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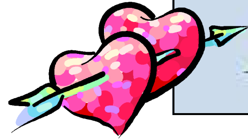

EMCoder Uplink

News for the Professional Coder

Volume 3 Issue 1 **February 2006**

Winter Greetings

Hello, and a warm welcome to all of our new subscribers! We hope you're having a safe winter season, and we wish for you a successful 2006.

The staff here at Spring Management Systems is very excited about the upcoming year and the launch of our new E&M Coder 8.5, as well as a new and innovative online service we'll be introducing in April. Stay tuned and we'll keep you posted.

We hope you'll enjoy our feature article on how E&M Code changes for 2006 might effect you, and be sure to check out the discussion on page 3 regarding the benefits of quality control and chart reviews.

As always, our goal is to provide you with the tools and tips you need to make your job easier. Enjoy!

Shirley Moy
President
Spring Management Systems, Inc.

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CPT 2006: New E&M Codes

Professional coders know that in order to provide accurate coding and prompt reimbursement, it's critical to stay up-to-date on the most recent CPT code revisions. Changes and additions to the coding requirements and guidelines are published annually by the AMA in their Current Procedural Terminology (CPT) Manual and should be reviewed carefully.

In 2005, very little changed in basic E/M codes. However, this year six sets of codes have been deleted and seven have been added - a significant number of E/M changes! The following is a brief summary of the changes made to E/M codes in 2006:

The description of modifier -25 has been expanded to further describe significant, separately identifiable services. It now explains: "A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see E/M services guidelines for instructions on determining level of E/M service)."

In addition to the changes to modifier -25, the CPT Editorial Panel has also deleted the follow up inpatient consultation codes (99261-99263) as well as the confirmatory consultation codes (99271-99275). The CPT manual explains that only one initial consultation should be provided by a physician for each incident of care, and that subsequent hospital care codes should be used to report services provided after the initial consultation.

Major revisions have also been made to the codes for care of patients in a nursing facility. Codes 99301-

Continued on page 4

Visit us at the AAPC Conference!

This year's AAPC Conference promises to be a grand event, held from April 2-5 at the America's Center in downtown St. Louis, Missouri. Entitled "The Spirit of Coding", the conference will provide a wide variety of educational and networking opportunities, and is a great time to share time and experiences with fellow coders.

In addition to the many educational sessions offered, the conference will also provide the opportunity for coders to browse some of the most recent developments in products, technology and services We hope you'll come and visit us at the E&M Coder Booth #416 - we'd love to meet you!

For more information or to register for this year's Conference, check online at www.aapc.com

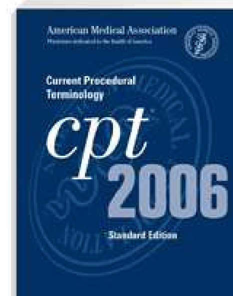
E&M Coder™ 8.5 Professional Edition

"Simple Compliance Since 1994!"

We're pleased to present E&M Coder v8.5, the compliance coding software that allows the professional E/M Coder to quickly produce consistent and accurate results! In addition to our easy-to-use screens, we've packed the newest version of our software with even more reports and features. Simply enter your patient visit information and E&M Coder will do the rest!

Features:

2006 CPT Codes



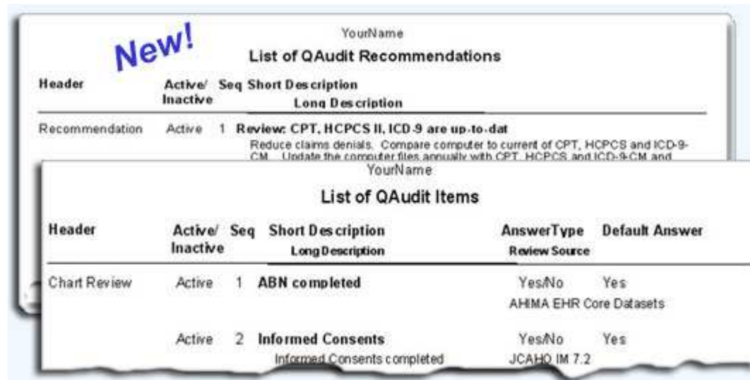
It's 2006, and the Evaluation and Management (E/M) codes have changed!

E&M Coder 8.5 utilizes the most recent and up-to-date E/M Codes as documented in the American Medical Association Current Procedural Terminology: CPT 2006 Manual for Evaluation and Management. Stay current and compliant with coding software that keeps you sharp in today's ever-changing world of Medical practices.

QAudit

We are excited to introduce QAudit™, the newest addition to **E&M Coder's** comprehensive coding package. Simple-to-use and flexible, this quality control tool is fully customizable and allows the Coder to track, review and report on a wide variety of quality control items. In addition, the Coder has the ability to select customized Recommendations based on chart quality analysis, providing a useful means of presenting and correcting quality control issues.

"At last! An easy-to-use quality control tool built right into my professional coding package!"



Reports

We know that good reporting can make the professional coder's life much simpler, and with E&M Coder we provide a comprehensive package of audit and analysis reporting. Our newest set of reports focuses on Office, Inpatient, Emergency Department, and Consult Visits by providing the Coder with a quick and accurate numerical analysis of the E/M codes Billed, Documented, and the Potential Optimal Codes for each area. As a companion report to our comprehensive Chart Review, this new Analysis Report provides a powerful tool for reviewing and improving current practice procedures.

For full details on our new E&M Coder v8.5, please visit our website at: **www.emcoder.com**

Go For the Gold!

In honor of the 2006 Winter Olympic Games, we would like to offer you a very "cool" special deal! Simply mention the following discount code (**N601010**) when ordering your new E&M Coder v8.5 between now and April 1 and receive a 10% discount off your purchase.

The Importance of Quality Reviews

The implementation of a good quality review program is essential to the efficient and accurate functioning of your coding systems. By reviewing your billing processes on a regular basis, you'll be more likely to identify potential problems and irregularities before they come to the attention of the federal review board.

In addition to providing clues to irregular coding procedures, periodic chart reviews often provide a valuable means of discovering coding mistakes that result in lowered reimbursements and lost money. The following is a sample of the list put together by Candy Le'Oso, practice administrator for internist Gregory Hood in Lexington, KY, and Alice Morgan, his billing office manager, of coding mistakes that represent lost income:

- Not billing appropriately for preventive visits.
- Not coding for counseling time connected with other codes.
- Failing to place the most significant service or procedure first with the correct diagnosis.
- Failing to remember that, when determining a code on established patients, only two of the three key components are required: history, physical, and decision-making. History and decision-making are enough, but an exam with either of the two is also enough
- Not documenting legibly.

Practice management experts suggest that in order to keep staff current with up-to-date procedures and to minimize problems, reviews should be conducted on at least an annual basis. Monthly, or ongoing regular quality reviews are even more ideal, providing constant feedback and regulation of procedures. Making sure physicians are trained in documentation guidelines will also help to ensure that chart files received are well-documented and complete.

Quality reviews - a great idea for 2006!

Coder's Forum

Field-Tested Way to Ease Your Modifier 25 Claims

The AMA will provide helpful clarification on when to append modifier 25 in CPT 2006, but if you're seeking still more on how to ace your modifier 25 claims, here's a surefire tip.

1: Report Only 'Significant' Services

To gain separate payment for an E/M service the physician provides at the same time as another procedure or service, the E/M service must be both significant and separately identifiable.

All procedures, from simple injections to common diagnostic tests, include an "inherent" E/M component, according to CMS guidelines. Therefore, any E/M service you report separately must be "above and beyond" the E/M service the surgeon provides that normally accompanies a procedure, says **Barbara J. Cobuzzi, MBA, CPC, CPC-H, CHBME,** president of CRN Healthcare Solutions, a coding and reimbursement consulting firm in Tinton Falls, N.J.

Example: The patient arrives for a previously scheduled diagnostic endoscopy (43235, *Upper gastrointestinal endoscopy including esophagus, stomach and either the duodenum and/or jejunum as appropriate; diagnostic, with our without collection of specimen[s], by brushing or washing [separate procedure]*). The surgeon provides a cursory exam to assess the patient's fitness for the procedure. In this case, the exam, history and medical decision-making (MDM) does not exceed a level-two E/M service (99212), and therefore the service does not qualify as significant.

Extra tip: "I ask myself, 'Can I find in the notation a clear history, exam and medical decision-making?' If so, I've got a separately billable service" with modifier 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service), says **Laureen Jandroep, OTR, CPC, CCS-P, CPC-H, CCS,** director and senior instructor for CRN Institute, an online coding certification training center based in Absecon, N.J.

Jan 30, 2006 - www.medicalnewswire.com, Medical Coding Wire

CPT 2006: New E/M Codes *continued*

99303 have been replaced with codes 99304-99306 (Initial nursing facility care, per day), and subsequent nursing facility care is now reported by codes 99307-99310. A new code, 99318, has been added under other nursing facility services for reporting nursing facility assessments.

The codes for Domiciliary or rest home (boarding home) visits, or custodial care services have also been dramatically revised. Codes 99321-99323 have been replaced with new codes 99324-99328, and 99331-99333 have been replaced with 99334-99340. This provides a more standardized structure for new and established patient visits in the rest home or custodial care services.

Two new time-based codes, 99339 and 99340, are now used for reporting care plan oversight provided to a patient who is not under the care of a home health agency, enrolled in a hospice or residing in a nursing facility. These codes provide flexibility and are similar to care plan oversight codes for home health/hospice.

For details on the new E/M code guidelines, please review the 2006 CPT Manual.

Excerpts taken from the Family Practice Management Web site at www.aafp.org/fpm

DELETED E/M Codes	
99261-99263	Follow-up inpatient consultation codes
99271-99275	Confirmatory consultation codes
99301-99303	Nursing facility assessment
99311-99313	Subsequent nursing facility care
99321-99323	Domiciliary or rest home visit, new
99331-99333	Domiciliary or rest home visit, estab.

NEW E/M Codes	
99300	Subsequent intensive care, per day, for the eval. and mgmt of the recovering infant (present body weight of 2501-5000 grams)
99304-99306	Initial nursing facility care, per day
99307-99310	Subsequent nursing facility care, per day
99318	Annual nursing facility assessment
99324-99328	Domiciliary or rest home (e.g. boarding home), or custodial living facility, new patient
99334-99337	Domiciliary or rest home (e.g. boarding home), or custodial care services, guidelines now state including assisted living facility, estab. patient.
99339-99340	Domiciliary, rest home (e.g. assisted living facility), or home care plan oversight services.

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- Audit Report highlighting Visits without a Chief Complaint

And much more...

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