Eli's Rehab Report

Want to Report 99205? Read This First

Many PM&R practices are stuck reporting low-level new patient E/M codes even though they've performed higher-level services. The reason? Some physicians don't appropriately document the patient's history and cannot justify reporting a higher-level E/M code. If the physiatrist spends just a few extra minutes on his or her new patient documentation, you may be able to report higher-level codes and increase your practice's reimbursement.

Physiatrists often see new patients who have serious conditions, such as stroke, traumatic brain injury and spinal cord injury. These patients may require high-complexity medical decision-making, which, when combined with a comprehensive exam and a comprehensive history, could warrant reporting 99205 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components: a comprehensive history, a comprehensive examination, and medical decision-making of high complexity).

Suppose your physiatrist performs a comprehensive history, comprehensive examination and high-complexity medical decision-making (MDM) on a new patient. She documents the comprehensive exam and high-complexity MDM, but only documents a detailed history. What your practice could have billed as a 99205 (netting about $180) is now a 99203 (netting only about $100). Had she spent about five more minutes thoroughly documenting the comprehensive history, your practice could have collected an additional $80.

Note the Four Levels of History

Medicare and CPT both recognize four levels of history for an E/M service: problem-focused, expanded problem-focused, detailed, and comprehensive. See the chart on page 77 to determine which history level the physician's documentation warrants.

The chief complaint and related history of present illness (HPI) tend to be the areas where physiatrists document the most. The patient intake form usually covers the review of systems (ROS) and past, family and social history (PFSH). The patient usually completes this form on his own or with a nurse's help.

Differentiate Between HPI and Complaint

The chief complaint is a concise statement explaining why the patient is in the physician's office, says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS**, director and senior instructor for the CRN Institute, an online coding certification training center. "All E/M services need a reason for the visit, which will be found in the chief complaint."

The HPI is a more thorough description of the patient's chief complaint, Jandroep says. It may include one or more of the following eight elements: location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms.

A very brief sentence can convey several of these elements at once. A patient who complains of sharp pain (quality) in his lumbar spine (location), which occurs after bending (context) and has been happening for the past six weeks (duration), has already given you an extended HPI because it includes four elements.

Two Elements Make It 'Brief'

If the physiatrist merely documents lumbar pain that started six weeks ago, however, he qualifies for only two elements, reducing the HPI to "brief." Because you need to document an extended HPI to report codes 99203, 99204 and 99205, you would have to report 99201 or 99202 based on your documentation of only two elements for this visit.

Note System Review Elements

The ROS consists of the positive and negative responses the patient gives to a series of questions designed to inventory the systems of the body. Most of the time, it is part of the patient intake form, says **Gina Collins**, billing supervisor for three PM&R coders at Northeast Billing in Hartford, Conn.

Medicare and CPT define the elements of a system review as constitutional (general appearance, weight loss, etc.); eyes; ears, nose, mouth and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; integumentary (skin and/or breast); neurological; psychiatric; endocrine; hematologic/lymphatic; and allergic/immunologic.

Use the Patient Intake Form As a Guide

Because the patient intake form is an effective guide to document the ROS, physiatrists can usually quickly review the 10 systems needed for the comprehensive ROS. To indicate that he performed an ROS, however, the physiatrist should note his review of the form in the patient's medical record and note any significant findings, and initial and date the patient information form.

The final aspect of the history is the PFSH, which is a review of the patient's experience with illnesses, injuries and treatments as well as age-appropriate questions about past and current activities (marital status, occupation, and use of drugs, alcohol and tobacco). The patient probably answered many of these questions on the patient information form. Again, the physiatrist should indicate in both the patient's record and the patient information form that this area was discussed during the visit.

ROS and PFSH Carry Forward

During a subsequent visit, if the patient has no significant changes, Medicare payers allow physicians to carry the PFSH and ROS forward from the initial visit. The physiatrist should write "no change" on the patient information form, sign and date it, and make a similar notation in the patient's medical record, Collins says.