Part B Insider (Multispecialty) Coding Alert

PART B CODING COACH :Maximize E/M Payment for Hepatitis Patients With Accurate MDM

Follow these 4 tips and learn how to make the most out of initial visit claims through diagnosis and follow-up.

Diagnosis of hepatitis can be a more drawn-out process than diagnosing other ailments. Check to see if your doctor's E/M documentation is capturing every aspect of the visit.

Fully Document the Initial Visit

The first service you'll report for a potential hepatitis patient may be an initial visit (such as 99201-99205 for new patients) during which your internist will perform an exam to confirm the hepatitis diagnosis.

Most first visits with a potential hepatitis patient involve a higher level of medical decision making (MDM). Your physician evaluates risk factors, orders lab tests, and often provides counseling to the patient. MDM, therefore, can frequently fall into the moderate-complexity range for most patients.

Generally, your physician's properly documented visits would probably fall into the 99203-99204 range, says **Marvel Hammer, RN, CPC, CCS-P, PCS, ACSPM, CHCO,** owner of MJH Consulting in Denver.

As always, the key words here are "properly documented" -- without crystal-clear notes, your coding and reimbursement may suffer.

Example: Your physician sees a new patient who complains of fatigue and weight loss and shows signs of jaundice. After performing a comprehensive history and exam with moderate MDM, your physician diagnoses acute hepatitis C without hepatic coma after lab tests. For this new patient visit, you should claim 99204, Hammer says.

Careful: Be sure you have met all the documentation requirements for an initial visit before billing.

Report Panel When Parts Performed

One often-requested lab test is 80074 (Acute hepatitis panel) for a hepatitis panel. The panel combines several tests, including the hepatitis B surface antigen (87340), hepatitis C antibody (86803), hepatitis B core IgM antibody (86705), and hepatitis A IgM antibody (86709).

The panel includes all the above individual tests. You should bill the panel code when your physician performs all the component codes.

When to order a panel: CMS gives two indications of when your physician may provide a hepatitis panel:

• To detect viral hepatitis infection when there are abnormal liver function test results, with or without signs or symptoms of hepatitis

• Prior to and subsequent to liver transplantation.

CMS regulations also state patients with a negative result may need a repeat panel when the time of exposure or stage of the disease is unknown. (For more information, see the Medicare National Coverage Determinations Manual, Chapter 1, Part 3, Sections 170-190.34.)

Important: After your physician establishes a diagnosis of hepatitis, you may report only individual tests, as necessary,

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rather than the entire panel (80074). In other words, your physician should not repetitively order this test panel for a single patient when monitoring progress or changes after he has identified the initial specific cause of hepatitis.

Free Doc's Time: Employ NPPs for Follow-Up

After your physician confirms a diagnosis of hepatitis, you may be able to call on nonphysician practitioners (NPPs) to handle many follow-up tasks, including adjusting medications, ordering lab tests, and counseling and educating patients.

Using NPPs in this way can free your physician to see other patients, which can then boost your office's bottom line.

Careful: Consider scope-ofpractice rules before assigning services of this type to NPPs.

Different states, facilities, and so on specify different rules for the services NPPs may render, and NPPs may not qualify to provide the above services in all states.

For example: Following scope-of-practice rules, the NPP provides a follow-up visit for a patient diagnosed with hepatitis C several weeks previously. The NPP takes a blood sample, examines the patient, and provides a "current" history. The visit lasts approximately 15 minutes.

In this case, you can report the NPP's services using the appropriate E/M service code; for instance, 99213 (Office or other outpatient visit for the evaluation and management of an established patient ...). Depending on the circumstances, you may report this service either "incident-to" the physician services or using the NPP's provider number. If you report the service as incident-to, be sure you meet all of the Medicare or other payer rules for such services.

Tally Time as Key Component

Early in a hepatitis patient's treatment, your physician might spend time counseling the patient.

In this case, you may be able to rely on time when determining an E/M service level, according to **Marianne Wink, RHIT, CPC, ACS-EM,** with the University of Rochester Medical Center in New York.

CMS states that if counseling and/or coordination of care takes up more than 50 percent of the face-to-face physician/patient encounter -- or floor time in the case of inpatient services -- time can become the key factor in selecting the level of service.

Generally, to bill an E/M code, your internist must complete at least two out of three criteria (history, exam, and medical decision making), applicable to the level of service provided for an established or follow-up patient, or three of three criteria if the visit is the initial service, Wink says. However, your physician may document total time spent with the patient in conjunction with the medical decision making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim and total time is required to bill an E/M as a time based code.

For example: During a 15-minute visit, your physician spends more than 10 minutes discussing treatment outcomes and possible problems of hepatitis.

You may report 99213 (which has a reference time of 15 minutes) for this visit if the documentation is sufficient to support the medical necessity for spending the time.

"Documentation should include discussion such as diagnosis, prognosis, outcomes of treatment, and follow-up plans," Wink says. Simply documenting total time with 50 percent or more in counseling is not sufficient.

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