Coding for the Internist:
The Basics

Evaluation and management is the most important part of the practice for an internist and coding for these visits can have an important effect for the bottom line of a practice. The decision about what level to bill an evaluation and management code is rarely clear to most physicians. Even with only a handful of options, getting it right can be difficult. In this guide, we will focus on the documentation standards for evaluation and management codes, the codes that will drive the business of most internists and many internal medicine subspecialists. Other educational material on billing and coding for procedures is available at the ACP website www.acponline.org.

In order to determine what code to select for an evaluation and management procedure, it helps to first learn the elements of a code. Once you understand the elements and how they come together to create the level, it can be a lot easier to select a code with confidence.

Evaluation and Management versus Preventive Services
This guide primarily addresses the very commonly billed acute evaluation and management visits, but it is worth noting that there are codes for services performed strictly for preventive measures. These codes are 99381-99397. Unlike the codes described below, they are determined based on appropriate preventive services for the age of the patient. Insurers may or may not reimburse for these services. Medicare notably does not pay for them at all.

Chief Complaint
Your patient has shown up at your office for a reason of some kind – you need to document that reason. Every evaluation and management visit should start with a chief complaint – some kind of reason why the patient needs to be seen. Only a simple explanation is needed, it may be "cough" or "1 year recheck of diabetes" or "nausea since Tuesday." The chief complaint is required in order to establish medical necessity, a fundamental element of the Medicare program and a required element for billing this series of codes for the private sector as well. It is best to avoid overly generic chief complaints like "annual checkup" or "feeling sick." Chief complaints such as "no complaints" or "no symptoms" are even worse and could cause serious problems if the claim is audited. Before you even think about selecting a code, you have to document a chief complaint, or the visit will not be considered properly coded.

Once you have the chief complaint, you can move on to the three elements that vary with each that you use to consider when selecting a coding level: history (everything the

patient tells you); examination (everything you discover on examination); and medical decision making (how sick the patient is and what you do about it).

HISTORY
History is all subjective information that is gathered from the patient. The information may be gathered in the form of an interview or a questionnaire that the patient completes. There are three different elements of history to be considered for a coding level: 1) History of Present Illness; 2) Review of Systems; and 3) Past, Family, and Social History.

History of Present Illness: There are a number of defined elements in a history that will help you in selecting a level. It is important to note that the physician should only ask the information that is pertinent to the patient, and should not be asking unnecessary information in order to reach a higher coding level. When an auditor looks at an evaluation and management visit, he will look for the following elements when considering the level of history:

Location – where does it hurt?
Duration – how long has it been hurting?
Timing – does it hurt only during the day?
Severity – how badly does it hurt?
Associated signs and symptoms – does is always happen with a headache?
Modifying factors – does it hurt less when ice is applied?
Context – does it hurt when you watch TV?
Quality – is it a stabbing pain or a burning pain?

Review of Systems: The review of systems is considered part of the history in which the physician asks the patient about his health by each body area or organ system. The review of systems is often left out of the visit or the documentation and is a primary driver for codes that do not meet high standards for history. There are 14 different body areas and organ systems that are considered for the review of systems. They are:

1. Constitutional (general appearance, vital signs)
2. Eyes
3. Ears, Nose, Mouth, and Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumetary
10. Neurologic
11. Psychiatric
12. Endocrine
13. Hematologic/lymphatic
14. Allergic/immunologic

In order to have a comprehensive history element, a physician must ask or attempt to ask the patient about all of these body areas and organ systems. There are many cases in which it is not necessary to ask about all of these areas (e.g., a bruised knee in an otherwise healthy person), but in those cases a lower-level code would be required. Documentation requirements are not perfect but they are very clear about one thing: The physician should do what is medically necessary. The coding level selection should not play into his decision as to what to do. Many physicians are best able to capture the review of systems using a form completed by the patient at each visit, allowing the patient to complete the documentation for the physician.

Past, Family, and Social History
In addition to asking the patient about her current state of health, a physician may find it appropriate to ask the patient about her past history of illness, social history, or her family's history of illness. These elements are also considered a part of the history. In order to reach the highest level of code on a new patient, a physician must ask about past medical, family, and social history.

A past medical history is simply a list of medical ailments or surgeries that have affected the patient in the past.

A family history is simply a list of medical ailments that have affected the patient's family. This may also include causes of death of family members.

Social history is a very broad category and may include patient history with drugs, alcohol, employment, and education.

Asking the Patient to Complete a Form
Many physician practices request that patients complete forms generally describing their state of health at the time of the visit. These forms generally follow the format of the history section. A physician may count the completion of these forms in determining the history level as long as he has documented that he has reviewed the information. The physician should pay special attention to the history of present illness, because many auditors believe that this section must be completed by the physician. Newer electronic medical records may make this recording difficult, but it is often cited as a requirement. The physician must show that she has reviewed this information. The design of the forms is important. See the examples below from two history forms and see if you can spot the difference:

Example 1
Check if you had any problem with the following:
__ Eyes
__ Ears
__ Nose
__ Throat
__ Stomach

Example 2
Have you had any problem with the following:
Eyes   __Yes   ___No
Ears   __Yes   ___No
Nose   __Yes   ___No
Throat   __Yes   ___No
Stomach __Yes   ___No

Example 1 would not be good documentation because if the patient did not have a problem with her eyes, for instance, she would not check the box. But, since it is impossible to tell if she just missed that box because she could not see it, it cannot be considered part of the history. In order to count towards a coding score, negatives must be noted.

Examination
The examination is a relatively simple concept. The level of an examination is measured merely by the number of body areas or organ systems that are examined. There are two different standards for determining the level of exam, one introduced in 1995 and one introduced in 1997. They are generally referred to by the year of their introduction. The 1997 guidelines are far more detailed than the 1995 guidelines in the exam area. This discussion will use the 1995 guidelines which are generally easier to understand and more obtainable for those in internal medicine and internal medicine subspecialties. The body areas and organ systems that are considered follow:

Body Areas	**Organ Systems**
Head	Eyes
Neck	Ears, nose, mouth, and throat
Chest	Cardiovascular
Abdomen	Respiratory
Genitalia, groin, buttocks	Gastrointestinal
Back	Musculoskeletal
Left arm	Skin
Right arm	Neurologic
Left leg	Psychiatric
Right leg	Hematologic/lymphatic/immunologic

The more body areas or organ systems that you examine, the more complex your exam is considered to be. For a higher level of code, a physician may only count organ systems. There are four levels of exams for CPT purposes:

Exam	**Minimum Elements**
Problem-focused	1 body area or organ system
Expanded problem-focused	6 body areas or organ systems
Detailed	6 organ systems
Comprehensive	9 organ systems

The 1995 coding standards do not specify what is required in order to consider a body area or organ system as being examined. This means that even very simple documentation of a rudimentary body exam may be considered an exam element by an auditor. For example, the common notation HEENT normal will be considered to be an examination of one body area (head) and two organ systems (eyes and ear, nose, and throat).

Once again, it is important to note that the extent of the exam should be driven by the patient's presenting problem. A patient with a relatively simple problem in most cases will not require a comprehensive exam. Doing such an exam merely to raise the coding level is not appropriate and may be considered fraudulent. Similarly, writing only simple documentation when more complex documentation is called for is not good service to the patient.

Medical Decision Making
The medical decision making element of a code is the most complex and the most open to debate. The history and examination sections include counting elements that make determining a level relatively simple – the medical decision making element includes judgments about what is considered serious or major or an intervention. There are three elements that go into the scoring of the medical decision making section.

The first consideration is the number and severity of diagnoses or treatment options. There is a fairly complicated rubric that is used, but as a more basic consideration, the more difficult it is to make a decision about what to do with the patient, the higher the score is. Consult ACP's coding audit tool to see how this affects the audit of a progress note.

The second consideration in determining the score for the medical decision making section is the amount and complexity of data reviewed. This would include all data that is not a part of the history or the examination, and may include lab studies, x-rays, reviewing old records, or speaking with the patient's previous physician. It is important to note in this section that an auditor will consider a note ordering a study to be the same as reviewing the study, so the data need not be reviewed before the patient is dismissed. Again, there is a fairly complex rubric for determining the precise score but again, the more data that is reviewed by the physician, the higher the score in this section. Consult ACP's coding audit tool to see how this affects the audit of a progress note.

The third consideration in medical decision making scoring is the risk of complications and/or morbidity or mortality. This section wraps up many of the other sections, and elements that were used to establish a score in other areas may be repeated here. This element itself is composed of three separate considerations: 1) nature of presenting problem, 2) diagnostic procedures ordered, and 3) management options selected. Each of these elements is determined to be minimal, low, moderate, or high risk. There is guidance provided by the rules in determining what exactly constitutes the difference between low and moderate risk, but there is ample room for interpretation within this area of the guidelines. Physicians, nurses, and non-clinical staff will often score charts

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completely differently based on different understandings of what exactly risk is. There is no one who can truly answer if something classifies as moderate risk.

Phone calls, e-mails, and other non-visit work
Medicare will not pay a physician separately for the work involved in phone calls or e-mails with patients that may occur. This work is instead considered included in the face-to-face E/M service that took place before or after the phone calls. This inclusion is referred to as a bundled service. There may be times where extensive time spent on the phone with a patient can increase the level of a visit, especially if you dealt with a relatively complex problem via phone that has improved considerably when you see the patient. If you choose to consider your phone time when selecting a level, then you must be very careful to document in that day's progress note a reference to the phone calls that you had previously. You need not repeat the entirety of the phone conversation if it is recorded elsewhere (e.g., a messages tab), but you must provide some kind of link that would tell an auditor to go looking for these phone discussions. You may also consider the phone calls that take place after the visit, but that is more likely to present a problem, because most physicians submit a bill to an insurance company the day that they see a patient.

Private insurers typically follow the policies of Medicare on telephone and e-mail payments. However, there are some insurers that are paying for these services. As is always the case, verify all private insurance policies directly.

Billing based on time
For many physicians, it just seems as though the entire system would be easier if they could just bill like attorneys or plumbers: by the hour. In some cases, evaluation and management codes can be determined by time. In order to select a code level based on time, the physician must spend at least 50% of the time counseling or coordinating care for the patient. The level is based on the typical times found in the CPT books (e.g., 50 minutes with 50% time counseling or coordinating care is considered to be a 99215). In this case, the documentation of history, exam, and medical decision-making is not relevant at all to the selection of the code. The physician should still be documenting for the purposes of patient care. In addition to this documentation, the physician should indicate in the record the total time spent with the patient and the time spent on counseling or coordination of care.

Billing for services provided by staff
A physician may bill for services that his staff performs if those services are directed by the physician. State laws and local regulations may limit what clinical staff members are allowed to do, but this kind of billing may be done in appropriate circumstances. Minor visits like blood pressure checks or weight checks may be performed by a nurse or a medical assistant without the patient seeing the physician. In this case, the established office visit 99211 may be billed as long as there is some element of evaluation and management, whether it is counseling or discussion of medication. In fact, if the physician sees a patient, a 99211 should never be billed. Physician billing for staff

services is referred to in Medicare regulations as incident-to billing, meaning that the services provided are part of the overall service provided by the physician.

This kind of billing may also be used in some cases for a mid-level practitioner like a physician assistant or a nurse practitioner, as long as the services those practitioners are providing are for existing problems and the overall plan of care is directed by the physicians and the physician is immediately available to provide assistance if needed, i.e., in the same suite but not necessarily the same exam room. If the PA or NP is operating independently of the physician and addressing new problems, that PA or NP must bill using her own billing number for Medicare. For those services, the provider would be reimbursed 85% of the Medicare fee schedule. Private payer's policies may vary from Medicare.

Billing for a procedure and an office visit on the same day
There are times when a physician performs an evaluation and management visit and a procedure on a patient on the same day. If a code for an office visit if charged along with a procedure, the office visit code is likely to be denied, because CPT considers evaluation and management to be a "bundled" element of a procedure. If, however, the evaluation and management and the procedure are unrelated, then the physician may be paid for both services through the use of a modifier. For example, a patient comes in for sore throat and has a wart removed on the same day. The modifier to be used in this case is -25. A modifier is appended to a CPT code on billing paperwork to show differentiation from the standard service.

Consultation
A physician will generally be paid more for a consultation than a comparable office or inpatient visit, but an encounter must meet a couple of important distinctions in order to qualify as a consultation. First, the encounter must have been requested by another physician or other qualified health care provider. Second, the requesting physician must indicate that she is looking for advice on the treatment of the patient – she is not merely transferring the care of the patient to the consultant. The third requirement is that the consultant must send some kind of written report to the requesting physician. That may be in the form of a letter or merely a copy of the progress note, but communication must be sent back to the requesting physician. It is important to note that the rules for a consultation are in some state of transition, with CMS increasingly looking to reduce the number of consultations by making requirements narrower. Both primary care physicians and specialists can bill for consultations.

More information
The coding and billing world can seem hopelessly complex. Fortunately, we live in a time in which resources on the issues are available very easily and in many cases for free through the internet. If you have a question, chances are that someone has experienced that same question before and might have found a solution. If the solution cannot be found, ACP members can contact the Practice Management Center for an answer.