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Part B Insider (Multispecialty) Coding Alert

E/M CODING REFRESHER: These 3 Q&As Will Eliminate E/M Coding Confusion

Make sure your practice doesnt become an E/M coding error statistic.

If you glean anything from CMSs recent CERT report (see page 113-114 for more information), its that youve got to buckle up your coding for E/M services.

CMS paid out over $1 billion in error for E/M codes between Sept. 30, 2006 and Sept. 30, 2007, according to the most recent comprehensive error rate testing (CERT) report.

After our E/M coding quiz last week, questions poured in from our subscribers asking for more insight into how to correctly bill for E/M services. Today weve got three more answers from the experts.

Avoid In-Hospital Incident-tos

Question: How should we code a mid-level providers (MLPs) report of a consult that she performs on a hospital inpatient? Is incident-to consult billing allowed for inpatient MLP services?

Answer: Incident-to is not allowed in the hospital at all, says **Suzan Berman-Hvizdash, CPC, CEMC, CEDC,** senior manager of coding and compliance with the UPMC Departments of Surgery andAnesthesiology. Shared/split visits are what can be done in the hospital, however, not for consultations, she advises. The MLP would bill the consultation out under his/her own provider number. To Medicare, the reimbursement would be 85 percent of the physician fee schedule.

Scrutinize Shared Consults

Question: I know that a MLP and a physician can share an E/M visit, with the nurse, for instance,taking the history and performing some preliminary work and then handing off the patient to the MD for the exam. Does this apply for consult services as well?

Answer: The RN can only take the past, family, and social histories (PFSH), as well as the review of systems (ROS), Berman-Hvizdash says.The MLP would note his or her visit in the chart, making a statement that the doctor will also see the patient.

Keep in mind: The physician **must** reference back to the notes (which he or she wants to use toward the billed level of service). The note must also include proof that he or she saw the patient, Berman-Hvizdash says. The doctor cant just write that the records were reviewed or tests were viewed; but face-to-face time with the patient must be evident within the note written by the M.D.

Check Payer Rules for 99211

Question: If a new patient presents for an office visit, sees the nurse but then has to leave suddenly, can we report 99211 for that visit? Also,can we bill 99211 for prothrombin time testing that the nurse performs on an established patient if the patient requires a brief evaluation?

Answer: There is no one complete source for the correct use of 99211, says **Quinten A. Buechner,MS, MDiv, CPC, ACS-FP/GI/PEDS, PCS, CCP, CMSCS,** president of ProActive Consultants in Cumberland, Wis. Each payer does its own thing. CPT hasnt been very helpful either, so some practices avoid using the code. That is a shame because just five encounters a week adds up to about $5,000 a year, Buechner says.

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New patients: Youll find code 99211 listed under the established patient office visit codes, so you should not report it for the new patient.

Prothrombin time (PT): Under Medicare rules, you can report 99211 for PT testing if you meet the following requirements, Buechner says:

" Your practitioner provides face-to-face medication management

" Your documentation establishes a need for clinical evaluation and management of significant new symptoms or clearly demonstrating how the relevant lab information was used to modify therapy

" Current medications are listed with notation of compliance, an indication is documented showing the physician/practitioners evaluation of the labs and recommendation, and the clear identity and credentials of the staff and practitioner are clearly noted.

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