MDM, E/M Code with Injection Codes

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Q. I was approached by a member of the hospital billing department who does urgent care (office based practice) and emergency department billing about a coding question. As the medical director, they asked for my thoughts and support. It's nice to work at a place that includes the docs! The question revolves around prescription drug management within the management options under the medical decision making (MDM) section pertaining to E/M calculation. We currently do not use this as a criterion to determine the billing level. If we were to use this option, I believe we would be able to raise many level 3 visits to level 4 visits.

For example, the patient presents with a sore throat and a rapid strep test is performed. That would most likely be billed as a level 3 by most providers in our group, based on the following information when calculating the MDM:

- Treatment Options: New problem to examiner with added workup = 4, Extensive
- Complexity: Order of clinical lab tests = 1, Minimal
- Risk: Undiagnosed new problem with uncertain prognosis = Moderate
- MDM = Moderate

Based on the information above, we should bill the sore throat/pharyngitis as a level 4, even without taking into account the prescription drug management.

Adding prescription drug management (Rx for Amoxicillin or other drug) would add more support to Treatment Options. I received a Medicare audit suggestion a few years ago about an influenza patient I treated with rapid flu testing and Tamiflu. I billed as a level 3, but the audit suggested level 4. What are your thoughts?

The next example is a patient who presents with an ankle sprain or fracture. An x-ray is ordered, and a prescription for Vicodin is given. We would calculate the MDM as follows:

- Treatment Options: New problem to examiner with added workup = 4, Extensive
- Complexity: Order of radiology test = 1, Minimal
- Risk: Prescription drug management = Moderate
- MDM = Moderate

What are your thoughts on billing level 4 visits in the scenarios presented?

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A. It is nice to include the docs, as you say. Unfortunately, we have found that getting providers to consistently code E/M codes correctly is essentially impossible. I discovered years ago that most providers cautiously and consistently under-code the E/M so much that most providers cause the practice to lose ~$50,000 to $80,000 per year. Training doctors was almost impossible. Even after taking full-day coding trainings, they would revert to their old habits within a few days. That is why we actually created our EMR - to automate the coding and eliminate these coding errors.

E/M coding is quite complex, but the scenarios that you describe can be coded as a level four (as far as complexity). I just differ a little with the algorithm and results that you show, but the final MDM levels are the same. I have always taken a con-

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servative stance and interpreted "work up planned" as referring to a work up that is "planned" to be completed after the actual visit.

Using Marshfield Clinic guidelines for MDM, you can code your scenarios as described below.

The patient presents with a sore throat and a rapid strep test is performed:

- Diagnoses: New problem (to examiner), no workup planned = 3, "Multiple"
- Data Reviewed: Order of clinical lab tests = 1, "Limited"
- Risk: Prescription drug management = 3, "Moderate"
- MDM = Moderate

The patient presents with an ankle sprain or fracture. An x-ray is ordered, and a prescription for Vicodin is given:

- Diagnoses: New problem (to examiner), no workup planned = 3, "Multiple"
- Data Reviewed: Order of clinical lab tests = 1, "Limited"
- Risk: Prescription drug management = 3, "Moderate"
- MDM = Moderate ■

Q. I would like information on coding an E/M code with an intramuscular (IM) injection procedure code for an urgent care EMR.

A. You can bill an E/M code with an IM injection code if a separate E/M service was performed. You would bill the appropriate E/M code with a modifier -25, "Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service." Keep in mind that some payors may still bundle the E/M service into the injection code, so be sure to check payor agreements.

CPT also states, "Do not report 96372 for injections given without direct physician or other qualified health care professional supervision. To report, use 99211...." Therefore, if no physician is on the floor to supervise an injection given by a non-physician, then you can only bill 99211 for the injection service and 96372 is not billable.

You can often also bill the medication supply codes. You would find these codes in the HCPCS Level II manual. ■

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