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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: The Experts Weigh In On Chronic Conditions And E/M Levels

Hint: Simply mentioning inactive conditions could lead you down the wrong path

The 1997 documentation guidelines state that if your physician can update the status of at least three chronic or inactive conditions, the documentation would meet the criteria for an extended -history of present illness- (HPI). Get up to speed on how your provider should document these cases--and how you should code them.

Watch Where The Documentation Is

Although some physicians reference the patient's chronic conditions in the assessment section of the medical decision-making (MDM) section, some physicians choose to also discuss the chronic diseases in the HPI section of notes. But is this the best tactic for your group?

The short answer: Many coding consultants discourage physicians from documenting the illnesses in two separate sections unless you specifically address that issue during the visit.

Example: -Very few pain management doctors document the status of chronic conditions outside the diagnoses they are treating,- says **Marvel J. Hammer**, owner of **MJH Consulting** in Denver.

Even if your physician includes the patient's current conditions in the assessment portion of his documentation, he might not include comorbidities that can impact care. -An auditor should not give credit in both key components unless the chronic conditions are specifically addressed in both areas and meet medical necessity for their inclusion,- Hammer adds.

If your physician does address the chronic condition during the visit, be sure he has distinct documentation for HPI and MDM.

Example: The physician typically documents the history in the first part of the visit note following the patient's chief complaint or presenting problem. The history helps the physician determine which aspects of the physical exam are complete, so he can continue the patient assessment and care plan. Documenting these steps helps justify the physician's medical decision-making.

Which Guidelines Are Better For You?

Coding for E/M services can be confusing because of having two sets of accepted guidelines you can follow. Because of this, be sure you know the differences between the 1995 and 1997 versions before determining your best coding route.

1997 advantages: Using the 1997 guidelines may help you report higher-level services for patients who have chronic conditions, such as postlaminectomy syndrome (722.8x), rheumatoid arthritis (714.x, Rheumatoid arthritis and other inflammatory polyarthropathies), complex regional pain syndrome (CRPS) (337.2x, Reflex sympathetic dystrophy; 354.4, Causalgia of upper limb; or 355.71, Causalgia of lower limb) or fibromyalgia (729.1, Myalgia and myositis, unspecified).

Unlike the 1995 version, the 1997 history elements allow a provider to meet an extended level of HPI by meeting either the requirements of the four elements of HPI or the status of three or more chronic conditions. Therefore, the 1997 guidelines may allow you to report a higher-level E/M code for encounters that involve periodic prescription renewals without the pain management specialist having to go into as much detail.

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1995 advantages: -Frequently, auditors find it is easier to meet the criteria for a higher level of the physical exam key component with the 1995 guidelines than using the bullet method with the 1997 guidelines,- Hammer says. -To my know-ledge, there is no difference in the MDM key component between the two guidelines.-

Don't Mix and Match 1995 and 1997 Guidelines

Be careful: You can only use the 1995 or 1997 guidelines individually; you cannot pick and choose aspects from both sets of guidelines to achieve a higher E/M level. Select one set of guidelines (either 1995 or 1997) and stick with it.

Know your carriers: -Some payors have created audit tools that combine the guidelines in certain areas,- says **Suzan Hvizdash**, a coding consultant and physician educator for the department of surgery at the **University of Pittsburgh Medical Center**. -You-ll want to check with your top payors to see what audit tool they use and make certain to stay current with them from time to time.-

Note: Some carriers might not have an -audit tool- in place for you to follow. You should still talk with carriers and understand how they -judge- a provider's documentation during a payor's review.

Put It Into Practice

Consider this example and determine whether you would code following the 1995 or 1997 guidelines:

Mr. Jones has chronic pain due to complex regional pain syndrome (CRPS) type I of the lower extremity (337.22, Reflex sympathetic dystrophy of the lower limb); controlled type II diabetes (250.00, Diabetes mellitus without mention of complication; type II or unspecified type, not stated as uncontrolled); insomnia due to chronic pain (327.01, Insomnia due to medical condition classified elsewhere); and depression (311, Depressive disorder, not elsewhere classified). He presents for a follow-up of his chronic pain and CRPS.

After an appropriate exam, the provider renews Mr. Jones- prescription and notes:

- CRPS, type I--active, stable on current prescriptions
- Diabetes--active, well controlled with diet and oral medications, prescriptions written by primary-care provider
- Sleep disturbance--active, stable on current prescriptions
- Depression--active, well controlled on current prescriptions

Because the physician indicates the status of at least three chronic or inactive conditions, using the 1997 guidelines you may report an ex-tended HPI. When combined with an appropriate review of systems and past, family and social history, the extended HPI may lead to a detailed history key component.

If your doctor performs either a detailed examination or moderate-complexity medical decision-making, you may report the encounter with code 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).

Altered scenario: Even if your physician doesn't note this many conditions during the history and exam, your coding might not change.

-If the provider still performed a detailed exam and a moderate-complexity MDM, then he could still report a 99214 because the -established patient- codes only require meeting two of the three key component requirements to compliantly code the level,- Hammer says.

If your physician doesn't complete a detailed exam and reach moderate-complexity MDM, you would report 99213 for the office visit instead.

Remember: Medical necessity should ultimately drive the visit's history and examination.

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-If the physician does not indicate the status of the patient's conditions, but only mentions that the patient has them, the HPI chronic condition status aspect of the guidelines does not apply,- Hvizdash says.

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