
## CODING Q&A

# E/M for Sinusitis and Pharyngitis

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**Q. The clinic I work at uses 99214 for most patients (50%) for sinusitis and pharyngitis. Is this a common code to use for these problems?**

A. The E/M levels of services recognize seven components:

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

The history, examination, and medical decision making are considered to be the key components in selecting a level of E/M service. Counseling, coordination of care, and the nature of the presenting problem are considered contributory factors. Although they are important E/M services, they are not required for each patient encounter.

When face-to-face counseling and/or coordination of care dominates (more than 50%) the encounter with the patient and/or family, then time shall be considered the key or controlling factor to qualify for a particular level of E/M service. This does include time spent with parties who have assumed responsibility for the care of the patient.

E/M codes for office or other outpatient services are based on the patient being new or established. According to CPT guidelines, a new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the same specialty and subspecialty who belongs to the same group practice within the past 3 years. Professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report E/M services.

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You can read more on this subject in one of my columns in *JUCM*: http://jucm.com/magazine/issues/2009/0209/files/36.html.

In addition to having different codes for new and established patients, you must also determine the extent of the history obtained, examination performed, and the complexity of the medical decision making in order to determine the correct E/M code.

Let's look at a scenario in which an established patient presented with a sore throat. Because the provider had not seen that patient previously she did an extended history of present illness (HPI) (5 elements), complete review of systems (ROS), and a complete past, family and social history (PFSH). Eight systems were documented for the PE. The rapid test was positive and the provider prescribed an antibiotic.

If you were just counting the elements as noted in the 1995 E/M guidelines, the algorithm for the documentation noted would produce a 99215. According to CPT guidelines using the case presented above, the history (Hx) component would be deemed comprehensive, the physical examination (Px) deemed comprehensive, and the medical decision making (MDM) moderate. The final code should result from meeting at least two of the three key components (Hx, Px, MDM) for an established patient visit. Thus, you drop the lowest component (MDM) and the code results from the lowest remaining component. However, in this case, the two remaining components (HX and PX) are both documented at a level consistent with a level 5. Many providers might choose to throttle the code to the level of MDM, which would result in a 99214 code.

Even though you can count key elements to get a code, according to the Medicare Internet-Only Manual, publication

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100-4, chapter 12, "Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed." It is up to the provider to determine what information is medically necessary to evaluate the patient and document accordingly.

If this was an otherwise healthy patient with a sore throat, the question for you to answer is this: "Was it medically necessary to perform a comprehensive history and exam?" That is a provider decision, but in many cases, in urgent care the provider is not very well acquainted with the patient (even if officially an "established" patient), so doing a more thorough history and physical exam is often quite appropriate. I have written about this specific issue in *JUCM*:

- http://jucm.com/magazine/issues/2011/0511/files/43.html
- http://jucm.com/magazine/issues/2011/0611/files/33.html
- http://jucm.com/magazine/issues/2011/0911/files/45.html

One of the main criteria to consider in selecting an Electronic Medical Record (EMR) is to make sure that you choose an EMR that systematically and automatically codes (preferably using 1995 rules for E/M coding) the same way for every provider, so that your providers can be comfortable that they are fully compliant in their coding and still being fully compensated for the work that they have done. Having such a system is important to avoid and detect outlier physicians that can cost over $100K in annual lost revenues and/or get your practice into serious compliance issues. No matter what EMR you select, it still remains important to regularly audit charts of each provider to make sure that the coding is accurate and the documentation and procedures are consistent with medical necessity. ■



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