CODING & DOCUMENTATION

Cindy Hughes, CPC, CFPC

E/M coding and preventive visits

Q If a new patient comes in for a preventive visit and the physician also addresses a significant, separately identifiable and documented problem, we bill for the additional E/M service with modifier 25. Should we bill a new patient code for the E/M service or an established patient code?

A Report both services as "new" patient encounters because the patient cannot simultaneously be considered new and established from a coding perspective. The Centers for Medicare & Medicaid Services includes the new patient E/M office and other outpatient service codes in their answer to the question of whether a separate E/M service may be billed at the same visit as an Initial Preventive Physical Examination (IPPE): "Medicare payment can be made for a significant, separately identifiable, medically necessary E/M service (CPT codes 99201-99215) billed at the same visit as the IPPE when billed with modifier 25. That portion of the visit must be medically necessary to treat the beneficiary's illness or injury, or to improve the functioning of a malformed body member." Individual payer guidance may vary based on electronic claim adjudication rules.

You may also wish to consider that a new patient E/M service requires documentation of all three key components, whereas an established patient E/M service requires only two of three key components. Physicians must be careful to consider only the additional work related to the problem-oriented E/M service when selecting that level of service. The preventive service likely includes a complete past, family, and social history, complete review of systems, and some extent of examination. Given this, the problem-oriented history of present illness, expanded review of the problematic and related system, and extended examination associated with the E/M service may not meet the requirements for a new patient visit code. Also note that you may code the E/M portion of the visit based on time if more than 50 percent of the face-to-face time associated with the problem-focused service was spent counseling and/or coordinating care. In this case, be sure to specifically document the time devoted exclusively to the problem-oriented service.

Transitional care management

Q Regarding transitional care management codes 99495 and 99496, if we see the patient for a 99213- or 99214-level service before the end of the 30-day period, can we bill for that visit at that time and then bill the 99495 after the 30 days?

A The first face-to-face visit with the patient is a required component of the transitional care management (TCM) service and is included in either code 99495 or 99496. Any additional visits would be separately reported with the appropriate E/M code and billed on the date of service. TCM states that for care of moderate complexity you must see the patient *within* 14 calendar days of discharge. For care of high complexity, you must see the patient *within* seven calendar days. The TCM service should be reported after the 30-day period.

E-prescribing penalties

Q The code I use to indicate that prescriptions were sent electronically for Medicare patients (G8553) is being rejected. I thought we still needed to report this to avoid the penalty for not e-prescribing. Should we still be submitting this code?

A As of Jan. 1, 2014, that code does not exist. The e-prescribing initiative was applicable for 2011, 2012, and 2013. This year, practices will receive either a bonus for successful participation in 2013 or a 2 percent penalty based on failure to successfully participate. Alternatively, practices may qualify for an exemption for the reporting periods in 2012 or the first half of 2013. For more information, see http://go.cms.gov/1qFuSC8. FPM

About the Author

Cindy Hughes is an independent consulting editor. Author disclosure: no relevant financial affiliations disclosed. These answers were reviewed by members of the *FPM* Coding & Documentation Review Panel, including Asia Blunt, MBA, CPC; Robert H. Bösl, MD, FAAFP; Marie Felger, CPC, CCS-P; Thomas A. Felger, MD, DABFP, CMCM; Emily Hill, PA-C; Joy Newby, LPN, CPC; and Susan Welsh, CPC, MHA.

WE WANT TO HEAR FROM YOU

Send questions and comments to **fpmedit@aafp.org**, or add your comments to the article at **http://www.aafp.org/fpm/2014/0500/p29.html**. While this department attempts to provide accurate information, some payers may not accept the advice given. Refer to the current CPT and ICD-9 coding manuals and payer policies.