Part B Insider (Multispecialty) Coding Alert

Quick Quiz Answers: Evaluate Your Own E/M Coding Skills With 3 Test Answers

See where you should focus your E/M education.

Answer 1: Yes. Based on E/M guidelines, if a patient's past medical, family and social history (PMFSH) has not changed since a prior visit your physician doesn't have to document the information again. He does, however, need to document that he reviewed the previous information to be sure it's updated and also note in the present encounter's documentation the date and location of the initial earlier acquisition of the PMFSH. Some payers will give no PMFSH credit if you overlook one of these criteria.

Both the 1995 and 1997 E/M documentation guidelines include the following: "A ROS and/or a PFSH obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information. This may occur when a physician updates his or her own record or in an institutional setting or group practice where many physicians use a common record. The review and update may be documented by:

- describing any new ROS and/or PFSH information or noting there has been no change in the information; and
- noting the date and location of the earlier ROS and/or PFSH."

Answer 2: The answer depends on your practice, your physician, the documentation, and the encounter specifics. You can choose whichever set of guidelines is most advantageous for each encounter, explains **Suzan Berman, CPC, CEMC, CEDC,** Senior Director of Physician Services at Healthcare Revenue Assurance Associates based out of Plantation, Florida.

The key, however, is that you have to use either 1995 or 1997 guidelines for a single encounter. "Typically the 1995 documentation guidelines are going to be more advantageous for most practices," says **Marcella Bucknam, CPC, CPC-I, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC,** audit manager for CHAN Healthcare in Vancouver, Wash. "This is because they are more flexible and also because they reflect the way most physicians were taught to document. However, some physicians may have been taught or may have developed good documentation practices around the 1997 guidelines, and this may be advantageous to them."

Answer 3: Medical necessity should always be the overarching factor used to select the E/M service level. Just because a physician completes a comprehensive history and examination doesn't always mean he should report a level-five code. Medical necessity should always drive the components that he performs. Practices that try to exploit this loophole could be severely miscoding E/M levels.

This mindset is particularly worrisome with the implementation of EHR systems, which often automatically code encounters without regard to medical necessity. It is very easy to document high levels of history and exams, particularly for established patients, which will result in level four and five services when the medical necessity may dictate only level two or three services. This constitutes "electronic upcoding," which is defensible based on history and physical key elements, but indefensible and inconsistent with medical necessity for the service provided.

Caution: Remember that medical decision making is not the same as medical necessity. "The patient may be told to go home with no further treatment, but that doesn't negate all the decision-making that went into that determination," Berman warns. "Thus, the two are not the same. MDM does not have to be one of the two elements in determining the established patient."

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