Coding for same-day visits and procedures

By Emily Hill, PA-C

Can you get insurers to pay you for a procedure like endometrial biopsy performed at the same time as a problem-oriented visit? Sometimes. Be sure to bone up first on the intricacies of proper coding.

If your ob/gyn practice is like most, your staff uses an appointment log to schedule a day's work. At a minimum, it consists of a patient's name and a general reason for her visit. These encounters may include postoperative visits, preventive medicine services, office-based procedures, and problem-oriented visits. But very often, the appointment log is only a hint of what is to come at the time of the visit.

Certainly, it is not uncommon to address more than one problem at a single encounter. This sometimes results in the performance of a test or procedure. Suppose a young woman presents with a complaint of pelvic pain that has persisted over several months. After a history and physical exam, sonography is ordered and interpreted. When filling out insurance reimbursement forms, most ob/gyns would not hesitate to report both services to the patient's health plan. If an established patient comes in with a complaint of dysfunctional uterine bleeding and you perform an endometrial biopsy, however, you might be uncertain about how to report the encounter. Although you would like to report both services, perhaps you've heard that only the *procedure* should be billed.

Understanding the rules

You have plenty of company if you find it daunting to correctly interpret the annually changing rules outlined in the procedure coding "bible" commonly known as CPT-4—or the 4th edition of the AMA's Current Procedural Terminology. (See also our symposium, "Prescription for coding nightmares: Take control," in the September 2000 issue of Contemporary OB/GYN). Also revised annually are ICD-9-CM diagnosis codes—the codes that must be matched with CPT codes to support the medical necessity of a service (Table 1).

TABLE 1: Glossary of terms

CPT- Current Procedural Terminology: Listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other health professionals to payors

Evaluation and Management Services (E/M): Code set in CPT that describes medical encounters or visits. Codes are organized in categories, subcategories, and levels of service.

Explanation of Benefits: Information provided to patients and providers by payors indicating how the claim was processed

ICD-9- International Classification of Diseases, 9th Edition: Classification system of illnesses, injuries, conditions, signs, symptoms and other reasons prompting health care encounters. Reported in conjunction with CPT codes to payors for reimbursement.

Modifiers: Means to indicate that a service or procedure has been altered by a specific circumstance without changing the definition or code for the service

Resource-Based Relative Value Scale (RBRVS): Payment methodology used by Medicare and some other payors to reimburse for physician and certain other professional services

Relative Value Unit: The unit of measure for the RBRVS. The RVU is multiplied by a dollar conversion factor to become payment amounts

"Starred" procedures (*): Certain relatively small surgical services that involve an identifiable surgical procedure but include variable preoperative and postoperative services

According to CPT, both the Evaluation and Management Service (E/M) and the procedure should be reported if a patient's condition requires a "significant, separately identifiable" E/M service. "Significant" implies that the E/M service required some level of history-taking, examination, and/or medical decision-making. "Separately identifiable" means the visit is distinct from the procedure. In other words, the E/M service should be above and beyond the usual care associated with the procedure.

The basis for this distinction lies in how codes are defined and subsequently valued for reimbursement. In general, CPT codes are designed to represent the typical activities normally associated with performing the basic service. The same concept is at work when Relative Value Units (RVUs) under the Resource-Based Relative Value Scale (RBRVS) are applied. E/M services do not include the performance of tests or procedures. Most surgical procedures, however, include some E/M activities. In the case of office-based procedures, the work associated with obtaining an informed consent, checking on medications and allergies, and observing the patient following the procedure was factored into the payment for the service. Therefore, you should report separately only those services that exceed this typical work.

This general rule is not affected by the type of E/M service reported. It may be appropriate to report both services at the time of a consultation, a new or established patient encounter, or even a hospital visit. The key is that you've provided distinct services.

CPT designates certain relatively small surgical procedures with a star (*), indicating that they have variable pre- and postprocedure services. The same guidelines for reporting preoperative E/M services apply to these "starred" procedures. Also take a look at the introduction to the surgical section of CPT, which offers additional guidance when the procedure constitutes the majority of work at an initial visit. CPT 99025 is the mechanism for indicating the type of E/M service provided in this circumstance. It is important to note that most payors do not reimburse for this code, since it implies a minimal service that is usually considered integral to the procedure. For example, a new patient is sent to your office by her primary-care physician for a colposcopy following an abnormal Pap smear. If the colposcopy is performed with only minimal E/M service, then the visit would be reported with code 99025. Furthermore, CPT instructions state that an appropriate visit code should be reported when "significant" E/M services are provided in conjunction with a starred procedure. Therefore, if additional E/M services are provided to review the patient's history, perform an exam, and determine the appropriate course of action, then the visit would be reported using a problem-oriented E/M service.

Identifying the additional work

When E/M services are provided on the same day as a procedure, you must identify the additional service on the insurance claim form. CPT instructs the provider to append the –25 modifier to the E/M service to confirm that distinct services were performed. The CPT brief descriptor for the –25 modifier reads "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service."

CPT further states in its instructions for using the –25 modifier, "The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date." Therefore, in the case of the patient with dysfunctional uterine bleeding, the diagnoses for both the E/M service and the endometrial biopsy would likely be the same. You could correctly report both services. In other situations, the visit might be prompted by a condition unrelated to the procedure. For instance, you might have a patient come in for a previously scheduled colposcopy and biopsy because of an abnormal Pap smear result. At the time of the encounter, she indicates that she noted a lump in her breast a few days earlier. All appropriate diagnoses are reported, but it is important that you link each CPT service to the applicable ICD-9-CM diagnosis code(s) on the insurance claim form as illustrated in Figure 1.

Figure 1: Sample claim form fro E/M service provided on same day as a procedure

21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 795.0 Abnormal Pap smear 2. 611.72 Lump in breast 3. 4.											22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER	
24. A						B	C	D		E	F	G
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	RVUs	DAYS OR UNITS
From MM DD YY			To MM DD YY					CPT-4/HCPCS	MODIFIER			
						11	2	57454		1		
						11	1	99213	- 25	2		

57454- Colposcopy of the cervix including upper/adjacent vagina; with biopsy(s) of the cervix and endocervical curettage

99213- Level 3 established patient E/M service

The visit was necessary to evaluate the breast lump and so you would not report and identify any of the usual pre- and post-procedure work associated with the colposcopy. Therefore, only ICD-9 code 611.72 was associated with the E/M service on the claim form. As long as distinct services are performed and documented, it is appropriate to report both CPT codes using the –25 modifier for the visit.

Applying the guidelines

The following example shows how you would apply these guidelines. Holly, a 28-year-old established patient of Dr. Waddell, was seen on 11/1/00 with a developing Bartholin's gland abscess. After evaluation, Dr. Waddell prescribed oral antibiotics and hot baths q.i.d. Holly was instructed to return in 3 days for a probable incision and drainage (I&D). On 11/4/00, Holly returned after having followed her doctor's instructions. Dr. Waddell briefly examined Holly and decided to continue with the procedure.

At the initial encounter, Dr. Waddell reported an E/M service for the evaluation of Holly's complaint (Figure 2). The level of service was based on the extent of the medical history taken, the exam, and the medical decision making required to evaluate the problem. When Holly returned, only the I&D (CPT 56420) was reported since the evaluation of the problem and the decision to perform the procedure occurred at the previous visit (Figure 3).

Figure 2: Insurance form reporting an E/M service on first of two visits for patient "Holly" in example

21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 616.3 Bartholin's gland abscess 2. 3. 4.												22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER	
24. A						B	C	D		E	F	G	
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	RVUs	DAYS OR UNITS	
From MM	DD	YY	To MM	DD	YY			CPT-4/HCPCS	MODIFIER				
11	01	00	11	01	00	11	1	99213		1			

Figure 3: Claim reporting only I&D at patient "olly's" second visit

21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 616.3 Bartholin's gland abscess 2. 3. 4.												22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER	
24. A						B	C	D		E	F	G	
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	RVUs	DAYS OR UNITS	
From MM	DD	YY	To MM	DD	YY			CPT-4/HCPCS	MODIFIER				
11	04	00	11	04	00	11	2	56420		1			

56420- Incision and drainage (I&D) of Bartholin's gland abscess

Very likely, at this second visit, Dr. Waddell completed a brief review of Holly's symptoms, medications, and allergies. The patient also may have signed a consent form, had vital signs taken, and certainly would have been observed for any unexpected signs or symptoms following the procedure. These activities, however, are within the range of services that would typically occur at the time of a procedure and therefore an additional E/M service was not reported.

On the other hand, if at the initial encounter, Dr. Waddell had decided to proceed with the I&D, both services would have been reported on the same day (Figure 4). The –25 modifier would have been applied to the visit code to indicate that distinct services had been provided.

Figure 4: Claim for reporting same-day E/M service and procedure

21. DIAGNOSES OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 616.3 Bartholin's gland abscess 2. 3. 4.											22. MEDICAID RESUBMISSION CODE 23. PRIOR AUTHORIZATION NUMBER	
24. A						B	C	D		E	F	G
DATE(S) OF SERVICE						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		DIAGNOSIS CODE	RVUs	DAYS OR UNITS
From MM DD YY			To MM DD YY					CPT-4/HCPCS	MODIFIER			
11	01	00	11	01	00	11	1	99213	- 25	1		
						11	2	56420		1		

If "Dr. Waddell" had combined "Holly's" two visits into one, he might have filled out the insurance claim form as shown above

In general, report *both* the E/M service and the procedure if:

- The decision to perform the procedure was made at the same encounter as the E/M service (even if for the same diagnosis); or
- The diagnosis for the E/M service is different from the one for the procedure.

Generally, report *only* the procedure if:

- The decision to perform the procedure was made at another visit; or
- The E/M service provided on the same day did not require significant history-taking, physical exam, and/or decision-making

Documenting the encounter

It is important to clearly document a distinct visit whenever you report a procedure on the same day. Since all procedures include some element of patient evaluation, it is necessary to provide evidence of additional services. It is helpful, in the event of a review or appeal to the insurance company, to physically document separate notes. That doesn't mean they have to be on different pieces of paper or that a lengthy note is required. Simply skipping a space and labeling the procedure portion can help distinguish the services.

Since each CPT code represents a separate element of work and reimbursement, payors expect complete documentation of all services for which reimbursement is requested. The level of E/M service that represents "significant, separately identifiable" work is debatable. It has been suggested that a problem-focused encounter, such as a 99212 (established patient E/M service representing a problem-focused history and exam and straightforward medical decision making), may not be indicative of a significant visit. At a minimum, you should note some level of history-taking, performance of an examination, medical decision-making and/or the amount of time involved. Your procedure note should clearly describe the service identified by the selected CPT code.

Payors and reimbursement

CPT-4 and Medicare have similar rules governing the reporting of visits on the same day as a procedure. Medicare will pay for both the E/M service and a procedure provided on the same day at the full allowable amount. This is true regardless of whether single or multiple diagnoses apply. You must apply modifier –25 to the E/M service in order for it to be reimbursed, since the carrier's computer systems are designed to "read" the modifier. This holds true even when different diagnoses are attached to each service. As with all services, they must be medically necessary for the evaluation or treatment of a patient and clearly documented.

Other third-party payors may have their own guidelines based on internal payment policies. Payors that follow CPT guidelines reimburse for both services and usually require that the –25 modifier be attached to the E/M code. As does Medicare, they may elect to randomly review the documentation associated with these claims to ensure that payments were made appropriately. That's why it's obviously important that you include documentation in the record clearly supporting the medical necessity and the separate nature of the services.

Still other payors reimburse for both services, but only if there are different diagnoses for the visit and the procedure. Therefore, it is important to carefully consider the ICD-9 options and report the code most specific to each service. In the previous example of Holly, Dr. Waddell might have chosen "vulvar pain" (ICD-9 code 625.9) as the reason for the visit and "Bartholin's gland abscess" (ICD-9 code 616.3) for the procedure. As some payors see it, this provides the rationale for both services occurring on the same day. The use of a single diagnosis implies that the condition had been previously diagnosed and the decision to perform the procedure was made at an earlier encounter. You need to carefully format the claim form to ensure that the appropriate diagnosis has been related to each CPT code. The modifier –25 is still applied to the visit to differentiate these services from those typically associated with the procedure.

There are some health plans that may never reimburse for both services on the same day. This policy may persist even when the –25 modifier is used and distinct diagnoses are linked to the individual services. When both services are reported, the payor will often reimburse for the procedure and deny the E/M service as "bundled" into the procedure. For patients covered by these plans, you'll need to schedule a separate encounter for the procedure in order to be paid for all the work provided. When it is not medically appropriate to delay the procedure and the work of both services is performed, report the E/M and procedure code using the appropriate diagnoses and the –25 modifier. In the event that one of the services is denied, it may be helpful to appeal with clear documentation of both services that carefully indicates the medical necessity of the encounter.

Dealing with denials

Some managed-care plans require a "referral" from a primary-care physician before reimbursing for specialty services. In some cases, the referral must specify the services requested. For instance, if the referral was for E/M services only, then reimbursement for the procedure will be denied. This denial does not necessarily indicate that the plan's policy is to reimburse for only one service per encounter. It simply means that payment had not been approved for any procedure performed at the same time.

The reverse situation may also occur. Even though a patient may have a referral for a given procedure, the specialist may perform a distinct evaluation to determine the necessity and appropriateness of that course of action. In this circumstance, both services can be coded, but you may receive payment only for the procedure, if performed. Educating referral sources to assure that appropriate referrals are sent may be necessary for optimal patient care and reimbursement.

Make sure you understand the reason for a denial before deciding whether to appeal the decision. If the Explanation of Benefits states that the visit is included in the payment of the procedure, an appeal including documentation of the "separately identifiable" encounter may result in payment. In these instances, it is critical that you provide clear and distinct documentation delineating the visit and procedure.

On the other hand, if the denial indicates that payment for only one service will be made for a given date, then the chances of overturning the appeal decline. Always check to make sure that the modifier has been attached to the E/M service, particularly for Medicare claims.

Conclusion

Although proper coding does not guarantee reimbursement, it is important to apply the CPT guidelines consistently for all types of payors. Table 2 lists some important reminders. Understanding the rules can improve your chances for reimbursement while protecting your practice from potential audit liability.

TABLE 2: Checklist for reporting multiple services

1. Only report the visit if it is truly "above and beyond" the work typically associated with the procedure.
2. Make sure that the documentation clearly reflects the distinct nature of both services.
3. Attach the –25 modifier to the E/M service.
4. Report the most specific ICD-9-CM diagnosis codes and link them to the associated CPT services on the claim form.
5. Monitor the Explanation of Benefits from the payor.
6. Appeal with documentation as appropriate.

Ms. Hill is Consultant on Coding and Compliance, Hill & Associates, Wilmington, N.C.
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