Codify
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Part B Insider (Multispecialty) Coding Alert

PART B MYTHBUSTER: Auditors Review the Op Note -- Not Just Its Title

Plus: Bust this myth about same-day E/M services.

Myth: The title of your physicians medical record is enough to justify the codes you report.

Reality: The physician must document the services he performs in the body of the record or an auditor would assume that he didnt perform the procedures.

For instance: Suppose the subject of the physicians note is Patient Smiths Corticosteroid Knee Injection, but then he only dictates details about the diagnosis and E/M service (not an injection) in the body of his report.

Solution: You can report the E/M service but not the injection.

Explanation: Most coders and auditors do not use the title in their review of the documentation, says **Suzan Berman (Hvizdash), CPC,CEMC, CEDC,** senior manager of coding and compliance with the UPMC departments of surgery and anesthesiology in Pittsburgh.

If it is not indicated in the body of the note, it is presumed that it was something that wound up not happening, Berman says. The body of the note should match the title as closely as possible to all the things done during the service session.

Check Same Day E/M Regs

Myth: Two physicians within the same practice cannot both report codes from CPTs E/M service section on the same date.

Reality: If the physicians are of different specialties, treating different complaints or problems and not doing co-management of the patient,both can report E/M services, says **Barbara J. Cobuzzi, MBA, CPC,CPC-H, CPC-P, CENTC, CHCC,** president of CRN Healthcare Solutions in Tinton Falls, N.J.

Example: A patient sees her primary care provider in your group practice for lumbar instability (724.8,Other symptoms referable to back) and low back pain (724.2, Lumbago) and then sees one of your neurologists for assessment of possible cubital tunnel syndrome.

Since the physicians have different specialties, you may report both services. Assign a diagnosis code for the neurologists service based on what the physician finds or the patients symptoms if no definitive diagnosis is established --for instance, 354.2 (Lesion of ulnar nerve) or 782.0 (Disturbance of skin sensation).

You may need to add modifier 25 (Significant, separately identifiable E/M by the same physician on the same day as the procedure or other service) to the E/M service with the lower RVUs if your payer denies the second E/M as included in the first, Cobuzzi says. Recode the service with modifier 25 on the second E/M and appeal the denial. Explain that two separate specialists treated the patient for different problems as exhibited by the different diagnoses and the attached notes.

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