Eli's Rehab Report

Coding E/M Levels: Note Counseling and Coexisting Conditions to Optimize Pay Up

Choosing the appropriate evaluation and management (E/M) service level is always challenging. **Barbara Cobuzzi, MBA, CPC, CHBME,** president of Cash Flow Solutions, a physician reimbursement consulting firm in Lakewood, N.J., says that a variety of coexisting conditions may accompany a patients presenting complaint. When coexisting conditions and the amount of time spent counseling the patient with or without the family present are not taken into account, physical medicine and rehabilitation (PM&R) practices may erroneously charge for a lower evaluation and management (E/M) level than it should.

Checking for Coexisting Conditions

As physiatrists 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 patients 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. **Catherine A. Brink, CMM, CPC,** president of Healthcare Resource Management Inc., a practice management and reimbursement consulting firm in Spring Lake, N.J., says that 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 doctors history-taking. The complexity and number of coexisting conditions uncovered during the history may dictate how detailed an examination he or she will need to perform, she reports.

The physiatrist may choose the appropriate E/M level to bill for the visit in one of two ways. First, he or 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 patients complaint and the complexity of the aforementioned three key factors: history-taking, examination and level of medical decision-making. Alternatively, the physiatrist 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. These two coding options are outlined in the Evaluation and Management Services Guidelines section of CPT Codes 2000.

Coding for Time

Patricia Niccoli, HBMA, president of ElectroAge Billing, a physician billing service in Phoenix, says that 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 treatment options; instructions for treatment and/or follow-up; importance of compliance with chosen treatment options; risk factor reduction; and patient and family education.

For example, a 14-year-old male 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 physiatrist 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 physiatrist would need to document what issues

were discussed in counseling, such as possible treatments, recommendations for exercise regimens, additional testing needed, prognosis, etc. He or she also should note the time spent in counseling and that spent for examination to clearly show in the medical record that this requirement has been met.

Catherine G. Fischer, CPA, reimbursement policy advisor for the Marshfield Clinic, a 650-physician group regional healthcare system in Marshfield, Wis., says, 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.

Coding for Established Patients

A 60-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.

With an established patient (99211-99215), the physiatrist 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.

Time spent in counseling is a variable that can create the entire level of E/M service, states Fischer. Provided that time spent in counseling is the majority of the service, it well may override all other considerations.

Physiatrists should note that they cannot count the time spent in taking the patients history or performing an examination as counseling time. The physiatrist 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.

With appropriate documentation, whichever method gets you to the appropriate higher level is what you should use, says Fischer.