PINNACOL
ASSURANCE

Tips for E&M Coding Level Documentation

We get it. Getting paid accurately is difficult. And we understand that payment issues and delays can wreak havoc on your cash flow and cause extra work. Pinnacol is here to help. We have certified coders on staff who can help you navigate the unique aspects of workers' compensation billing. One of the most common questions Pinnacol experts receive relates to documentation requirements for the five levels of Evaluation and Management (E&M) codes.

The Division of Workers' Compensation of Colorado (DOWC) sets the billing requirements for all workers' compensation cases in Colorado. Please refer to the DOWC's Rule 18, Exhibit 7 for additional details.

For medical services to be reimbursed, the Centers for Medicare and Medicaid Services (CMS) state medical necessity is the overarching criterion for payment. The CMS addresses overarching criterion in this way: "It would not be medically necessary or appropriate to bill a higher level of E&M service when a lower level of service is warranted." The volume of documentation should not be the basis for the level of service billed.

Medical necessity is defined as the activities justified as reasonable, necessary and/or appropriate based on evidence-based clinical standards of care.

E&M codes

99201-99205 — New patient

// Requires ALL three key components at the same level or higher

99211-99215 — Established patient

// Requires two of three key components at the same level or higher, one of the two must be the medical decision-making.

99241-99245 — Consultation

// Requires ALL three key components at the same level or higher.

Unsupported or under-documented codes may be subject to denial or audit.

Time for counseling and/or coordination of care

History

// Includes history of present illness, review of systems and past medical, and family and social/work history.

// To meet any given level, *all three elements* must be met and documented in the record. Documentation must be patient-specific and pertain specifically to the current visit.

// Copying and pasting history from a previous visit will not count toward meeting this component.

Exam

// Each requirement will be counted only when it is pertinent and related to the workers' compensation injury and the medical decision-making.

// History and exam components can be problem-focused, expanded problem-focused, detailed or comprehensive.

Medical Decision-Making

// The coding level for medical decision-making is determined by the highest two of three categories: diagnosis management, the complexity of the reviewed data, and the risk.

// Copying and pasting from previous visits will not be counted as meeting the requirement for medical decision-making.

// Medical decision-making can be straightforward, low, moderate or high.

// Time cannot always determine the level of service. Time can determine the level of service only if you submit patient-specific documentation for the visit that more than 50 percent of a physician's time was spent face to face with the patient in counseling and/or coordinating care.

// Counseling should include documenting the discussion/dialogue of what the patient and physician said, not just what they discussed. Documentation should include specifics and notations of the patient's understanding of the counseling — e.g., return-to-work discussions, pharmaceutical management (drug side effects and potential of addiction/problems).

// Documentation must support the amount of time spent with the patient.

// Coordination of care requires the physician to call another health care provider (outside of the clinic) to discuss the patient's diagnosis and/or treatment, or the physician to visit or call the employer to ensure the patient's safe return to work.

// Documentation must support the amount of time spent on coordination of care.

E&M level with closing report

// A final office visit billed with the closing report should rarely be billed as a moderate or high level E&M visit. If the injured worker is determined to be at maximum medical improvement, it is likely the injury is sufficiently improved without worsening problems or needing further workup.

// E&M guidelines indicate a level 99212 or 99213 would be appropriate for the medical decision-making for an established problem (stable or improved) with minimal or low risk and no further discussion or data review of labs, imaging or test results.

If you have any questions, please contact the Medical Payments and Appeals team at 303.361.4940 or billingsuccess@pinnacol.com. (Fax: 303.361.5940) For additional coding guidance and training, please visit www.aapc.com/training/medical-coding-training.aspx.