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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Don't Stress Out--Spruce Up Your E/M Skills In A Flash

Bonus: Learn 2 E/M pitfalls that could clog up cardiology practice claims

Reporting E/M codes requires a lot of study beyond reading the code descriptors. And extra procedures, such as separate stress tests, can throw a kink into your well-made coding plans.

Don't forfeit reimbursement your practice rightly deserves. Take a lesson from these four Q & A scenarios that tackle tough E/M issues.

1) Look Closely At Level 99215

Question: True or False? The rules say that I can bill a level 99215 (Office or other outpatient visit for the evaluation and management of an established patient) based on history and examination if I can substantiate in the record a comprehensive history and examination, even though the medical decision-making is low risk and there is no data to review. In other words, I can report 99215 regardless of medical necessity for that exam level.

Answer: False. -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,- - says **Stephen R. Levinson, MD**, author of the AMA's Practical E/M: Documentation and Coding Solutions for Quality Health Care.

Tip: Specialty societies developed and approved the Clinical Examples in Appendix C of CPT to illustrate the level of care warranted by representative patient problems, Levinson says.

Example: The 99215 example for oncology and hematology is an -office visit for restaging of an established patient with new lymphadenopathy one year post-therapy for lymphoma.-

Remember: Simply meeting the description of the clinical example is not enough to report the code--documentation must still support the visit level you charge.
E/M Guidelines also point out the need to base your code on medical necessity. Example: Page 10 of the 1995 E/M Guidelines says, -the extent of examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s).-

-The clear message here is that the history, exam and medical decision-making performed should correlate with the presenting problem(s),- says **Erica D. Schwalm, CPC-GSS**, CMRS, billing and coding educator in Springfield, Mass.

2) Same Day, Separate Diagnosis Codes?

Question: When I report an E/M service on the same day as another procedure, do I need a separate diagnosis code for each CPT code?

Answer: No. When reporting any E/M service, you must link it to a diagnosis that explains the reason the physician performed the service. The E/M service does not have to be unrelated to the other service(s) or procedure(s) the physician provides on the same day, says **Marcella Bucknam, CPC, CCS, CPC-H, CCS-P**, HIM program coordinator at **Clarkson College** in Omaha, Neb.

CPT specifically states, -The E/M service may be prompted by the symptom or condition for which the procedure and/or

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service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date.-

But separate diagnoses, when available, do further help to demonstrate the distinct nature of the E/M service--especially when dealing with payors other than Medicare, says **Raequell Duran, CPC,** president of **Practice Solutions** in California.

Example: A patient presents for chemotherapy related to a breast neoplasm (96413, Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug; V58.11, Encounter for antineoplastic chemotherapy and immunotherapy; encounter for antineoplastic chemotherapy; 174.6, Malignant neoplasm of female breast; axillary tail).

During the encounter, the patient requires a level-two E/M service for severe nausea (99212, Office or other outpatient visit for the evaluation and management of an established patient ...; 787.02, Nausea and vomiting; nausea alone).

3) Don't Let Stress Tests Frazzle Your E/M Coding

Question: If my physician urgently needs to evaluate a patient following a stress test to determine whether the patient's condition requires more care or discharge, can I report this? How do I report both the E/M service and the stress test?

Answer: You can report both services, but you need to make certain the E/M visit is separately identifiable from the stress test, says **Tammy Anderson, CPC**, supervisor of claims at **Managed Care Systems** in Bakersfield, Calif.

Background: When you report a stress test, you-ll use 93015 (Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report), if performed in the office, for the global service.
But when you report an E/M service separately, you-ve got to be wary of two pitfalls.

Pitfall #1: In many circumstances, the diagnosis code you report for the E/M service may be the same as the diagnosis code you use for the stress test. -This is the only problem we have,- says **Connie Cofer, CPC, CIC,** a coder at NE George Heart Center in Gainesville, Fla.

Payors may question whether the E/M service was truly significant and separately identifiable. Regardless of payor suspicions, you should assign the most accurate codes for all claims. See the section below on modifier 25 to find out what you can do to help these claims succeed.

Pitfall #2: If, at the time of the stress test, the physician merely reviews the patient's current status for the sole purpose of verifying that the patient is physically stable to undergo the stress test, you should consider that review as part of the test and not report a separate office visit.

4) Weigh in on Modifier 25

Question: In the situation above, should I attach modifier 25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or other service) to the significant and separately identifiable E/M service code when my physician performs a stress test during the same visit?

Warning: -I-ve noticed much misuse of modifier 25 to get the office visit paid when the documentation may not clearly indicate the cardiologist needed to perform it,- Anderson says. Therefore, you-ve got to be extra vigilant when reviewing your physician's documentation and knowing what your payor truly requires.

Based on current CMS guidelines, you do not need to attach modifier 25 when your physician provides a separate E/M service on the same date as a stress test. In 2006, CMS released Transmittal 954, which instructs you to use modifier 25 only when your cardiologist provides a significant and separately identifiable E/M service on the same day as a procedure that has a global period. (Resource: For the exact language, go to

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www.cms.hhs.gov/transmittals/downloads/R954CP.pdf to read the full transmittal.)

The codes associated with stress tests (93015-93018), however, have a global-day indicator of -XXX,- which means that the global-period concept does not apply.

Alert: But you may find that many payors--including Medicare carriers--routinely and inappropriately deny claims without modifier 25 appended to the E/M code. Consequently, you may need to use the modifier, Anderson says.

Note: The guideline that instructs you to append modifier 25 only when coding procedures with a global period is Medicare-specific. So you should check with your carriers to learn if they want you to append modifier 25 to your separate E/M service code on the same day as a stress test.

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