Part B Insider (Multispecialty) Coding Alert

Q&A: Eliminate E/M Coding Confusion With 5 FAQs

Make sure your practice doesn't become an E/M coding error statistic.

You've met all of the incident to requirements and submitted your claim correctly for your non-physician's inpatient services. Why was it denied? The answer may surprise you.

After our E/M coding quiz in the Insider's vol. 13 no. 34 issue, questions poured in from our subscribers asking for more insight into how to correctly bill for E/M services. Today we've got five more answers to help you submit your E/M bills correctly.

Avoid In-Hospital Incident-to's

Question 1: How should we code a mid-level provider's (MLP's) report of an E/M service that she performs on a hospital inpatient? Is incident-to billing allowed for inpatient MLP services?

Answer: Incident-to is not allowed in the hospital at all. The MLP would bill the visit out under his/her own provider number. To Medicare, the reimbursement would be 85 percent of the Physician Fee Schedule.

Check Payer Rules for 99211

Question 2: If a new patient presents for an office visit, sees the nurse but then has to leave suddenly, can we report 99211 for that visit? Also, can we bill 99211 for prothrombin time testing that the nurse performs on an established patient if the patient requires a brief evaluation?

Answer: There is no one complete source for the correct use of 99211. Each payer does its own thing. CPT® hasn't been very helpful either, so some practices avoid using the code. That is a shame because just five encounters a week could add up to about $5,000 a year.

New patients: You'll find code 99211 listed under the established patient office visit codes, so you should not report it for a new patient.

Prothrombin time (PT): Under Medicare rules, you can report 99211 for PT testing if you meet the following requirements:

- Your practitioner provides face-to-face medication management
- Your documentation establishes a need for clinical evaluation and management of significant new symptoms or clearly demonstrating how the relevant lab information was used to modify therapy
- Current medications are listed with notation of compliance, an indication is documented showing the physician/practitioner's evaluation of the labs and recommendation, and the clear identity and credentials of the staff and practitioner are clearly noted.

Only Bill for E/M Services You Actually Performed

Question 3: This is the first year we are considering providing FluMist without a physician visit. Our medical assistants (MAs) will be administering the shot after a questionnaire is filled by the parent. The MAs do not qualify to bill 90460. Should we report 90471 or 90473 for the FluMist? Or should we opt for 99212?

Answer: Your best bet is to report 90473 (Immunization administration by intranasal or oral route; 1 vaccine [single or combination vaccine/toxoid]).

You cannot report 99212 since the medical assistant cannot report that code and no physician saw the patient face-to-face during your visit. If your state law allows it and has communicated that to you in writing, 99211 is an option to report with 90473, since the MA did go over the questionnaire with the patient. Keep in mind that 99211 must be supported by a medically necessary E/M service and will required you to append modifier 25 (you'd bill 90473, 99211-25).

You should report V04.81 (Need for prophylactic vaccination and inoculation against influenza**)** as the diagnosis code.

Avoid Creativity With HPI

Question 4: Can you give me the total number of elements in the HPI example that follows:

70 year-old white male with history of renal colic and abdomen fistula presents with flank (location) pain consistent with prior episodes of renal colic. Patient is a 70 year-old male presenting with kidney stones. Pertinent negatives no chills (associated signs and symptoms), urinary frequency, hematuria, nausea, urgency or vomiting. His past medical history is significant for kidney stones.

Answer: There are two clear HPI elements for location and associated signs and symptoms. You could make an argument for adding severity as implied by the statement "consistent with prior episodes of renal colic," which would yield three elements. If the provider had stated when the pain started or how bad it was, then it would have been easy to get to a extended HPI using location, duration, severity, associated signs and symptoms. Unfortunately, the provider did not mention the onset. This would not make the grade for an extended HPI.

'Supple Neck' Classification Depends on Physician Choice

Question 5: When my physician writes "Neck is supple," should I count the phrase as part of the musculoskeletal exam or the lymph system when tallying the E/M level?

Answer: Supple means "able to bend." So you can always give the physician credit for the phrase "Neck is supple," as range of motion under the musculoskeletal section.

Some doctors may use the phrase to refer to the lymph system. The term "Neck is supple" has also come to mean the physician checked the patient's node and found no swelling, meaning the patient doesn't have enlarged lymph nodes. Not all physicians like using the term this way.

Regardless of which way your practice feels, be careful that you don't double-count the phrase. You can use the note under either the musculoskeletal system or the lymph system, but you shouldn't count it under both exams at the same time.

Exception: You can consider the term part of both systems if the note states, "The neck is supple without adenopathy." That means the neck is bendable and the nodes aren't swollen.

Communication is key: Discuss this as a practice. Ask the practitioners what they are looking for and what they specifically mean when they refer to the neck as supple.