

E/M Coding

Urban myths need to be debunked before they cause audits.

BY HARRY GOLDSMITH, DPM

Query: “I have heard repeatedly that if you write a prescription, then you can bill CPT 99213, even if your documentation is brief. For example:

S—CC itching feet x 2 weeks, sudden onset, progressive

O—erythema and scaling plantar aspect b/l

A—tinea pedis

P—Rx [name your favorite anti-fungal cream] bid

Can this be CPT 99213 because of the prescription?”

Response: Nope. This is an urban myth.

Joan Gilhooly, CPC, CPCO, a Codingline expert panelist, looked at the above in terms of its evaluation and management (E/M) components and concluded:

History—Problem Focused

- History of Present Illness: location, duration, timing;
- Review of Systems: none;
- Past Family, Social History: none

Exam—Problem Focused

- 1 organ system with limited exam

Medical Decision Medicare (MDM)—Low

- Number of diagnoses/management options: limited;
- Risk: moderate due to prescription

Based on the SOAP record provided, the answer is no, even though the MDM component is low complexity. In reality, it was only med-

ically necessary (again, based on the SOAP note provided) to do and document a problem-focused history and a problem-focused exam. The provision of a prescription is not enough to move the E/M service level beyond CPT 99212.

The takeaway point in the above example is that given the findings and documentation, objectively and clinically, a problem-focused assessment was done. There was no evidence that the physician needed to

CPT 99213-25
CPT 11750

CPT 99203
CPT 11750

I’m only asking because some payers are paying and some are not. There was a time that this was not an issue.”

Response: Whether or not an E/M service is payable when billed

It is inappropriate (or indefensible) to routinely add an E/M service code on your claim just because a patient shows up in your office.

expand the focus of the assessment to include potentially related systems (either from a review of systems perspective or an exam perspective). A problem-focused assessment is almost always going to be a CPT 99212.

Obviously, if there was additional relevant medical information documented in either the history or exam, or if there were other medical problems (diagnoses), risk factors, and/or management options, the level of E/M service could have gone up.

E/M with Procedure Coding

Query: “Are we allowed to bill an E/M service with a procedure?”

For example:
CPT 99213-25
CPT 20550

with a procedure that is performed at the same encounter should not be an issue at all. We have recognized guidelines defining the rules for E/M and procedure billing that have been in place and not changed since they were first published. Unfortunately, there are providers who think that each encounter with the patient automatically should result in an “office visit” charge regardless of whether the documentation fails to support an E/M service performance or whether the patient was specifically scheduled for a surgical or procedural service. And, unfortunately, there are some payers that ignore the rules and guidelines, and blanket exclude “additional” payment for an E/M service by announcing that the evaluation and management was already included in the surgical code allowance. These positions make

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it very difficult and frustrating for those practitioners who bill E/M services and procedures independently when circumstances allow for billing both.

First, it is inappropriate (or indefensible) to routinely add an E/M service code on your claim just because a patient shows up in your office. E/M service appropriateness is based on both medical necessity for the service and documentation of the components/elements making up the (any) level of evaluation and management performed.

Second, it is inappropriate (or indefensible) for a payer to outright deny reimbursement of an E/M service without first reviewing the patient's medical record to see if there was medical necessity for the evaluation and management service and documentation to support the level of E/M service billed. The only exception to this would be failure on the part of the doctor to include appropriate modifiers to the E/M service.

From CPT [copyright AMA]:

Modifier 25—Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on

the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

Modifier 57—Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier

foot. You work the patient up and perform an incision and drainage of abscess (CPT 10060). You would expect to be reimbursed for the initial E/M service and the minor procedure. Why? Let us look at the total RVUs of the two codes:

CPT 99202 (2.11RVUs)
CPT 10060 (3.32 RVUs).

Presuming CPT 99202 value would be built into CPT 10060, the procedure component itself would be no more than 1.21 RVUs (roughly \$42) which includes one post-op CPT

Typically, payers reimburse both the E/M service and a major procedure performed within 24 hours.

57 to the appropriate level of E/M service.

There is a reason these CPT modifiers exist: To alert the payer's software that requirements for independent evaluation and management service reimbursement have been met and are documented. If the standard was never to separately reimburse an E/M service and procedure performed on the same day, these modifiers would have either not been introduced or have, somewhere down the line, been deleted.

One would expect that all initial encounters—new patient—would involve significant, separately identifiable evaluation and management services because you are essentially starting out with a blank slate—there is no record, there has never been an examination, you haven't made any decisions on treatments or how they, from a practical standpoint, would apply to the individual sitting in front of you. All that relevant information, including the "development" of the physical or electronic chart from scratch, cannot be expected to be included in the value of a minor procedure without additional compensation. A good example would be the initial visit of a patient who presents with an abscess on the top of the

99212 E/M encounter (worth 1.23 RVUs)...hmm. If CPT 99202 was included in CPT 10060, then factoring out the E/M services, the incision and drainage procedure would be valued at 0.02 RVUs. The payer thanks you very much for your contribution. An even more egregious example would be:

CPT 99201 (1.24 RVUs)
CPT 11719 (0.4 RVUs).

If the initial E/M service was included in the value of the minor procedure, in this case CPT 11719, then we accidentally went through the looking glass where up is down, and in is out, and black is white. How is the lowest level initial E/M service included in a minor procedure that is significantly lower in value? It should never. Your argument on appeal is the math. Have the payer explain how $1 + 1 = -1$.

Interestingly enough, the "-57" modifier never seems to have the same problem. Typically, payers reimburse both the E/M service (could be performed, for example in an office, hospital, or an emergency department) and a major procedure performed within 24 hours. There are probably three explanations:

1) There are many more "-25" modifiers used every second than

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“-57” modifiers used every day;

2) Medicare has done its best to confuse providers regarding the “-25” modifier by tying it to its proprietary National Correct Coding Initiative (NCCI or CCI) guidelines and edits which left non-Medicare payers to separately interpret the “-25” modifier use as they saw fit... effectively destroying the modifier’s universality;

3) Proportionally, more general surgeons, orthopedists, vascular surgeons, etc. use the “-57” modifier, and they have significant clout...as opposed to the likes of podiatrists and dermatologists who do bunches of minor procedures; and

4) Payers are looking to cut costs, and denying a valid E/M service when performed with a procedure sure seems like a good way, especially when the doctor doesn’t appeal.

And, if you feel you are in the right, and you have the documentation to prove it, you should appeal.

To Summarize:

Guidelines: Modifiers “-25” and “-57”:

- Never apply either a “-25” or “-57” modifier to a

procedure or surgical code;

- Use the “-25” modifier (or the appropriate “X” modifier, if required by your MAC) for Medicare only when required by the National Correct Coding Initiative (CCI) guidelines and edits (i.e., not all E/M service and procedure(s), when performed on the same day, require a “-25” modifier on the E/M code for Medicare);

- Medicare considers the E/M “-25” modifier use appropriate only when a decision for a minor surgery or procedure (0-10 days global) is made;

- Medicare and most non-Medicare payers consider the E/M “-57” modifier use appropriate only when a decision for a major surgery (90 day global) is made—and the surgery is performed within 24 hours (e.g., cases of infection, trauma/injury, or wounds) (i.e., not appropriate for surgery scheduled in the future—next week, next month, etc.);

- Use the “-25” modifier only when the E/M service meets the definition of “significant, separately identifiable evaluation and management service” from that “built-in” a minor procedure.

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Dr. Goldsmith of Cerritos, CA is editor of Codingline.com and recipient of the Podiatry Management Lifetime Achievement Award.