Psychiatry Coding & Reimbursement Alert

E/M Coding: Watch These 4 E/M Coding Dos and Don'ts for Reporting Success

Benefit from using auditing tools when in doubt.

When you are reporting an E/M service, you should not get into the habit of automatically reporting the same E/M code for every encounter. You might end up raising red flags and land in trouble if you do so.

Use these four dos and don'ts to get on top of your E/M coding every time.

Tip 1: Don't Report Same E/M Code for Every Encounter

When your clinician performs an E/M service, if you are reporting the same E/M code (such as 99213, Office or other outpatient visit for the evaluation and management of an established patient...) each time, you are bound to be raising red flags. Do not invite trouble by reporting each and every E/M encounter with the same code.

Although when coding E/M services for your clinician, you might feel that each of these E/M encounters is to be reported by the same E/M code, you should still not go for that code every time your psychiatrist performs an E/M service unless the medical record supports doing so. Rather than just reporting one particular E/M code for every E/M service performed by your clinician, you should properly scour patient documentation and tally all the components and then finalize on the apt E/M code to report for that particular encounter.

"It would be a very rare situation in which the history, exam, and medical decision making of every patient seen by a psychiatrist led to the same E/M code," says **Kent Moore**, senior strategist for physician payment at the American Academy of Family Physicians. "Patients present with a variety of chief complaints and comorbid conditions, so a review of the documentation should generally reveal some variation in the level of service provided to different patients."

Even though going through documentation to identify the most appropriate code will involve you spending more time, you will be reporting the right code for each encounter and not raise any red flags that could result in an audit that could cost you dearly.

Tip 2: Don't Forget to Count All Components

When your psychiatrist performs an E/M service, you may need to go through patient chart notes to check if your clinician has covered all the components of history, examination, and medical decision making (MDM).

If your psychiatrist misses out on documenting the components properly, you will be forced to report a lower level E/M code even though the actual E/M service was a higher level E/M. "As the old adage goes, 'If it wasn't documented, it didn't happen,'" Moore notes.

When documenting history, you need to ascertain if your clinician has recorded all the elements of history that will help you report a particular level of E/M. The elements of history include history of present illness, review of systems (ROS), and past, family, and social history (PFSH).

When recording history of present illness (HPI), if your clinician documents one to three elements, it points to a brief HPI that can support 99213 while you may be able to report a higher level E/M such as 99214 if your clinician records four or more elements or an extended HPI. Code "99213 requires 1-3 HPI elements and the 99214 requires 4 or more if the history is going to be counted toward the service level," says **Suzan (Berman) Hauptman, MPM, CPC, CEMC, CEDC**, senior principal of ACE Med, a medical auditing, coding and education organization in Pittsburgh, Pa.

When it comes to PFSH, if your psychiatrist does not add notes in the PFSH or if he is failing to note no changes (with a

note that says "PFSH not changed from previous visit"), you might be forced to reach for a lower level E/M code. If your clinician does not document "no changes" in the chart notes, you should make your clinician aware that such lapses in the documentation might result in choosing a lower level E/M code.

Again, when checking on the review of systems, you will need to observe the number of systems that your psychiatrist reviewed as this will also help you in deciding the level of E/M code to report for the encounter. "The clinician should review the number of systems applicable to the current condition," Hauptman adds. "If billing a 99213, the ROS must include at least one system. When a 99214 is billed and the history is one of the two key components used toward the service level, at least 2 systems must be reviewed."

When you are looking at the medical decision making aspect, you need to look for the following components within the documentation:

- number of diagnoses and management options
- amount and/or complexity of the data reviewed
- risk of complications and/or morbidity or mortality.

Looking for these elements of MDM will give an idea about the level of MDM as well as point towards the E/M code that you will need to report for the encounter. "Medical Decision-Making reflects the intensity of the cognitive labor performed by the physician," says **Mary I. Falbo, MBA, CPC,** CEO of Millennium Healthcare Consulting, Inc. in Lansdale, PA. "The official rules for interpreting the MDM are identical for both the 1995 and 1997 E/M guidelines." The MDM elements will point towards severity of the problem the patient is having (e.g., self-limited/minor, low, moderate or high), and will also guide you to the level of E/M it supports.

"With established patients, only 2 of the 3 key components are required. Thus, if the MDM is one of them, then in order to bill a 99213 there must be 2 points in diagnoses/management options, 2 points in data, and a low risk," Hauptman says. If one of these is higher or lower, the level would be decided based on the other two. The same would be said for the 99214. Here, 3 points for diagnoses/management options is necessary as is 3 points for data. The level of risk is moderate.

Tip 3: Do Report E/M Based on Time in Select Opportunities

Even though you will mostly choose the E/M code for an encounter based on the components of history, examination, and medical decision making, you can select an E/M code based on time in some situations.

If your psychiatrist is performing the E/M service along with same day psychotherapy, then you have to report the E/M service only on the basis of the components of history, examination, and medical decision making. When your clinician performs an E/M service with psychotherapy, you cannot select the E/M code based on time.

However, if your clinician performs a standalone E/M service, then you should look for opportunities when you can select the E/M code on the basis of time. You use time as the basis for selection of the level of the E/M code when more than 50% the face-to-face time (in the case of an office visit) is spent on counseling and coordination of care. CPT®'s E/M guidelines state, "The extent of counseling and/or coordination of care must be documented in the medical record." Medicare's 1995 and 1997 E/M documentation guidelines add that the physician should document the total length of the encounter and "describe the counseling and/or activities to coordinate care" in these situations.

So, if your clinician spends about 15 minutes (total duration of the encounter was 25 minutes) discussing test results with the patient, you could report 99214 for the visit based on time. The reason is that more than 50 percent of the time was spent in coordination of care, and 25 minutes is the typical time associated with 99214 in CPT®.

Tip 4: Do Incorporate an Auditing Tool as Your Safe Bet

You might come across situations where you feel that you need to report a high level E/M code but still settle down for a lower level E/M code, because you aren't too sure if the higher level code is justified or not. If your use of a higher code is justified, you might end up losing out on ethical pay and thus cause unnecessary losses to your practice by choosing the lower level code.

To prevent the possibility of running into such circumstances, you could look to alternatives like using an auditing tool.

"An auditing tool is helpful, but knowledge of auditing is important to understand what diagnoses codes are included in the overall MDM; particularly in the outpatient setting," Falbo says. "The auditor needs to have knowledge and experience in how to apply the tool."

There are several options available to you if you are looking out for auditing tools. You might even find some useful auditing tools online. "An audit tool is a must for helping to select the best level of service for the documentation written," Hauptman adds. You too can use these tools to your advantage thus avoiding unnecessary losses that your practice might otherwise suffer.