

Selecting E/M Codes For Established Patients

Getting paid properly requires a thorough knowledge of the rules.

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A new set of Evaluation and Management Guidelines will not appear for use until at least 2005 according to the October 13th 2003 issue of Part B News. The Dec 8th Issue of Part B News reports that the recently passed Medicare Prescription Bill contains certain rules CMS must follow before implementing new E/M guidelines. "Five specific criteria must be met before their implementation:

1. Development must be in collaboration with physicians (primary care and proceduralists) and must allow for an "assessment by the physician community."
2. The new system must have, built-in, a statement of goals/objectives including a timeline for improving the use of the guidelines.
3. The objectives outlined must be met to the satisfaction of the Secretary of Health and Human Services who oversees Medicare.
4. Prior to implementation, pilot tests (see below) must be conducted.
5. Appropriate "outreach" and education must be conducted by CMS prior to the final implementation."

However, all physicians are reminded that until the newest guidelines are in place, physicians are expected to continue to use either the 1995 or the 1997 CMS guidelines to code E/M encounters. The major differences between the two sets of guidelines were that the 1997 guidelines introduced single specialty exams and the counting of exam elements or bullets. E/M services account for a large portion of the Part B Medicare expenditures and audits of these services is on the Office of Inspector General official Workplan for 2004.

99221-5

The CPT 99211-99215 series of codes is used to describe the five levels of intensity for evaluation and management services provided in the office or other outpatient settings for established patients. As a reminder, an established patient is defined by CPT "as one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years."

This article will compare the similarities and contrast the differences between the two most commonly used codes in this series: CPT 99212 and 99213. The following is the distribution of CPT codes 99211-99215 billed to Medicare during 2002 by podiatric physicians during 2002, the most current national data provided by the American Podiatric Medical Association to its members:

Table 1

CPT 99211
CPT 99212
CPT 99213
CPT 99214
CPT 99215

Podiatric Medicine and Surgery

6 %

50 %

42 %

2 %

0 %

E/M Compliance Thoughts

Podiatric physicians should compare the distribution of E/M encounters in their practice to those of their peers. In most cases peers would be all the podiatric physicians in the same state. Peer data may be obtained by one of two methods. First, this information is available on the APMA web site under the "For Members Only" section, and requires simple math to calculate. Secondly, this data may be obtained in a report available by written request from your Medicare Carrier's Freedom of Information Department called the Comparative Performance Report (CPR). The CPR provides the number of times a physician has billed a CPT code to Medicare during a specific period of time and the peer norms for the code during the same period of time.

What if the physician finds that his distribution of CPT codes differs significantly from his peers? Appropriate action does not include immediate panic and systematic down-coding. Instead performing a self-audit or hiring a professional consultant is in order. If the results of the audit demonstrate that each E/M encounter was medically necessary and that the documentation substantiated the service billed, the physician should not change his billing pattern.

While the threats of audits are very real, they should be considered an expected element of the practice of medicine in the twenty-first century. Audits should be viewed in a similar manner to malpractice suits. There is a strong probability that physicians who perform enough surgery will eventually be sued for medical malpractice, and the same probability exists for audits - if a physician practices long enough eventually he probably will be audited. In order to thrive, or even survive in this era of increasing scrutiny and diminishing reimbursement, a prudent physician should not overreact to threats of third-party audits.

Aberrant profiles place physicians at an increased risk of third-party audits, and the onus remains on physicians to prove their innocence by producing medical record documentation that substantiates their pattern of billing. An ongoing written compliance plan to which the practice strictly adheres, may help demonstrate to a third-party that the physician has been serious about complying with billing guidelines. However, there is controversy among healthcare attorneys about whether it is even prudent to develop a formal compliance plan. For more information on compliance, the reader is referred to the Draft Compliance Program For Individual and Small Group Physician Practices document created by the Office of Inspector General and posted on the internet at the following URL: <http://oig.hhs.gov/authorities/docs/physician.pdf>

Believe it or Not

While some physicians might expect that up-coding a 99212 to a 99213 would be a pretty innocent act, consider the following true story. A few years ago I was asked by a colleague to review the findings of his Medicare audit. His Medicare carrier audited his practice because he was aberrant in E/M codes. He was selected for audit because his statistics demonstrated that he billed more level-3 office E/M codes than his peers. The audit consisted of a review of just 20 E/M encounters for 20 different beneficiaries. The carrier's audit was reviewed by a podiatric consultant who found that each and every one of the

level-3 visits billed by this doctor should have been billed as level-2 visits. The carrier found this improper billing resulted in an actual overpayment of just under \$200.00 for the claims reviewed. Wait - the carrier then extrapolated this finding to all the doctor's billings for level-3 office E/M codes over a 6 month period which resulted in a demanded for over \$25,000!

To add insult to injury, this audit was this physician's first one, and he has been practicing podiatry since the early 1960's. At his request, my own review found that 19 of the 20 records unequivocally qualified as level-3 visits and he appealed and won this case. Disturbingly, this is not the first time I have heard of this type of egregious behavior by a carrier. Gestapo tactics and poor quality auditing by carriers must be protested to the highest levels by wrongly accused physicians. I believe all physicians who are practicing medicine deserve to be educated about billing errors and not put out of business the first time they are reviewed. A \$25,000 overpayment seems out of proportion for a first-time audit.

3 Key Components

The three key components in determining an E/M code are the history, exam, and decision-making. CPT codes 99212-99215 require that only two of the three key components meet or exceed the level of code that is chosen. An alternative method of coding - "by time " - will be reviewed toward the end of this article.

It is somewhat surprising to me that in 2002 Medicare Part B data continues to show that podiatrists continue to bill a fair number of CPT code 99211. A 99211 is described in the AMA CPT 2004 as an E/M service that may not require the presence of a physician. The presenting problem is usually minimal and typically 5 minutes is spent performing or supervising these services. There is no specific documentation requirements described for CPT 99211 in regard to the level of history, exam, or decision-making, which is expected. In my opinion, and those of my fellow reviewers, when a patient encounter is medically necessary and the physician personally examines and treats the patient a CPT 99211 is inappropriate. There are times in which a physician's documentation is missing information which would qualify the encounter as a 99212. This is probably the most common proper use of CPT 99211 by podiatric physicians. Vignettes quoted directly from the CPT 2004 Professional Edition describe for CPT 99211 include the following:

* Office visit for an established patient who lost their prescription for lichen planus. Returned for new copy.

* Office for visit for established patient for dressing change on a skin biopsy.

* Office visit for a 14 year old patient, established patient, to redress an abrasion.

* Office visit for an established patient who is performing glucose monitoring and wants to check accuracy of machine with lab glucose by technician who checks accuracy and function of machine.

* Office visit, established patient, for a blood pressure check.

Billing CPT 99211 does not require the person providing the service hold any type of license or training. They must be employed by the practice and the physician must be present in the office suite, and available to assist if needed. Documentation for each CPT 99211 should include "Dr XXX was in the office suite and supervising doctor."

If the level of history is counted as one of the two key components, a problem focused (PF) history is required for a CPT 99212 and an expanded problem focused (EPF) history is required for a 99213. What are the differences between a PF and an EPF history?

Both levels require a chief complaint. The chief complaint is the statement that describes the reason for the patient encounter and its site of service. This might be a statement as simple as "Patient presents to office for follow up of a skin rash" ,or " Patient presents to office for re-evaluation of left foot."

Both levels require a brief history of present illness (HPI). A brief HPI consists of 1-3 elements. An HPI is very similar to the NLDLOCAT (nature, location, duration, onset, course, aggravated by, past treatments). An HPI of one element would be "Patient reports pain is improved 50% " or "The patient reports the rash is not as itchy."

ROS

The Review of Systems (ROS) is the key difference between a PF (99212) and an EPF (99213) history. CPT 99213 requires documentation of at least one system, while the CPT 99212 does not require a ROS.

The ROS is a list of signs or symptoms a patient has had in the past, or currently may be experiencing. It is not, per se, a list of previously diagnosed diseases. Previously diagnosed diseases are considered a different portion of the history called past diseases. The ROS serves a number of different functions. If a complaint is new to the physician, the ROS are the questions asked to aid the physician in arriving at a diagnosis related to various organ systems. Often this is helpful in eliminating a diagnosis from the differential diagnosis.

An example of an ROS for the musculoskeletal system for a chief complaint of heel pain might be, "Are there any other joint aches or pains?" This question would be relevant in determining if heel pain is a local manifestation of a systemic disease such as arthritis or is an isolated biomechanical problem.

The ROS may also assist the physician in determining the appropriateness of a treatment option or to monitor its side-effects. This may be true in new or established complaints. A medically necessary review of the gastrointestinal system is performed when a physician inquires about the presence of active GI symptoms prior to prescribing an NSAID, or on a follow up encounter questions if the patient is experiencing acute GI symptoms which are common to this class of medication.

The documentation guidelines state that all positive responses and any pertinent negative responses should be documented and that review of systems may be recorded by the nurse or the patient, but the physician must date and countersign the information to attest that it has been reviewed.

If one is counting the history as one of the two key components, 99213 requires a documented ROS.

Physical Exam

One may use either the 1995 or 1997 AMA/ guidelines for scoring the physical exam. With either set of guidelines, a CPT 99212 requires at minimum of a problem focused (PF) examination and a 99213 requires a minimum of an expanded problem focused (EPF) exam, if one is considering the physical exam as one of the two key components. The 1997 guidelines define a PF exam as one which consists of 1-5 bulleted elements, while an EPF exam consists of 6-11 bulleted elements. The alternative and still acceptable 1995 guidelines define a PF exam as a "limited exam of body area or organ system" and an expanded problem focused exam as a "limited exam of body area or organ system and other symptomatic or related organ system(s)." Each extremity is considered one body area.

Problem-focused exams are common for established patients that are presenting for second or third follow-up visits with one established complaint - which is either usually stable or improving - such as capsulitis or heel pain. For example, a patient that was seen a week prior for heel pain, and is improving, often requires an examination of just the problem area - the heel in a case of heel pain or the 2nd MTPJ in the case of a capsulitis. The medical necessity to examine six or more elements with just a single improved complaint is often difficult to justify. A 99212 is often billed for this common scenario.

By contrast, an expanded problem-focused exam (6 -11 bulleted elements) may be medically necessary in a number of situations including, but not limited to, the following:

- * Complaint of an established patient which is considered a new problem involving more than one extremity.
- * Multiple straightforward complaints that are established to the examiner which are all improving
- * Single established complaint which is established to the examiner which is not responding to the usual treatment plan. This necessitates a reconsideration of the working diagnosis that often requires repeating exam elements or performing new exam elements.

Decision-making

Medical decision-making is the third key component. If decision-making is counted as one of the two key components to determine the level of code, a CPT 99212 requires straightforward decision-making while a CPT 99213 requires a minimum of low-level decision making.

What are the differences between straightforward and low-level decision making? All medically necessary E/M encounters performed by a physician involve at least straightforward decision-making because straightforward decision-making is the lowest level possible. That is all that is required for a CPT 99212.

The three equal elements of medical decision making are:

1. The amount of data and medical records reviewed
2. The number of diagnoses or treatment options.
3. The risk associated with a mortality or morbidity of a treatment option, diagnosis, or procedure. The highest level of risk associated with a procedure, problem, or management option determines the level of risk.

Only two of the three elements need to meet or exceed the level of decision-making which is selected.

Low-level decision making requires one bullet from at least two of three of the following areas (Data, Diagnosis, Risk):

1. At least limited data. These examples qualify as limited data:

- * Order or review a clinical lab test AND order an x-ray or review a written x-ray report OR
- * Review an actual x-ray film obtained from an outside source or from ones own equipment OR
- * Discuss the case with another healthcare provider OR
- * Review or summarize old records OR
- * Obtain a history of someone other than the patient

2. At least a limited number of diagnosis or treatment options. These examples qualify as limited number of diagnoses or treatment options:

- * Management of two self-limiting or minor problems OR

- * Management of two problems which are established to the examiner and are stable or improving OR
- * Management of one problem which is established to the examiner which is worsening OR
- * Management of one problem which is new to the examiner which does not require a work-up is "moderate" and exceeds "limited" number of diagnosis and treatment options

3. At least low-risk associated with a mortality or morbidity of a treatment option, diagnosis, or procedure. These examples qualify as low risk:

- * Management of two or more problems which are minor or self limiting or an acute uncomplicated illness
- * Recommendation to use OTC drugs (Rx drugs are moderate risk)
- * Performing minor surgery with no identifiable risk factors such as nail debridement on a patient with pain and without a systemic disease which meets class findings. Performing minor surgery on a patient with risk factors is moderate risk)
- * Physical therapy

Anatomy of a CPT 99213

A patient was seen one week prior to this encounter with a diagnosis of heel pain and reports no change in symptoms. The treatment for the first visit consisted of a Rx NSAID, shoe gear changes, a low dye strapping, and home physical therapy. A review of the GI system was performed at this visit to establish there were no untoward effects following the use of the prescribed NSAID.

A problem-focused exam of less than six bulleted elements was performed on this visit consisting primarily of examination of the involved heel. An outside x-ray film was reviewed which counts as limited data and the patient was injected with a steroid-local anesthetic mixture into the heel which is considered minor surgery without risk factors. Decision-making is scored as low. The E/M for this visit is considered a 99213 and above the usual E/M included with the injection. Both a 99213-25, the injection code, and the HCPCS code for the steroid medication injected may be billed.

Usually, the correct level of CPT code (ignoring coding by time) can often be narrowed down to two or three choices by a process of elimination. In my opinion, a 99211 can be eliminated if the encounter is medically necessary, if the physician examines and treats the patient. A 99215 can be eliminated if it is appropriate in only the rarest of circumstances. This leaves 99212, 99213, or 99214. In a previous article in this magazine I concluded that for an established patient with a significant new complaint(s) that has not been examined for a significant interval of time or has recently experienced a significant change in their medical status, that is treated with a prescription medication, or has minor surgery with risk factors, a 99214 may be appropriate. There are many other possible vignettes for proper billing of CPT 99214, and I believe it is underutilized by podiatrists. Beware that CMS feels 99214 is over-utilized by most physicians and has placed that code on their audit list. The two remaining choices are either a 99212 or a 99213.

Generalizations

Generalization are dangerous, but I will risk a few.

- If a patient presents for a third or fourth follow-up of a single complaint and it is established to the examiner that is stable or improving, such as capsulitis of the second MTPJ, a CPT 99212 is usually warranted.

- If the patient has a single straightforward complaint that is new to the examiner, is presenting for third or fourth follow up of an established orthopedic complaint that is worsening , or a second follow-up of an orthopedic condition that is improving, a CPT 99213 may often be warranted. Of course, appropriate documentation is required to substantiate the level of service billed.

Billing By Time

An alternative method to coding is using the time of the encounter. To bill using time, face-to-face counseling or coordinating care must account for more than 50% of the usual time required for a particular level of CPT code. A 99212 requires a 10 minute visit in which either coordination of care or face-to-face counseling of more than 5 minutes has been documented. A 99213 requires a visit of 15 minutes in which at least 7.5 minutes were spent in counseling or coordinating care.

If one chooses time to select a level of code the documentation should be audit-proof. This would documenting a start and stop time for the visit and a statement in the record describing the nature of care/counseling provided. Warning: Most consultants and carriers agree that claims for billing on time for a preponderance of encounters is suspicious, and that billing based on time should be the exception and not the rule for most practices.

In summary, the intensity (extent) of E/M service provided must be medically necessary for the particular circumstance. For example, an initial E/M encounter for a diabetic patient presenting with a draining ulceration requires a more intense level of E/M service than does a healthy 18 year old with a paronychia.

More information on E/M coding can be found in previous articles written by the author that have been published in Podiatry Management Magazine or in Malkin's Mediforms, a manual of reproducible forms for E/M coding written by the author and available by calling his office at 973-226-2263.