# Part B Insider (Multispecialty) Coding Alert

## PART B REVENUE BOOSTER: 3 FAQs Help You Get a Handle on Your E/M Claims

**E/M claims are the #1 billed codes to Medicare, but some practices are billing them incorrectly**

It's never too late to button up your E/M coding skills.

Last week-s Insider article, -CMS Reminds Practices That Observation Codes Differ Greatly- got people talking, and spurred our readers to send us their E/M coding questions in droves. If you feel like your E/M coding could use a tune-up, we-ve got just what the doctor ordered, with the answers to three E/M questions submitted by our readers.

**What Happens When Attending Isn't Available?**

**Question:** Dr. Jones admits a patient to the hospital, and three days later, the patient is ready to be discharged, but Dr. Jones isn't available. My understanding is that Medicare allows only the admitting physician to bill a discharge for the patient. So in this situation, how can we get paid for the discharge (99238-99239) since a different member of our practice performed it?

**Answer:** Go ahead and bill that discharge service.

Because the physicians are all members of the same group, any of them can perform the discharge, says **Suzan Berman-Hvizdash, CPC, CPC-EMS, CPC-EDS,** physician educator with the **UPMC-Department of Surgery** in Pittsburgh. -In a teaching setting, the resident, fellow or physician extender of the group- often performs the discharge, she says.

**Should We Report Entire First Visit With New Patient Codes?**

**Question:** How should we report a new patient visit during which the patient comes in for a physical and also to address chronic diagnoses?

**Example:** A patient new to the area makes an appointment with the physician for a yearly physical and to discuss chronic diagnoses of asthma and depression. The physician performs the preventive medicine service and has a long discussion with the patient regarding the chronic diagnoses. The documentation supports the physical code and also has enough stand-alone documentation to bill an E/M with the visit. Should I bill a new patient physical with the appropriate-level new patient E/M? Or should I bill a new patient physical with the appropriate-level established patient E/M?

**Answer:** The patient remains new throughout the initial encounter. So the physician should code such encounters with:

- 99381-99387 (Initial comprehensive preventive medicine evaluation and management of an individual -)

- 99201-99205 (Office or other outpatient visit for the evaluation and management of a new patient -) appended with modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) if you have separate documentation that supports both services.

Many practices were actually coding the preventive medicine services as new (99381-99387) and the office visits as established (99212-99215 with modifier 25) until CPT Assistant clarified the issue.

In the October 2006 CPT Assistant-s Q&A, the AMA confirmed that if a physician provides a preventive medicine service

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and an office or other outpatient service during the same patient encounter, you can appropriately report both services as new patient codes if the patient meets CPT's definition of a new patient as one -who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.-

Therefore, you should consider the patient's status for the encounter, not for the individual portions of the overall encounter.

**How Do I Bill Hospice Consults?**

**Question:** If a physician visits a patient in the hospice and performs a consult, does the physician report a normal consult code (such as 99241) or does he report G0337?

**Answer:** In this situation, G0337 (Hospice evaluation and counseling services, pre-election) is probably not the correct code -because this evaluation is to determine if the patient would like to be placed in hospice,- says **Kevin Solinsky, CPC, CPC-I, CPC-ED**, with **Healthcare Coding Consultants, LLC** in Gilbert, Ariz. -G0337 specifically reads, -hospice evaluation and counseling services, pre-election,-- which means you should bill it before the patient decides to enter into a hospice program, Solinsky advises.

In addition, always remember the -three R-s- of billing consults, even in the hospice setting. You need to document -the consult request, rendering of the consult and replying back to the requesting provider in writing,- Solinsky says.

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