E/M Coding for Nonphysician Practitioner Services

by William G. Cox, BS, RHIA

Effective January 1, 1988, a provision of the Balanced Budget Act of 1977 (Section 4511) removed restrictions on settings where nurse practitioners, physician assistants, and clinical nurse specialists provide services. The definition of a clinical nurse specialist was also modified to require a master's degree in a defined clinical area of nursing from an accredited educational institution.

Nonphysician practitioners (NPPs) may perform any service that a physician would provide in keeping with restrictions imposed by state licensing acts. NPPs could potentially use all of the Current Procedural Terminology (CPT) codes in the evaluation and management (E/M) and surgical sections of the *CPT Coding Manual;* however, it should be understood that many of the procedure codes will not be used by NPPs because they most likely lack the facility or payer credential to perform the services. This article will address the use of E/M CPT codes for NPPs.

Coding by Setting

An NPP may be found working in one of two environments or a combination of both, depending on the availability of a supervising physician:

- An individual practitioner with a collaboration agreement with a physician
- An incident-to practitioner under the direct supervision of a physician

When practicing in an incident-to setting under direct supervision of a physician, an NPP would only use the CPT codes from the 99211 to 99215 range, since this service category is to be provided under an already-established plan of care and only in the physician's office. The physician must be in the office, though not necessarily in the same room as the NPP, to meet the definition of direct supervision. Services would be billed by the physician, not the NPP.

An NPP may practice as an individual practitioner during the morning hours in a physician's office while the physician is seeing hospital patients and work as an incident-to practitioner in the afternoon while the physician is seeing patients in the office.

When practicing as an individual, the NPP may use the CPT codes from the 99201 to 99499 range. These codes are categorized into groups that include:

- Office and outpatient services
- Hospital services
- Consultations
- Emergency department services
- Critical care services
- Nursing facility services
- Domiciliary, boarding, or custodial care services
- Home services

With the exception of critical care services, the documentation requirements for all of the categories are similar in that the code descriptions require different levels of history, physical examination, and decision making to allow assignment of a code for the service provided.

The documentation requirements are not identical for each level of each code. The requirements to assign a New Patient Level I Office Visit CPT code (99201) are not the same as the requirements to assign an Established Patient Level I Office Visit code (99211).

Most of the E/M codes have five levels. However, this is not true for all of the categories. Hospital codes, with the exception of the consultation codes, have only three levels, and preventive medicine codes have seven levels and are based on the patient's age.

Documentation Requirements for E/M CPT

There are two classes of CPT office visit codes for evaluation and management services. These codes differ between providing an initial service to a new patient and providing follow-up services to an established patient. Consultation codes and emergency department codes do not differentiate between new and established patients. Hospital codes differentiate services as being provided on the initial day (usually the admission date) and subsequent days.

The definitions for new and established patients are listed on the first page of the evaluation and management services guidelines in the *CPT Manual*.

- **New patient:** A new patient is one who has not received any services from the physician or another physician of the same specialty in the same group within the previous three years. Medicare has refined this definition for its patients to mean services performed face to face with the exception of interpretations of diagnostic tests.
- **Established patient:** An established patient is one who has received such services within the previous three years.

Three Keys to E/M Coding

Each office visit evaluation and management CPT code consists of three elements: history, examination, and decision making. For new patients, all three elements must be present at or greater than the specified level in order to assign a specific code. For established patients, two of the three elements must be present at or greater than the specified level in order to assign a specific code.

The **history** consists of:

- Chief complaint
- History of present illness
- Review of systems
- Past medical history
- Family history
- Social history

History levels, based on the content of the above items, are:

- Problem focused
- Expanded problem focused
- Detailed
- Comprehensive

Examination levels, based on the extent of the examination, are:

- Problem focused
- Expanded problem focused
- Detailed
- Comprehensive

There are two sets of standards for documenting the physical examination. The General Medical Surgical standard was published in 1994 and uses the number of organ systems or body areas documented as examined to determine the level of the examination. A follow-up set of standards, published in 1997, defines documentation elements for specialty examinations. These standards use specific documentation within organ systems to determine the level of the examination. Both sets are available on the Medicare Web site (www.medicare.gov) and may be downloaded without charge. The General Medical Surgical standard would be most appropriate for use by the majority of NPPs unless they have a specialty practice.

Decision levels are based on the presenting complaint, performed diagnostic procedures (planned or considered) and the complexity of the management options available for treatment of the patient. Decision complexity levels are:

- Straightforward
- Low complexity
- Moderate complexity
- High complexity

All evaluation and management codes used to report a service to an ill patient require the listing of a chief complaint. This is found to be missing in many case reviews. The following were frequently found listed as a chief complaint:

- No new complaints
- Regular visit
- Check-up
- Here for physical
- To establish care

Preventive medicine visits, which would be included in these reasons for the visit, require a comprehensive history and physical examination. Such a visit without these components does not qualify for assignment of a preventive medicine code. The definition of comprehensive in the *CPT Manual* differs for preventive medicine; however, no clear definition is provided. There is a notation that the extent of the comprehensive examination depends on the age and gender of the patient rather than a strict documentation of details as is required for the other E/M codes. Patients often relate complaints during a preventive medicine examination that had not been anticipated when the appointment was made. Such situations become not only preventive medicine, but a combination of services.

The *CPT Manual* states "If an abnormality/ies is/are encountered or a pre-existing problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office code should also be reported. Modifier '–25' should be added to the Office code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the Preventive Medicine service. The appropriate Preventive Medicine service is additionally reported."

To submit the office visit E/M code with modifier –25, it will be necessary to ensure that all of the key elements for the level of code selected are documented in the medical record.

Billing recommendations for such combination visits include billing each service at the full rate normally submitted by the physician or to discount the preventive medicine service by the amount of the office visit rate. The latter is recommended by Medicare. This recommendation has the advantage of reducing the Medicare patient's responsibility by the amount of the discount, since Medicare does not cover preventive medicine visits and it is the patient's responsibility to pay for such visits.

Section 1862(a)(1) of the Medicare Law (Title XIIIV of the Social Security Act) states that "Medicare will only pay for services that it determines to be 'reasonable and necessary.'"

The 1997 Balanced Budget Act also requires that NPPs provide diagnostic information for all claims submitted to Medicare. The information, after having been coded, is used to determine if there is sufficient evidence of medical necessity to allow payment for the services provided. NPPs should become aware of the necessity to provide complete and accurate diagnosis information to allow the most appropriate diagnosis code to be submitted on the claim.

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