Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

E/M Quiz: Find Out How Your E/M Coding Skills Rank

This quick quiz will evaluate whether your E/M codes are on the straight and narrow.

Think you're an E/M coding ace? Consider these four questions, and then read the answers to find out how you scored. All of the answers can be found in issues of Part B Insider from the past year.

New Patient Rules Are Tricky

Question 1: We found several instances where our physician saw a new patient but didn't document the minimum levels of history required (he either documented no chief complaint or no HPI) to bill any new patient office visit codes (99201-99205). What can we report in circumstances like this?

A) Use an established patient code (99211-99215)

B) Select the appropriate new patient E/M code with modifier 52 (Reduced services) appended

C) Report 99499 (Unlisted evaluation and management service)

D) You can't bill an E/M for a new patient with no history.

Answer 1: D. Review the brief HPI information the physician documented to determine if the statement contains both elements of a CC (chief complaint) and history of present illness (HPI). The doctor must document the HPI, exam (with the exception being vitals, which an ancillary staff member can document), and the medical decision making (MDM). You need documentation of all three key components (history, exam, and MDM) to support even the lowest new patient level E/M code.

If you truly have no HPI documentation, you cannot submit a claim with the new patient E/M codes (99201-99205). Help educate your physicians on the importance of clear E/M documentation. The HPI is a vital part of the patient record that documents the reason why the patient is seeking care and the circumstances surrounding the problem that led up to and includes the present status and any changes since the patient's last visit. If a physician routinely omits the HPI, you'll be hard pressed to establish medical necessity for many patient encounters.

Don't Let EMR Select Your Codes

Question 2: Our physician is a very thorough documenter and treats very sick patients. Because he documents his EMR so well, almost all of his cases qualify for 99214s and 99215s. Since the documentation supports his code selections, is this acceptable?

A) Yes, as long as he documents a thorough exam, history, and MDM, you are fine

B) Yes, you should always trust the EMR's code choice

C) No, the E/M code should be driven by medical necessity

D) No, you should code based on time

Answer: 2: C. Your electronic health record will most likely offer an E/M code suggestion at the end of each visitbut that doesn't mean you can use that to justify all high-level codes.

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Several practices have told the Insider that their physicians "thoroughly document" the History and Physical Exam elements for all conditions, leading to high-level codes, even if the medical decision-making (MDM) doesn't support 99214 or 99215. They justify this by pointing out that established patient office visits only require two out of three criteria (History, Exam, MDM).

Reality: CMS indicates in its Carriers Manual that "Medical necessity is the overarching criterion for payment in addition to the individual requirements of a CPT® code." In addition, the 1995 E/M Guidelines state, "The documentation of each patient encounter should include: reason for the encounter and relevant history, physical examination findings and prior diagnostic test results."

If your patient has a runny nose and you're documenting a complete neurological exam, Medicare would not consider that "relevant." Therefore, you should use your EHR's code selection as a suggestion, but the final code choice should be up to the clinician, and should be based on medical necessity and the nature of the presenting problem.

Be Specific When Coding Based on Time

Question 3: Determine the best E/M code for this service: A 72-year-old patient seen for COPD (chief complaint) FU visit. She has been on inhalant medication (HPI-modifying factor) for one month (HPI-duration) but is not doing well (HPI-quality). She is still having problems breathing, especially while walking in the city, where she lives (social history-living arrangements) and with having difficulty when she leans back or lies down and then feels short of breath instantly (HPI-severity). Her sons have also noted problems with appetite (ROS-constitutional) and sleep issues (ROS-neurological or respiratory-not both). Physical examination consists of a brief respiratory examination (can't give credit here as there are no details). Extensive counseling is done, discussing additional ways she can use a pillow to prop herself up when she rests to decrease her symptoms, and also to talk about ways to combat breathing problems when walking in the city (suggested a mask and told her the pros and cons of oxygen and when it's likely that she may need to use it) (counseling description). Her inhalant dosage is increased (prescription drug management-table of risk-moderate) (MDM risk: 2 pts) and FU planned in one month. Total face-to-face time is 25 minutes.

A) 99212

B) 99213

C) 99214

D) 99215

Answer 3: B. Although it's tempting to select 99214 based on the fact that the physician spent 25 minutes with the patient, you actually can't code this chart based on time, since the doctor did not document how much of that time was spent counseling. Medicare requires you to not only document the total time spent with the patient when you're selecting a code based on time. The agency also expects you to document the time spent counseling and a summary of what was discussed.

Instead, you must base the E/M code on the elements (history, exam, and medical decision-making), which gets you to 99213.

Don't Jump to Report E/M Codes

Question 4: Our nurse gave a patient an allergy shot. Which E/M code can we report with it?

A. 99211

B. 99211-25

C. None

D. 99212

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Answer 4: C. You can't bill 99211 for just an allergy shot or vaccination. For allergy shots, you should code 95115 (Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection) for a single shot or 95117 (...2 or more injections) for two or more shots.

If the billing provider supplies the allergy serum, then you should bill for the serum at the time the provider makes the new serum. For vaccinations, bill the vaccine separately and use 90471 (Immunization administration [includes percutaneous, intradermal, subcutaneous, or intramuscular injections]; 1 vaccine [single or combination vaccine/toxoid]) for a single injection, 90473 (Immunization administration by intranasal or oral route; 1 vaccine [single or combination vaccine/toxoid]) for a single nasal/oral vaccination, or +90472 for each additional vaccination.

Note: If the nurse provides a separate, medically necessary E/M service for example, if the patient has a separate illness or a reaction to the injection that requires a separate evaluation then you can separately bill for these services using 99211. Make sure the documentation supports these services.

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