Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Put The Brakes On High-Level E/M Fraud

A hospital admission waiting to happen may be a green light to 99215

You know the Office of Inspector General watches evaluation and management (E/M) coding carefully, hunting down incorrect claims and overpayments. If you want to keep the auditors off your back, we've got the information you need about when you should--and shouldn't--report high level E/M codes.

Key In On Medical Necessity

When determining a visit's history--problem-focused, expanded problem-focused, detailed or comprehensive--the type of history must be medically necessary based on the encounter. "The extent of the history is dependent upon clinical judgment and on the nature of the presenting problem(s)," explains CPT's E/M guidelines section, "Instructions for Selecting a Level of E/M Service" (page 3, Ingenix 2005 Expert).

Even though a nurse may take the information necessary to support a comprehensive history, the physician's clinical judgment and the patient's problem should determine the amount of history to take and charge for. Consider this before reporting high level E/M codes 99214 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity ...) or 99215 (... a comprehensive history; a comprehensive examination; medical decision making of high complexity ...).

Warning: "Coding too many 99214s and 99215s could trigger an audit, especially if these codes are associated with one minor diagnosis," warns **William H. Ward, MD, IAFP**, associate director of **St. Francis Family Practice Residency Program** in Beech Grove, IN.

Example: A physician sees an otherwise healthy established patient for an earache. In this routine earache scenario, no medical need exists to collect a comprehensive history, says **Daniel S. Fick, MD**, director of risk management and compliance at the **University of Iowa** in Iowa City.

In fact, coding a comprehensive history for such a simple problem could prove unethical, even if your staff has gathered more history than necessary. "Payers and auditors may view such conduct as 'gaming the system'--obtaining a higher-level component than medically necessary just to charge a higher-level E/M service," cautions **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CHBME,** president of CRN Healthcare Solutions in Tinton Falls, N.J.

Best practice: Physicians should "obtain and document the medically necessary history and use that in their coding," Fick says. You shouldn't just code for everything you can collect.

Pinpoint Patient's Problem

You also have to consider medical necessity when determining the E/M service's exam type. CPT's instructions on selecting the exam type echo its history component guidelines. As for history, "the extent of the examination performed is dependent on clinical judgment and on the nature of the presenting problem(s)," state CPT's E/M guidelines.

Translation: A physician's decision to perform a comprehensive exam should stem from the patient's problem(s). Simple problems don't warrant this component level or the physician's time.

Example: A family practitioner (FP) evaluates an established patient with a common cold (460, Acute nasopharyngitis [common cold]) and no comorbidities. "Even if the FP performs and documents a comprehensive exam, no one would

claim it was medically necessary," says **Kent J. Moore**, manager of **Health Care Financing and Delivery Systems** for the **American Academy of Family Physicians** in Leawood, KS.

Other examples that may not warrant a comprehensive exam include an established patient visit for the following:

• recheck for otitis media (such as 382.00, Acute suppurative otitis media without spontaneous rupture of ear drum) or cystitis (for instance, 595.9, Cystitis, unspecified) that is now resolved in an otherwise healthy patient.

• evaluation of a wart (078.10, Viral warts, unspecified) or benign-appearing mole, such as dermal nevus or seborrheic keratosis (702.19, Other seborrheic keratosis), tinea corpora (110.5, Dermatophytosis; of the body), tinea pedis (110.4, ... of foot), etc.

• subconjunctival hemorrhage (372.72, Conjunctival hemorrhage).

Taking a comprehensive exam when the patient's problem doesn't warrant this level isn't customer-friendly. "It subjects the patient to a more extensive exam than necessary," Cobuzzi says. Instead, allow the patient's problem to drive the examination.

Separate MDM And Medical Necessity

To bulletproof your 99215s, stress medical necessity's role in E/M-level selection. "Medical necessity always has to come into play," Cobuzzi says. "You shouldn't code 99215 just because the physician performs and documents two of the three components." The history and exam have to be medically necessary.

Problem: Some coders confuse medical necessity and medical decision-making (MDM). "They're not the same thing," Cobuzzi says.

This myth leads coders to think that MDM must always steer the E/M level. "But you may ethically have a level-five established patient office visit without high-complexity MDM," Cobuzzi says.

Example: You could code 99215 for an established patient who has diabetes (250.xx, Diabetes mellitus) and chronic sinusitis (473.9, Unspecified sinusitis [chronic] . Even though the case may involve only moderate risk and straightforward medical decision-making, medical necessity could justify a high-level service, Cobuzzi says.

Why: The patient has an extensive history with an ongoing problem involving complications.

Future Inpatient Is Typical 99215 Profile

Our family physicians "often describe a 99215 as a hospital admission waiting to happen," Moore says.

Example: A patient presenting with any of the following conditions would clearly justify 99215, says Ward. Diagnoses may include:

• unstable angina (411.1, Intermediate coronary syndrome)

• pulmonary embolism (415.1x, Pulmonary embolism and infarction);

• severe exacerbation of chronic obstructive pulmonary disease (COPD) (491.21, Obstructive chronic bronchitis; with [acute] exacerbation) or asthma (493.x2, Asthma; with [acute] exacerbation);

• pyelonephritis (such as 590.80, Pyelonephritis, unspecified) with comorbidities; and

• transient ischemic attack (TIA) (435.9, Unspecified transient cerebral ischemia).

A patient with one of these conditions, may, however, turn into a hospital inpatient. You could still report 99215 if you

don't submit an initial hospital charge on the same day, Ward says.

Deteriorating Condition(s) May Require Level-5 Components

A patient with four or more chronic illnesses may also warrant 99215. If one of the patient's conditions is deteriorating and requires additional evaluation--even on an outpatient basis--you could be in level-five territory, Ward says. Examples may include the following:

• myotonic dystrophy type 2 (359.2, Myotonic disorders) with chronic renal failure (585.x, Chronic kidney disease, note: code 585 requires a fourth digit--585.x--effective Oct. 1.);

• coronary artery disease (such as 414.9, Chronic ischemic heart disease, unspecified); and

• congestive heart failure (for instance 428.0, Congestive heart failure, unspecified), especially if associated with a complaint such as increased swelling (e.g., 729.81, Swelling of limb) or shortness of breath (786.05, Shortness of breath).

Protect Yourself: Regardless of the diagnosis, remember that good documentation from the physician is essential to justify higher-level E/M coding.