Part B Insider (Multispecialty) Coding Alert

Part B Mythbuster: No 'Standard' Code Applies to Specialty E/M Services

Select the appropriate code based on the documentation--not the specialty or diagnosis.

When it comes to a joint injection or a chest x-ray, you may know the standard codes for each service by heart. When you're evaluating codes for an E/M service, however, the issue isn't so clear-cut.

Consider this question submitted to the Insider from a subscriber: "Which code should we report for evaluation of knee pain? We can't decide whether it should be 99212 or 99213."

This question supports a common myth--that each type of diagnosis has a standard E/M code associated with it. However, your E/M code should be based upon what the documentation supports, which can differ greatly even with the same diagnosis. A knee pain patient may have many other chronic conditions, taking the complexity quite high--or he may have simply bruised his knee, which could be lower.

Consider these two examples of knee pain visits that qualified for 99212 and 99213 so you can see the differences between the two:

99212: The patient is a non-smoking, retired 66-year-old woman who returns today for evaluation of chronic right knee pain. She previously had ACL surgery on this knee and it didn't bother her for several years but the pain returned last year and she is complaining of discomfort mainly over the medial femoral condyle. The area is tender to palpation, but the rest of the knee exam is unremarkable. I offered her a cortisone injection but she wants to delay it after talking it over with her son. I advised her to take Naproxen on an as-needed basis and suggested she should begin taking glucosamine. She will return on an as-needed basis or in six months.

99213: This 66 year-old retired male is here for follow-up consultation of right knee pain stemming from osteoarthritis. He is doing well since his last evaluation and his knee feels 50 percent better than it did at his last visit. Pain severity is a 5 on the 0 to 10 scale. Quality is dull, pain is intermittent but does not awaken him from sleep or keep him from driving. He mostly feels the pain when he is taking long walks, and since he is a docent at the museum, he is on his feet quite a bit. However, he no longer kneels in the garden, which had exacerbated his pain. Acetaminophen has helped, as has ice.

ROS: A complete and detailed interval history including review of 12 systems, past medical history, recent hospitalizations, and social history were performed by me and recorded in the patient questionnaire included in this chart.

Physical exam: Well-oriented male who answers questions normally. Mood, orientation, and gait are normal, knee alignment normal bilaterally. He has a slightly diminished ability to move his knee to the right and left but has no trouble extending it. Range of motion of right knee is appx. 85 percent, left knee is appx. 95 percent. No instability, normal sensations. Skin has no ulcerations and is normal temperature. No swelling or discoloration.

Impression: The patient has improved since our last visit. No further local care to the knee is required other than meloxicam on an as-needed basis, which I prescribed today and advised him to take on the days he will be walking extensively for his job. I gave him instructions regarding exercises and will see him back in three months to ensure that he is better.

Look at Your E/M Coding

Going forward, review your physicians' coding choices to confirm that they aren't choosing the same level of service for

every claim relating to the same diagnosis. For example, if your doctor primarily sees patients with melanomas and charges 99215 for every visit because melanoma is a high-risk diagnosis, she is coding incorrectly. Some visits may require less documentation and intensity even if the diagnosis is complex, while others might require more than expected, depending on the patient's other conditions.

The bottom line: The answer to which E/M code to report lies in the documentation, and nowhere else.