E/M coding can be easier than one might think

by Mark T. Savarise, MD, FACS; Linda M. Barney, MD, FACS; and Jenny Jackson, MPH

Surgeons and their coding staff sometimes find evaluation and management (E/M) codes difficult to understand. However, the fact of the matter is that insufficient or incorrect documentation of E/M services results in payment denials as well as sanctions and penalties.

This article addresses the use of the consultation codes and summarizes the changes in the 2011 *Current Procedural Terminology* (CPT)* manual that pertain to general surgery and closely related specialties.

Consultation codes

Outpatient consultations for Medicare patients are reported with new patient (99201–99205) or established patient (99212–99215) CPT codes. For non-Medicare patients (unless otherwise instructed by a payor), office or other outpatient consultations are reported with codes 99241–99245. The guidelines for all patients (Medicare and non-Medicare) indicate: If the patient has not received any professional service from the physician or another physician in the group of the exact same specialty within the last three years, the patient is considered a new patient. If the patient was seen by a physician in the group, but of a different specialty (for example, a plastic surgeon and a general surgeon), or different subspecialty (for example, a hand surgeon or a burn surgeon), the patient is considered a new patient. However, if the patient was seen by a physician of the exact same specialty and exact same subspecialty in the group within the last three years, the patient is considered an established patient.

E/M coding for Medicare outpatients seen in the emergency department (ED) poses a unique set of challenges. For Medicare patients, these visits should be reported with the ED codes (99281–99285). For non-Medicare patients (unless otherwise instructed by a payor), outpatient consultations provided in the ED are reported with codes 99241–99245. Example: A general surgeon is called to the ED to see a 75-year-old Medicare fee-for-service patient for assessment of abdominal distention, nausea, and vomiting. The surgeon documents a detailed history and performs a detailed examination. The medical decision making is of moderate complexity. The

continued on page 43

Coding highlight

Your specialty is general surgery. Your plastic surgeon partner saw a patient for an abominoplasty two years ago. The 65-year-old fee-for-service Medicare patient is now complaining of breast pain. Your partner refers the patient to you for a consult. You conduct a comprehensive history and examination, and the medical decision making is of moderate complexity.

Reportable procedure:
99204–Office or other outpatient visit for the evaluation and management of a new patient.

The patient was referred to the general surgeon by a plastic surgeon for a consultation. However, the patient is a fee-for-service Medicare patient, and Medicare no longer pays for consultations. Office consultations are reported with the new patient (99201–99205) or established patient (99212–99215) CPT codes. Although this patient has been seen by another physician in the same group practice in the past three years, the physician is of a different specialty. As a result, this patient is considered a new patient for the general surgeon.

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2010 American Medical Association. All rights reserved.

How to code consultations					
Consultation code	**History**	**Exam**	**Medical decision making**	**New patient (not seen in the past three years)**	**Established patient (seen in the past three years)**
Outpatient					
99241	Problem focused	Problem focused	Straightforward	99201	99212
99242	Expanded problem focused	Expanded problem focused	Straightforward	99202	99213
99243	Detailed	Detailed	Low complexity	99203	99214
99244	Comprehensive	Comprehensive	Moderate complexity	99204	99215
99245	Comprehensive	Comprehensive	High complexity	99205	99215
Inpatient					
99251	Problem focused	Problem focused	Straightforward		
99252	Expanded problem focused	Expanded problem focused	Straightforward		
99253	Detailed	Detailed	Low complexity	99221	99221
99254	Comprehensive	Comprehensive	Moderate complexity	99222	99222
99255	Comprehensive	Comprehensive	High complexity	99223	99223

Source: American Medical Association (AMA). *Current Procedural Terminology.* Chicago, IL: AMA. 2010.

CPT code	Subsequent observation
99224	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient's hospital floor or unit.
99225	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's hospital floor or unit.
99226	Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's hospital floor or unit.

Source: American Medical Association (AMA). *Current Procedural Terminology.* Chicago, IL: AMA. 2010.

patient has never been seen by the general surgeon in the office or at the hospital. The patient is sent home from the ED. For a Medicare fee-for-service patient, this case would be coded as 99284. For a non-Medicare patient, this would be coded as 99243.

Initial inpatient consultations for Medicare patients should be reported with the initial hospital care codes (99221–99223), even when someone other than the admitting physician conducts the consultation. The admitting physician uses modifier "AI" to designate that he or she is the principal physician of record. For example, take the same patient mentioned in the previous example, seen in the ED. However, this time after the exam, the surgeon decides to admit the patient. In this instance, the surgeons should use code 99221 with the AI modifier. On the other hand, if the Medicare patient was admitted by a gastroenterologist and later the general surgeon sees the patient for surgical assessment, performs a detailed history and a detailed examination, and the medical decision making is low complexity, the general surgeon would report 99221 without modifier AI. For non-Medicare patients, the correct code to report for the inpatient consultation would be 99253.

Subsequent observation

Subsequent observation care, per day, is now reported with a series of new codes (99224, 99225, 99226), meaning that surgeons now can report observation services that extend beyond the initial day of care. These codes are comparable to subsequent hospital care, but are reported for patients admitted for observation instead of inpatient facility status. All levels of subsequent observation care include reviewing the medical records, results of diagnostic studies, and changes in the patient's status (such as changes in patient history, physical condition, and response to management) since the physician's last assessment.

As an example, a general surgeon performs a comprehensive history on a 78-year-old patient who fell and suffered contusions to the head and shoulder, but no fractures. The patient, who has a history of stroke, is currently on Warfarin. Medical decision making is of high complexity. The patient is admitted to observation care. On the next day, the surgeon performs a detailed interval history and medical decision making continues to be of high complexity, with assessment for stability and possible intervention for internal bleeding. The patient remains in observation status and is not discharged. The initial observation care visit on the first day is coded as 99220. The subsequent observation care visit on the second day is coded as 99226. The subsequent observation care codes would be reported daily until the patient is discharged. The code for observation care discharge day management is 99217.

If you have any questions or comments on this article, contact Jenny Jackson at jjackson@facs.org or 202-672-1506. If you have additional coding questions, contact the Coding Hotline at 800-227-7911 between 8:00 am and 5:00 pm CST, excluding holidays. Ω

Dr. Savarise *is a general surgeon in Sandpoint, ID. He is the ACS Alternate Advisor to the AMA CPT Advisory Committee, and a member of the ACS General Surgery Coding and Reimbursement Committee*

Dr. Barney *is a general surgeon and associate professor of surgery, Wright State University Boonshoft School of Medicine, and associate director for the general surgery residency program, Miami Valley Hospital, Dayton, OH. She is the ACS Advisor on the AMA CPT Advisory Committee, and a member of the ACS General Surgery Coding and Reimbursement Committee.*

Ms. Jackson *is Practice Affairs Associate, Division of Advocacy and Health Policy, Washington, DC.*