E&M Coding Tips: Patient Advocacy Center

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Coding E&M services correctly can be an overwhelming task. When a physician is concentrating on the clinical care of the patient he or she does not always take the extra time to focus on the administrative tasks involved with correct documenting of an E&M service and determining the appropriate CPT code.

Compliant physicians understand they must base their selection of the appropriate code on the medical necessity of the patient's presenting problem, the services provided and the documentation. Many physicians find this to be a daunting task and one that requires a great deal of time pouring over the note and calculating the correct level of documented history, exam and medical decision making. There are some ways to lessen this burden.

First, it makes clinical sense to obtain and document a comprehensive history on all new or referred patients. Document the reason for the visit (chief complaint) and at least 4 elements of the History of the Present Illness. Then, documentation of at least one element of the patient's past history, Social history, Family history and at least 10 systems are reviewed and documented. This will provide the basis for clinical decision making. Based on the outcome of the history obtained and the nature of the presenting problem, the physician can determine how extensive a physical examination is required. The Complexity of Medical Decision Making will emerge from the comprehensive history and appropriate exam. In this manner it is less difficult for the physician to calculate the documented E&M service and clinical care is optimized for the patient.

After discussing and obtaining answers regarding current and past problems, family history, risk factors, etc., thus, documenting a comprehensive history; the Otolaryngologist must do an appropriate physical exam for the level of medical necessity of the problem(s). The resulting documentation together with the level of medical decision making will provide the necessary criteria for new patients, consultations, emergency room services, and initial hospital care because all three elements of an E&M (Evaluation and Management) are required (History, Exam and Medical Decision Making). For billing and reimbursement purposes, the level of service must be determined with the caveat of medical necessity and the nature of the presenting problem in mind.

Similarly, billing the appropriate CPT code for an established patient visit or follow up hospital care requires performance of (and documentation of) less information. The Otolaryngologist can determine the level of the service based on the higher of the exam or medical decision making for service rendered-again, using the over-riding criteria of the medical necessity required for the patient's presenting problem. If the comprehensive history is updated with relevant changes, there is documentation of the review of the most recent comprehensive history (example: initials and date of today's service on the prior date of service history documentation) then it may continue to support a comprehensive history. With the comprehensive history, the element (exam or medical decision making) which is documented to the higher level, determines the E&M level. This is because only 2 of 3 elements are needed to determine these service levels. It must be understood that the third-party insurance payers insist that regardless of the amount of documentation found in the medical record, the medical necessity of the service must be established to substantiate the level of service billed.

For example, a patient presents for a re-check of a treated maxillary rhinosinusitis. The infection has resolved and there are no other problems or co-morbidities that would necessitate additional medical decision making. There is no medical necessity (for billing purposes) to perform a comprehensive history or examination. Hence, even if there is documentation of a comprehensive history, it will not be billable as a high level of service.

When performing an E&M service together with a procedure, such as a diagnostic nasal endoscopy (31231) on the same day, the physician must keep in mind that the procedure, has a minimal E&M service included in its valuation. In order to justify a payable E&M service with a diagnostic procedure, the physician must document an E&M well beyond the basic E&M associated with the procedure, and code the claim with a -25 modifier associated with the E&M. This informs the payer that the E&M service was "significant and separately identifiable" from that which would be associated with the procedure. When the -25 modifier is utilized, the physician must be able to demonstrate, via the chart note, that the findings of the procedure are not intertwined with the E&M exam (note the definition of "separate") and the elements of the exam for the E&M content are not based on the findings of the diagnostic endoscopy. The exam may indicate that findings cannot be determined and refer to the endoscopy procedure note. Coding and billing for the E&M which includes the exam and the diagnostic procedure could be considered "double dipping".

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Although it is preferred that the diagnostic endoscopic findings be placed on a separate procedure report, it can be placed in the chart note, but it should be physically separate from the E&M documentation, i.e., after that date of service (history, exam and medical decision making) thereby demonstrating the separate nature of the procedure.

In 2007 Otolaryngology will have an overall 5% reduction in Medicare reimbursement. Appropriate E&M coding will be essential to ensure that you receive all the reimbursement you are entitled to for the services you perform. In addition, understanding the documentation and billing requirements are essential to reducing your risk associated with non-compliance with payer regulations and laws.