, it does not affect the new patient designation.

Is 'Likely' A Diagnosis?

Question 4: A new patient reported to our office complaining of wheezing and shortness of breath. The physician performed a level-four E/M, and then ordered spirometry with graphic record (we own the equipment, and the test was performed and interpreted in-house). Encounter notes describe "likely" emphysema, though the spirometry would not be expected to confirm it. How should I handle the diagnosis coding here? Should I wait for a definitive diagnosis before coding this claim?

Answer 4: Just because the encounter resulted in an inconclusive diagnosis, that does not mean you cannot report -- and be paid for -- the physician's services. Just make sure the documentation supports the patient's presenting symptoms.

ICD-9-CM coding guidelines (Section I.B.6. and Section IV.E) state, "Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider."

Translation: If the doctor does not confirm emphysema, do not consider reporting any emphysema diagnoses. If the patient comes back for further testing that does reveal emphysema, then you can report an emphysema diagnosis. Instead, you'll probably look to 786.05 (Shortness of breath) and 786.07 (Wheezing).