Codify
BY AAPC

Pain Management Coding Alert

E/M Coding: Follow This Advice to Choose the Best E/M Level

Hint: Check for patterns of reporting highest codes in a range.

Some errors tend plague even the most veteran coders, especially when you're reporting office visits and E/M services. One common pitfall for coders and red flag for insurers is misreporting the level of E/M code. Read on for tips to ensure you aren't over- or under-coding your provider's services.

Don't Assume Higher Level

Some providers feel that they should always bill the highest level of service, such as 99205 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity ...) or 99215 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity ...) for the work they perform. If the notes don't support the use of the highest level code, however, you cannot bill that code, even if your provider feels that is what he performed.

Example: The physician wrote 99205 in a patient's record for notes that only support an expanded problem focused history and exam with straightforward medical decision making (MDM). Without documented comprehensive history, comprehensive exam, and high complexity medical decision making or appropriate time-based documentation, you cannot report 99205 even if your physician states the patient was very sick and he spent a lot of time with her.

Instead, in this example, you should code 99202 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; straightforward medical decision making ...), which is what the notes support. Speak to your physician to explain why you have to code at a lower level to give him the opportunity to improve his notes next time.

Watch for Reporting Patterns

Be on the lookout for physicians who code high on a regular basis. In the May 2014 release of the OEI-04-10-00181, the Office of Inspector General (OIG) reported that "physicians increased their billing of higher level codes, which yield higher payment amounts, for E/M services in all visit types from 2001 to 2010." That means OIG, CMS, and other payers are carefully scrutinizing your high-level E/M claims to see if they are really supported.

Tip: If you see a pattern of only the highest code level being reported by your physician, talk to your physician. Explain to him that if his notes don't support the highest codes in a code range, you code only what is documented and that the components that he provides are what come together for you to reach a level of service.

"Most providers need to understand the components that are in place for determining what constitutes a higher level visit," says Sharon A. Morehouse, MPA, IA, owner of Beyond Basics Medical Billing Service, LLC of Honeoye Falls, N.Y. "It is the coder's responsibility to bring this to the provider's attention, particularly if there is a large volume of these services being billed on a given day." It's not to say that your provider doesn't see complicated patients, perhaps it's just that the documentation must support the high level care code.

Know When Time Justifies Codes

If your provider's documentation doesn't meet the proper history, exam, or MDM levels for the high-level code he is reporting, check to see if he is trying to bill based on time alone. But be careful. You should only code an E/M service based on time alone if at least 50 percent of the visit was spent on counseling or coordination of care, and this fact must

be noted in the documentation.

The documentation must contain the following three elements:

- Notation of the total time spent on the encounter
- Notation of the total time spent on counseling and/or coordination of care or the percentage of the visit spent on counseling/counseling and/or coordination or care (CoC)
- The reason for/topic of the counseling/CoC.