Codify
BY AAPC

Pain Management Coding Alert

Reader Question: Provider Can Complete Established E/M Without Exam

Question: I have newly joined pain management coding. Recently, when reporting an E/M encounter for a follow-up patient, I noticed that our physician didn't perform a physical examination for the patient. He did, however, document history and record the patient's vitals. He had also written a detailed treatment plan for the patient. Can I report an E/M code for this encounter, even though our clinician did not perform a physical examination?

Virginia Subscriber

Answer: If you look at the descriptors for "new" patient E/M codes and "established" patient E/M codes, you will notice that established patient E/M codes 99212-99215 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components ...) need only two of the three components of history, examination and medical decision-making, while new patient codes 99201-99205 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components ...) need all three elements to be performed by your clinician.

Since your clinician has recorded history and documented the treatment plan (medical decision-making) and the patient is an established patient, you won't need your clinician to perform a physical examination for you to report an E/M code for the visit.

That said, both the 1995 and 1997 versions of the documentation guidelines for E/M services maintained by the Centers for Medicare and Medicaid Services (CMS) consider recording vital signs to be part of the physical examination.