Coding for Evaluation and Management Services

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2006 CPT E&M Updates
E&M – Deleted Codes

- Deleted codes
  - 99261-99263  Follow-up consultation
  - 99271-99275  Confirmatory consultation

- The American Medical Association (AMA) (CPT Changes 2006) and the Center for Medicare and Medicaid Services (CMS) (Transmittal R788) instruct providers to use subsequent care hospital codes, 99231-99233 for visits following an initial in-patient consultation.

Confirmatory Consults

- Confirmatory consults that are required by private payers should be reported using the appropriate consult code with a modifier -32
  - Modifier -32 is not recognized by Medicare as a payment modifier
  - A second opinion evaluation visit required by a third party payer is not a covered service in Medicare
  - A second opinion evaluation in the office or outpatient is reported to Medicare using the appropriate level of a new or established E&M codes (99201-99205, 99211-99215)
E&M - Added Codes

The E&M codes that were added effective 1/1/06 will not be applicable to pain specialists that do not go to nursing facilities, rest homes, etc.

Added E&M codes:

- 99304-99307 Initial nursing facility care, admission
  - 99307-99310 Subsequent nursing facility care

- 99324-99328 Domiciliary, rest home (eg. boarding home), or custodial care services – E&M of a new patient
  - 99334-99337 Established patient visit
  - 99339-99340 Domiciliary, rest home (eg. assisted living facility) or home care plan oversight services

Consultations
Consultations

- Medicare requires written documentation of the reason for the consultation in the referring physician’s record and the consultants record— it can be written on a Physician’s Order form in a shared record (such as in the hospital)
- Medicare allows only one initial consultation per hospital stay— all other follow-up care is reported using subsequent visit codes (99231-99233)
- A qualified non physician practitioner (NPP) can perform a consultation when all the requirements are met
  - A split/shared visit may not be reported as a consultation service

Consultations (Cont)

- In a facility setting, a second opinion that is requested by the patient or family and arranged through the treating physician is reported by a consulting physician/qualified NPP as an Initial Consultation when the consultation requirements are met
  - A written report is not required by Medicare to be sent to a physician when a second opinion has been requested by the patient or family
Consultations (Cont)

- In an office/outpatient setting, another consultation can be requested of the physician/qualified NPP if the consultant has not been providing ongoing management for the condition following the initial consultation.
- In a group practice one physician/qualified NPP can request a consultation from another physician/qualified NPP if the provider has expertise in a specific medical area beyond the requesting professional’s knowledge.
- Medicare warns that this should not take place routinely on every patient seen in a group practice!!

Consultations (Cont)

- “Payment for a consultation service shall be made regardless of treatment initiation unless a transfer of care occurs”
- “A transfer of care occurs when a physician or qualified NPP take over the responsibility for managing the patient’s complete care for the condition and does not expect to continue treating or caring for the patient for that condition.”

Medicare Claims Processing Manual, Chapter 12
30.6.10 – Consultation Services (99241-99255) Read full details including CMS vignettes:
New Patient

- Definition of a “new” patient
  - No professional services by the same physician or another physician of the same specialty, in the same group for 3 years (Anesthesia “05” Interventional Pain “9”)

- Definition of a “professional service”
  - Medicare: “E&M or other face-to-face service (e.g., surgical procedure)”
  - AMA/CPT: “professional services are those face-to-face services rendered by a physician and reported by a specific CPT code(s)”

There is no code when a prescription refill is called in.

Choosing the Level
Using the Bullets

- Potential for abuse
  - Electronic record and/or template may lead to documentation of medically unnecessary and/or elements not performed
  - New patient exam, higher levels performed in 20 minutes when the AMA lists a “typical” time for the visit as 45 minutes
  - Follow up medication management for patient taking medication as prescribed, pain controlled with current dosage, no new complaint – spends 10 minutes reports code 99214 with typical time 25 minutes
Counseling/Coordination of Care

- When 50% of the time is spent counseling the patient and/or family
  - Time drives the level of service
  - Even if the physician provides and documents a history, exam and/or medical decision making associated with a particular level code – coding on the basis of time may be appropriate and lead to a different level code
  - “45 minutes was spent with Mrs. ___ explaining her treatment options which are ________________”

CPT Assistant October 2003: “E/M Coding Challenge”

Counseling Includes

- But is not limited to discussions of
  - Diagnostic results, impressions, recommended studies
  - Risks, benefits of treatment options
  - Importance of compliance with instructions
  - Prognosis
  - Management/treatment and follow-up instructions
- Counseling/coordination must be relevant to the condition for which the physician is treating the patient
Office vs Facility

- When using counseling/coordination of care time as the determining factor:
  - **AMA - Office:** Face-to-face time spent with the patient and/or family
  - **CMS - Office:** Face-to-face time must be spent with the patient
  - **AMA and CMS – In-patient:** Face-to-face with the patient or on the patient’s hospital floor or unit
  - **CMS instructions are specific:** “Time spent counseling and/or coordinating the patient’s care after the patient has left the office or the physician has left the patient’s floor or begun to care for another patient is not considered…”

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Typical Time-New or Consultation

<table>
<thead>
<tr>
<th>New Patient Office or Outpatient</th>
<th>Consultation Office or Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPT</strong></td>
<td><strong>CPT</strong></td>
</tr>
<tr>
<td>99201 10 min.</td>
<td>99241 15 min</td>
</tr>
<tr>
<td>99202 20 min.</td>
<td>99242 30 min.</td>
</tr>
<tr>
<td>99203 30 min.</td>
<td>99243 40 min.</td>
</tr>
<tr>
<td>99204 45 min.</td>
<td>99244 60 min.</td>
</tr>
<tr>
<td>99205 60 min.</td>
<td>99245 80 min.</td>
</tr>
</tbody>
</table>
## Typical Time- In Patient Consult

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99251</td>
<td>20 min.</td>
</tr>
<tr>
<td>99252</td>
<td>40 min.</td>
</tr>
<tr>
<td>99253</td>
<td>55 min.</td>
</tr>
<tr>
<td>99254</td>
<td>80 min.</td>
</tr>
<tr>
<td>99255</td>
<td>110 min.</td>
</tr>
</tbody>
</table>

## Typical Time- Follow Up Care

<table>
<thead>
<tr>
<th>Established Patient Office or Outpatient</th>
<th>Subsequent Care In Patient Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>Time</td>
</tr>
<tr>
<td>99211</td>
<td>5 min.</td>
</tr>
<tr>
<td>99212</td>
<td>10 min.</td>
</tr>
<tr>
<td>99213</td>
<td>15 min.</td>
</tr>
<tr>
<td>99214</td>
<td>25 min.</td>
</tr>
</tbody>
</table>
Prolonged Service

- CPT codes 99354-99359 are not stand-alone codes
- An E&M service must be provided the same day by the same physician
- Count only the physician’s face-to-face time with the patient
- The total duration of all physician direct face-to-face service must equal or exceed the threshold time for the E&M visit code plus 30 minutes
- Apply to any E&M code not just the highest level

Examples of Prolonged Services

<table>
<thead>
<tr>
<th>E&amp;M Visit</th>
<th>Physician Spends</th>
<th>Report Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212 - 10 min.</td>
<td>45 min</td>
<td>99212 &amp; 99354</td>
</tr>
<tr>
<td>99212 - 10 min</td>
<td>85- min</td>
<td>99212, 99354, &amp; 99355</td>
</tr>
<tr>
<td>99203 – 30 min</td>
<td>60 min</td>
<td>99203 &amp; 99354</td>
</tr>
<tr>
<td>99203 – 30 min</td>
<td>105 min</td>
<td>99203, 99354 &amp; 99355</td>
</tr>
</tbody>
</table>

www.CMS.gov  Refer to Manuals, Claims Processing, 100-04  Chapter 12
Examples of Prolonged Services

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<thead>
<tr>
<th>E&amp;M Visit</th>
<th>Physician Spends</th>
<th>Report Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231 - 15 min</td>
<td>45 min</td>
<td>99231 &amp; 99356</td>
</tr>
<tr>
<td>99233 - 15 min</td>
<td>90 min</td>
<td>99231, 99356, &amp; 99357</td>
</tr>
<tr>
<td>99252 – 40 min</td>
<td>70 min</td>
<td>99252 &amp; 99356</td>
</tr>
<tr>
<td>99252 – 40 min</td>
<td>115 min</td>
<td>99252, 99356 &amp; 99357</td>
</tr>
</tbody>
</table>

www.CMS.gov Refer to Manuals, Claims Processing, 100-04 Chapter 12

Defining “Prolonged”

- Some examples are
  - Requires a translator and takes longer to perform usual services
  - Patient is deaf - requires sign language interpretation
  - Patient is hard of hearing – questions and instructions are repeated several times
  - During the visit, the patient has an asthmatic attack that requires the physician’s constant care for 30 minutes or longer
  - Medicare does not publish criteria - use sound judgement – keep in mind that medical necessity governs

May 2006
Medication Management

- An office visit with an R.N. employee for the purpose of prescription renewal may be reported to Medicare as an “incident to” service using code 99211 according to CPT coding guidelines when all the requirements are met.
- “Incident to” reporting is not applicable to all payers. For example, in Alabama: “…a physician should not bill an office visit to Blue Cross and Blue Shield of Alabama if only a non-physician practitioner sees the patient. This guideline applies whether or not the physician is in the office…”

Medication (cont)

- A physician should report the level of service that is medically required when s/he sees a patient for medication management. Base the code on the amount of the physician’s work and/or time, not the medication the patient is taking.
  - Stable 10 minutes or less interm visit = 99212
  - New problem requires HPI, exam, decision = higher level
  - Adverse reaction to the appropriate use of the medication that requires a history sufficient to determine if it is the medication or another possible cause and/or a change/adjustment of medication = higher level
Modifier -25

- Modifier -25 is not mentioned in the 2006 OIG Work Plan, however in a report released 12/05 for payments in 2002, a study shows:
  - $538 million in improper payments were made because 35% of claims for E/M services did not meet program requirements (*above & beyond usual pre/post procedure work*)
  - Modifier -25 was also used unnecessarily on a large number of claims where it did not result in improper payments but did not meet program requirements (*reported in addition to a “new” patient visit*)
  - OIG recommends that CMS work with Carriers to reduce the use of modifier -25

The Definition of -25

- Modifier -25 means that the E&M service reported in addition to the procedure or other service, is *significant, separately identifiable, and above and beyond the usual preoperative and postoperative care* associated with the procedure
  - The physician evaluates and treats, writes a prescription, orders tests for a different condition – link a different ICD-9 code to the symptom or confirmed diagnosis
  - The patient is having an adverse reaction to medication severe enough that the physician must spend additional time to determine the appropriate treatment modification – link an ICD-9 code(s) to the reaction
**Modifier -24**

- When a patient is seen for a condition unrelated to the condition for which a procedure was performed, append modifier -24 to the appropriate level of E&M code.
- Procedures with global days:
  - 62287 – 10 days (Disc Decompression)
  - 62263-62264 – 10 days (Lysis of Adhesions)
  - 62350-62365 – 90 days (Pumps & Stimulators)
  - 64600-64681 – 10 days (Destruction by Neurolytic Agent)

**Global Days**

- The global period for major procedures (90 day global) begins the day before the surgery:
  - Date of surgery January 5
  - Preoperative period – January 4
  - Last day of postoperative period April 5
- Global period for minor procedures begins with the date of the surgery:
  - Date of surgery – January 5
  - Last day of postoperative period – January 15
Group Practice

• Physicians in a group practice who are in the same specialty bill and are paid as though they a single physician

• When different physicians in the group participate in the care, the group bills for the entire global if all the physicians reassign benefits to the group

AND TODAY’S THOUGHT…

A positive attitude may not solve all your problems, but it will annoy enough people to make it worth the effort.

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