Codify
BY AAPC

Psychiatry Coding & Reimbursement Alert

Reader Question: Account for Medical Necessity in E/M Code Selection

Question: Our psychiatrist is a very thorough documenter. Because he documents his EMR so well, almost all of his cases qualify for 99214s and 99215s. Since the documentation supports his code selections, is this acceptable?

Nevada Subscriber

Answer: The answer depends on the medical necessity of the encounters. Your electronic health record will most likely offer an E/M code suggestion at the end of each visit--but that doesn't mean you can use that to justify all high-level codes.

Several practices state that their physicians "thoroughly document" the history and physical exam elements for all conditions, leading to high-level codes, even if the medical decision-making (MDM) doesn't support 99214 or 99215. They justify this by pointing out that established patient office visits only require two out of three criteria (history, exam, medical decision making).

Reality: CMS indicates in its Claims ProcessingManual (Section 30.6.1.A of Chapter 12) that "Medical necessity is the overarching criterion for payment in addition to the individual requirements of a CPT® code." In addition, both the 1995 and 1997 E/M Documentation Guidelines state, "The documentation of each patient encounter should include: reason for the encounter and **relevant** history, physical examination findings and prior diagnostic test results."

If your patient has a runny nose and you're documenting a complete neurological exam, Medicare would not consider that "relevant." Therefore, you should use your EHR's code selection as a suggestion, but the final code choice should be up to the clinician, and should be based on medical necessity and the nature of the presenting problem as well as the key components (history, exam, and medical decision making) of the encounter.

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