CME

Special Edition: E/M Changes

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PROVIDING E/M SERVICES AND A PREVENTIVE PHYSICAL

Q Do the E/M code revisions change how I should bill when I provide a problem-oriented office visit and a preventive physical on the same day? Can I bill an E/M office visit based on total time, plus a preventive physical exam code? Can I bill an E/M office visit based on medical decision making, plus a preventive physical exam code? Or can I bill only an E/M office visit but increase the total time to include everything?

A The code revisions are unlikely to affect how you bill for preventive care services provided on the same date as a problem-oriented office visit. However, when billing a problem-oriented E/M visit based on total time, you must carve out the time spent on separately reportable services. For example, if you spend 30 minutes providing and documenting the preventive service, this cannot be included in your total time for the E/M office visit. Follow CPT guidelines for reporting combinations of preventive and problem-oriented services unless payer policies instruct otherwise.

DISCUSSING DATA WITH AN EXTERNAL PHYSICIAN

Q In the "data" section of the medical decision making table, category three includes discussion of management or test interpretation with an external physician. Does that mean calling the physician on the date of service, or does making a referral to an external physician count, even if I don't talk to the physician on that day?

A The rules for medical decision making are different than the rules for total time. If you are billing based on total time, only the time you spent on the visit on the date of the encounter would count. But if you are billing based on medical decision making, all data related to the visit would count, whether you reviewed it on the day of the visit or not. For instance, you may request a call from a subspecialist on the date of the encounter but not actually communicate interactively with the subspecialist until the next day. This interactive communication, when documented, counts toward your medical decision making for the visit. But solely making a referral — without interactive communication with the external physician about problem management — would not count as discussion of management with an external physician for purposes of medical decision making.

WARFARIN MONITORING

Q The "risk" section of the medical decision making table refers to "drug therapy requiring intensive monitoring for toxicity," but not monitoring for therapeutic purposes. Warfarin monitoring involves both, so does it count toward medical decision making or not?

A As you note, monitoring of warfarin is done for both toxicity and therapeutic purposes. However, some payers do not recognize warfarin as a drug that requires monitoring for toxicity, while other payers do (including at least one Medicare Administrative Contractor). Unfortunately, this drug must be evaluated on a payer-by-payer basis when leveling visits.

E/M OVER THE PHONE

Q How do I choose between codes G2012 and 99441 when an E/M service provided by telephone lasts 5-10 minutes?

A The Centers for Medicare & Medicaid Services (CMS) defines G2012 as communication to determine if a face-to-face visit is needed, while code 99441 does not have a defined intent. That means that 99441 might be appropriate for a telephone call that rules out the need for a face-to-face E/M service, and it might also be appropriate for a telephone call to evaluate a patient's response to management or treatment. But G2012 would only be appropriate for the first call. The potential overlapping use of the codes is due to a CMS policy that usually does not allow payment for E/M services reported with codes 99441-99443. That policy has been waived during the COVID-19 pandemic. FPM

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EDITOR'S NOTE

Reviewed by the *FPM* Coding & Documentation Review Panel. Some payers may not agree with the advice given. Refer to current coding manuals and payer policies.

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