Professional Billing Compliance Frequently Asked Questions

Evaluation and Management

1. How do I bill for a preventive medicine visit with an evaluation and management of a problem?

Many times patients will present with a complaint or problem at the time of their "annual" or "well" examinations. There may be abnormalities encountered or preexisting condition(s) that are addressed during these sessions. If the problem is significant enough to require additional work, the physician may bill an additional evaluation and management code that will cover this additional E&M code. However, an insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine service that does not require additional work or the performance of the key components of an office visit should not be reported separately.

When billing for both use the ICD-10 code for "Routine General Medical Examination" with the preventive visit code and the ICD-10 code for the problem/abnormality encountered with the E&M visit code. Also, the elements of the problem oriented service must be clearly documented separately and those elements cannot be used in the preventative service. The addition of Modifier -25 to the E&M code is required.

2. Is it true that medical decision-making drives selection of an accurate E/M code?

Medical decision-making is a thought process driven by the patient's presenting problem(s). The severity of the patient's condition(s) will begin this thought process and should lead to taking a history and performing an examination that is medically necessary for the condition. So, in essence, the MDM is critical to selecting an accurate code. Example: you shouldn't

see an expanded problem focused history and physical when high complexity MDM is documented and medically necessary. Medical decision-making refers to the complexity establishing a diagnosis and/or selecting a management option. Medical Decision-Making is the element most likely to prevent upcoding because it takes into account the nature of the presenting problem(s) – something outside the physician's control.

3. **How should I bill if I spend 20 minutes of a 30 minute office visit counseling a patient and/or coordination that patient's care?**

   You can code according to total face-to-face time, regardless of the level of history, exam and decision-making that you perform, because counseling and/or coordination of care accounted for more than half of the visit. Assuming that it was an established patient office visit, bill CPT code 99214 because the 30-minute encounter exceeded the "typical time" of 25 minutes for that code and fell short of the 40 minute typical time for CPT code 99215. Be sure that the patient visit meets the CPT definition of counseling and is supported by the documentation by summarizing the subjects of discussion. CPT defines counseling as a discussion with a patient and/or family concerning one or more of the following areas: diagnostic results, impressions, and/or recommended diagnostic studies; prognosis; risks and benefits of management (treatment) options; instructions for management (treatment) and/or follow-up; importance of compliance with chosen management (treatment) options, and; patient and family education. Finally, it is important that you document the time you spend on counseling and/or coordination of care in the patient's medical record.

4. **For a "complete" ROS (history), is it necessary to document at least 10 body systems?**

   To correctly document a complete ROS, you must show that you have reviewed at least 10 organ systems, one of which is the system directly related to the problem identified in the HPI. However, you do not have to individually document all the systems reviewed; you only have to document those with a positive or pertinent negative response if you document a review of the remaining systems with a notation like "all others negative." For example, if you see an elderly patient with severe myocardial degeneration, congestive heart failure and hypertension, you do not need to individually document all the systems reviewed. Instead, you could document the positive or pertinent negative responses for the relevant systems and then simply note "all others negative" to cover the other systems the physician reviewed.

5. **Can a nursing home discharge (99315-99316) be reported when a patient from the nursing home expires, and the billing physician pronounces the patient dead?**

   Yes. The physician must have face-to-face contact with the patient, examine the patient and prepare the necessary discharge records in order to appropriately report a nursing home discharge service code.

6. **If someone other than the physician documents the history, ROS, medical, social, family history, can I use it when determining the level of E & M cpt?**

   You can use the ROS, past medical, social & family history. The provider's documentation should support that they reviewed the ROS and PFSH documented by the ancillary staff. The history of present illness needs to be taken and documented by the physician.

7. **Does family history information just need to be part of the initial consultation, or does it need to be present in each revisit also?**

   To reach a problem focused (PF) or an expanded problem focused (EPF) History level, no documentation of past medical, FAMILY history and social history (PFSH) is required. A pertinent PFSH (at least one specific item from any areas of PFSH) would support a detailed level of History, while a complete PFSH (a review of two (for ER) or all three of the PFSH areas) would support a comprehensive level of History.

   Therefore, family history is always required when billing for a comprehensive History level in a new patient visit, consultation, hospital H&P, and observation services. However, a family history may or may not be required when billing for an established patient visit or ER visit. It will depend upon your clinical judgement and the nature of the presenting problem to determine whether or not a family history is needed in a follow up visit or ER visit.

8. **Is it acceptable to use "noncontributory, unremarkable or negative" when reporting past, family or social history?**
   No. The statement "noncontributory, unremarkable or negative" does not indicate what was addressed. Did the nurse or physician ask specific conditions (e.g. any family history or coronary artery disease?) If for some reason you cannot obtain the family history, the documentation must support the reason why (e.g. the patient was adopted.)

Back to Top