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Internal Medicine Coding Alert

Three Key Tips for Avoiding "Illegal" 99215's

Many physicians still have a difficult time understanding why preventive-medicine visits cannot be billed as office/outpatient visits, and at a high level, when they have a patient with several chronic health conditions, says **Susan Stradley, CPC,** senior coding consultant with the accounting firm of Elliott, Davis, and Co., in Augusta, GA.

You will see physicians who have dictated a beautiful note, covered all of the documentation requirements for the different body systems and areas, and they want to bill a high-level code because they have satisfied the documentation guidelines, she says. But, the fact remains that if the patient is not having significant problems, then this is a preventive medicine visit.

The physician may have documented the exam components, but the reason for the visit will not support the medical necessity required for a high-level office/outpatient visit code.

If your history and your note indicate that the patient is having no problems and there is maybe a two-line history of hypertension, then you cant bill that as if it were a problem-focused visit, Stradley explains.

1. Check the history on the patient chart. If a coder receives a superbill from the physician that indicates a 99214 or 99215, but the chart does not indicate a chief complaint or a history that indicates a problem, then that should be a red flag that this is probably a preventive-medicine visit, says Stradley.

No history in the chart is a sure sign that this was a preventive service, she says. For example, there is no documentation on history of present illness (HPI) because there is no present illness.

Once, Stradley saw a chart that was coded to a 99215, but the entire note for the history said, New patient came in for physical exam.

To ensure these errors are avoided, **Bonnie Lewis, RN, CPC,** a coding advisor to the Idaho State Medical Association, tells physicians to be as specific as possible when stating the reason for the visit and the chief complaint.

2. Discourage physicians from use of the generic term annual physical. You want to get them away from just using the phrase, annual physical because that can be misleading, she says. If the patient came in for a physical and then had other problems, they should state patient is here for evaluation of multiple medical problems.

Even better is to state the problems specifically, she continues, such as, patient is here for an annual physical and for an evaluation of hypertension and diabetes.
Auditors may rely heavily on the chief complaint and HPI when reviewing a chart, says Lewis.

I know one Medicare auditor who told me that if she gets confused reading a chart, then she just goes right back to the top to look at the chief complaint and HPI, she explains. If it says the patient is here for an annual physical then that answers the question of medical necessity [for the code assigned].

3. Make sure documentation supports two CPT codes. In addition, the physician must be specific about documenting the history, exam and medical decision-making necessary for evaluating the patients additional problems, says Lewis.

One way to ensure that both a preventive service and problem-focused visit level are supported is to have two separate notes, contends Stradley. Most consultants will tell you, if you have a significant problem that comes up during a

preventive-medicine visit, write a separate portion of the note. You do see notes written that way, preventive-medicine portion that list the services performed, and then say something like ear infection, and document the history, exam and medical decision-making for that portion separately.

That way there is no doubt about how the codes were assigned.