Codify
BY AAPC

Pain Management Coding Alert

Reader Question: Lack of CC Can Cause Coding Confusion

Question: An established 66-year-old patient presented to our provider. She did not state a specific complaint. The physician ordered a basic metabolic panel, venipuncture, a dipstick urinalysis, and a complete blood count with differential. Her results came back showing nothing abnormal. What level evaluation and management (E/M) should I report for this encounter?

Virginia Subscriber

Answer: The level of E/M in this, and any, encounter depends on the history, physical exam, and level of medical decision making (MDM) the provider documents, which is not clear from your question. When none of these things is present in the note for an established patient, the only level of E/M that can be reported is 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal ...) since the descriptor does not reference history, exam, or MDM.

Even then, the note should reflect that some evaluation and management of the patient occurred.

In this case, as you point out, even a chief complaint is missing from the note. A chief complaint is integral to a visit note, and requires a concise statement, usually in the patient's own words, of some symptom, condition, or diagnosis that is the reason for the visit. Without it, there is no justification to bill for an E/M, and even 99211 is probably off the table for this visit.

So, you may only be able to report the laboratory services your practice performed in this particular situation.