Avoid denials when selecting Level 4 E/M office visit codes

It’s a scenario probably familiar to many primary care physicians. A new patient presents with multiple chronic conditions. In most cases, the history, exam, and medical decision-making will drive the E/M level that the physician reports for billing.

However, what if the physician spends 30 minutes out of the 45-minute appointment counseling the patient on diabetes management? CPT guidelines permit E/M code selection based on time when face-to-face counseling and/or coordination of care accounts for more than 50 percent of the encounter. If the physician selects CPT code 99204 (Level 4 new patient office visit) for this encounter, does that mean the claim will pass payer scrutiny even if he or she only performed an expanded problem-focused history rather than a comprehensive one?

Not always, says Sonal Patel, CPMA, CPC, a healthcare coder and compliance consultant with Nexsen Pruet LLC, a business law firm in Charleston, S.C. Payers have been looking more closely at Level 4 E/M codes because of the higher payments associated with these codes, she says. If physicians choose a Level 4 E/M code based on time, their documentation must clearly describe what they did and why, she adds.
In the absence of clear and detailed documentation, physicians could be subject to post-payment audits if payers suspect they’re upcoding—something that’s relatively easy to do if documentation isn’t adequate, says Patel. In that case, “Medicare will pay you for the Level 4 established patient visit again and again,” she says. “You’ll be happy for a year, but then next year, they’re going to come back, look at you under a microscope, and recoup that money.”

Document time spent

The biggest mistake physicians make when selecting an E/M level based on time is not providing sufficient documentation regarding the extent of the counseling and coordination of care, says Patel.

For example, a physician might document, ‘I had a lengthy discussion with the patient for more than half of the visit.’

“That tells the payer nothing,” says Patel. “You can’t make a blanket statement and think that’s going to count on the payer or auditor side.”
She provides this example of proper documentation for billing CPT code 99204 based on time: “I spent 30 minutes out of the 45-minute visit with the patient talking about their surgical options [list the specific options]. The patient had many questions and concerns, and we discussed the following pros and cons of each option [insert details].”

Another example of proper documentation: “This patient with cancer has undergone all preliminary studies and is deciding whether to receive chemotherapy. During the visit, I spent 30 minutes out of the 45-minute appointment discussing specific chemotherapy options [list the options] and subsequent lifestyle effects of treatment that the patient may experience, such as [insert details].”

Think ‘exception’

Most of the time, physicians won’t actually be able to select the E/M level based on time because counseling and care coordination aren’t often the focus of the visit, says Patel. Even when they are, there may be a more appropriate CPT code to report rather than a single E/M office visit code based on time, she adds.

For example, a physician spends more than half the visit providing smoking cessation counseling. In this case, it may be appropriate to a report a CPT code from the 99406-99407 code range for the smoking cessation counseling in addition to an E/M code with modifier -25 based on the three key components (i.e., history, exam, and medical decision-making). However, the E/M code with modifier -25 must be separate and distinct from the smoking cessation counseling, says Patel. The same may be true for several other types of services, such as:

- Individual preventive medicine counseling and/or risk factor reduction (99401-99404)
- Alcohol and/or substance (other than tobacco) abuse counseling (99408-99409)
- Group preventive medicine counseling and/or risk factor reduction intervention (99411-99412)
- Psychotherapy (90833, 90836, or 90838) [Note: These are add-on codes, meaning physicians must also report an E/M office visit code.]

As always, it’s important for physicians to review payer policies to determine whether the E/M code with modifier -25 will be paid in full, paid at a reduced rate, or not paid at all, Patel says.

Here's another scenario: A patient presents with an acute asthma exacerbation. The patient stays in the office for 65 minutes more than what CPT deems the average time associated with that service to receive intravenous medication and monitoring until stable. In this case, it may be appropriate to report the E/M code based on the three key components (i.e., history, exam, and medical decision making) along with a separate code for prolonged services.

"The documentation must really support the fact that you've gone above and beyond the E/M code," says Patel. "I don't think all patients in the office setting would qualify for this type of extended service, but patients with acute exacerbations or uncontrolled diabetes mellitus are good examples of where prolonged services may be warranted."

Focus on diagnosis codes

Diagnosis codes can help justify the rationale for selecting an E/M level based on time, says Patel. However, they can also call attention to potential upcoding. For example, payers will question why a physician spent more than half of a visit counseling a patient with an ear infection.

What to do when a payer down-codes your services

Payers frequently down-code Level 4 E/M office visits during a pre- or post-payment audit when physicians don't document all of the work they perform, says Leslie C. Murphy, JD, CHC, partner at King & Spalding, a healthcare law firm in Sacramento, Calif. Unless it's documented, physicians have no way of proving they did the work, and payers certainly won't give them the benefit of the doubt, she adds.

Do physicians have any recourse if a payer downcodes a Level 4 E/M office visit code? Possibly, says Murphy. First, they must review the explanation of benefits. How did the payer process the claim? Did the payer designate a certain amount as the patient's responsibility? If so, the physician can almost always bill the patient directly for this amount. On the other hand, physicians cannot usually bill the patient for the difference between the billed charge (e.g., 99214) and the allowable (e.g., 99212). Physicians should review their contracts with each payer to determine whether and how much they're allowed to bill the patient directly, she adds.

If a payer denies the entire claim—and assigns no patient responsibility—the physician's only recourse is to contact the payer to understand the reason for the denial and then correct and resubmit the claim or appeal it, says Murphy.