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Part B Insider (Multispecialty) Coding Alert

Part B Revenue Booster: Document Counseling and Coexisting Conditions to Justify E/M Level

Show physicians how to thoroughly document all diagnoses addressed to ensure complete documentation.

If your physician sees a large number of patients who have complex cases with multiple diagnoses, selecting an appropriate E/M level might be a challenge. However, once you take the coexisting conditions and the amount of time spent counseling the patient into account, you should be able to see the whole picture--and you may justify selecting a higher E/M level than you thought.

The key? Show your physicians how to thoroughly document every condition they evaluate, and not just the presenting complaint.

Checking for Coexisting Conditions

As physicians know, coexisting conditions may not be immediately apparent and often are discovered during the history-taking component of the initial patient encounter. The information about coexisting conditions may come from the patient, the patient's family, or previous medical documentation.

Within the entire history component of an E/M visit, there is usually a chief complaint, history of the present illness, review of body systems or areas, and a past/family/social history. A variety of coexisting conditions, such as malignant hypertension (401.0), insulin dependent diabetes (250.01), congestive heart failure (428.0), or respiratory cardiovascular problems, can be discovered during the review of systems portion of the doctor's history-taking. The complexity and number of coexisting conditions uncovered during the history may dictate how detailed an examination she will need to perform.

The physician may choose the appropriate E/M level to bill for the visit in one of two ways. First, she can review the documented history that was taken from the patient and family, the exam that was performed on the patient, and the medical decision-making that was needed for this patient. The code may then be assigned based on the severity of the patient's complaint and the complexity of the key factors: history-taking, examination, medical necessity, and level of medical decision-making. Alternatively, the physician may choose to code by time, but only if more than 50 percent of the total visit was spent on counseling and coordination of care for the patient.

Watch the Clock for Coding Based on Time

"Counseling" is one of the key components used in defining the levels of E/M services. Counseling is a discussion with a patient and/or family concerning one or more of the following areas: diagnostic results, impressions and/or recommended diagnostic studies; prognosis; risks and benefits of management options; instructions for management and/or follow-up; importance of compliance with chosen management options; risk factor reduction; and patient and family education.

For example, a 67-year-old male with underlying hypertension, COPD, and diabetes presents with an extremely stiff neck (723.1), intermittent pain (729.5), numbness down his left arm (782.0), and muscle spasms in his upper right shoulder (728.85). If the physician meets with the patient for 30 minutes, the visit can be coded as a 99203 (Office or other outpatient visit for the evaluation and management of a new patient that requires a detailed history and examination and medical decision-making of low complexity) rather than a 99202 (office or other outpatient visit for the evaluation and management of a new patient that requires an expanded problem focused and examination and straightforward medical decision-making), provided that more than 50 percent of that time was spent in counseling. The physician would need to document what issues were discussed in counseling, such as possible treatments, recommendations for exercise

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regimens, additional testing needed, prognosis, etc. He or she also should note the time spent in counseling and the total time spent on examination to clearly show in the medical record that this requirement has been met.

Keep in mind: Good medical recordkeeping requires that you document all the pertinent pieces of information. Just because you bill by time does not replace documenting history, exam and plan as appropriate. All pertinent medical information needs to be included in the note.

Encourage Thorough Documentation

If your doctor tells you that she addressed several conditions but only documented the chief complaint, you might be forced to bill a lower-level E/M than she actually performed. If this happens, show your doctor how much money she's losing on every such encounter and show her examples of thorough notes so she can more accurately document her report next time.

Example: A 69-year-old male recovering from a pinched nerve (355.9) presents for a follow-up visit to determine whether his course of therapy has been successful. During the visit, he complains of chest pain (786.50), shortness of breath (786.05), pain in the arm (729.5) and chest pressure (786.59). The patient reports he has never experienced these symptoms before. In this case, a level-five established-patient exam (99215) may be warranted whether it is coded by time (40 minutes spent counseling the patient) or the comprehensive level of the history and the exam as well as the high complexity of the medical decision-making, assuming that the physician thoroughly documents her examinations of each system addressed.

With an established patient (99211-99215), the physician will need to document either two out of the three CPT-required E/M components (history, exam and medical decision-making) or that more than 50 percent of the time in the patient encounter was taken up with counseling. The diagnosis, treatment options, and questions from the patient and his or her spouse all factor into the overall time, and the amount of time spent counseling must be documented appropriately. This is especially important with patients who must be referred to other specialists, and you should encourage physicians to document every aspect of each condition she reviews.

Physicians should note that they cannot count the time spent in taking the patient's history or performing an examination as counseling time. The physician must look at the entire patient encounter and decide if the majority of time was spent in counseling and coordination of care, or if the other three components should be the deciding factor when choosing an E/M level. But remember, the medical record must document the time spent.

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