Coding Issues for Interventional Radiology: Get Paid for What You Do!

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ABSTRACT

As interventional radiology continues to evolve into a true clinical practice, more time will be spent on the clinical decision process; this time is reimbursable in the form of evaluation and management (E&M) services. Once assumed to be an inherent part of the procedure itself, we know many procedures now do not include follow-up E&M components. Unfortunately, E&M coding is somewhat complex and requires rigorous documentation. Below is a discussion of the fundamentals of E&M services, general principles of documentation, and the mechanics of coverage and reimbursement.

KEYWORDS: Coding, interventional procedures, evaluation and management, E&M

Objectives: Upon completion of this article, the reader will (1) understand the economic connection between patient management and reimbursable codes, (2) gain the ability to bill for services not directly related to the procedure itself but related to time spent in the management and counseling of the patient prior to the procedure, and (3) gain access to references for future inquiries.

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In their role as consulting providers or specialty care physicians for many patients, interventional radiologists have been providing additional services in the form of clinical evaluation and management (E&M) services. These services have historically been thought of as an inherent part of the procedure. However, as many procedures do not include follow-up E&M components, these services are themselves reimbursable but only if properly documented and coded. The complex nature of E&M coding and the documentation requirements have made many practices reluctant to bill for the legitimate services they provide. However, by not billing for these services, they are losing revenue.

Interventionalists are assuming increasing clinical responsibilities. A recent Society of Interventional Radiology survey estimates that the average interventionalist

spends 6% of his time providing such services. In addition, introduction of new *Current Procedural Terminology*, 4th Edition (CPT) codes has resulted in a significant reduction in reimbursement for some percutaneous procedures, such as transjugular portosystemic shunt (TIPS). With the new codes, a 0-day global period has been assigned with the intention of separating reimbursement for the procedure itself from reimbursement for patient evaluation and management. To recoup potentially lost revenue for services provided, practices providing clinical management services need to bill for them.

This article will address the fundamentals of E&M services, general principles of documentation, the approach to code and document E&M services, and the basic mechanics of coverage and reimbursement.

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The discussion of coding services is based upon guidelines provided in the CPT manual, published by the American Medical Association (AMA), and documentation guidelines provided by Medicare billing as published by the Centers for Medicare and Medicaid Services (CMS). However, each payer may have its own billing and documentation requirements.

These documentation guidelines for use with E&M codes were developed by CMS and the AMA in 1994 and were updated in 1997. However, due to delayed implementation of the 1997 update, auditors have been instructed to use either the 1995 or 1997 guidelines when reviewing medical records, *whichever is the most beneficial to the provider*. These guidelines can be found at the CMS website at: <http://www.cms.hhs.gov/medlearn/emdoc.asp>.

Note that although E&M services provided by physicians and nonphysician providers (NPPs) do not vary with regard to documentation guidelines, levels of service or types of service, Medicare reimbursement, when provided by NPPs, is reduced to 85%. For other third-party payers, there may be no difference in reimbursement.

THE CODING ENVIRONMENT

Medicare, Medicaid, and other third-party payers use CPT codes to evaluate use of health care services and determine provider reimbursement. CPT codes constitute level I of the Centers for Medicare and Medicaid Services' Common Procedural Coding System (HCPCS). CPT coding translates physician procedures/services into five-digit codes. To receive correct payment for their services, physicians must submit claim forms with correctly assigned CPT and HCPCS codes, supported by diagnostic codes from the International Classification of Diseases, 9th revision, Clinical Modification (ICD-9-CM).

Clinical services are reimbursed based upon the relative value unit (RVU) weighting of the appropriate CPT code. With changes in the RVUs of some of the procedures commonly performed by interventionalists

and with the removal of clinical evaluation and management from the RVUs for these procedures, it is appropriate for radiologists to bill separately for these clinical services. In fact, it is the only method by which the interventionalist will be reimbursed appropriately for this care.

Codes for E&M services are service-specific but not specialty- or provider-specific. However, there are very specific rules and circumstances that determine whether an interventionalist may bill E&M services (e.g., the global surgical package, unbundling, and the amount of documentation contained in the medical record).

ELEMENTS OF E&M CODES

As shown in Table 1, the E&M categories represent the type of services rendered, and the subcategories define the services or circumstances more specifically.

The following major factors affect code assignment:

- The three "key components" defining the level of service performed
- Whether the patient is new or established; for some services, this may be irrelevant
- Typical amount of time spent providing counseling and coordination of care services
- Severity of the presenting problem
- Site where the service is performed
- Written result of the encounter (e.g., a note, report, or dictated letter)

Each E&M CPT code is defined by three "key components." These are specific actions that must occur during the patient encounter for a code to be assigned. These include the history, physical examination, and medical decision making. These are further qualified according to the level of effort/complexity of the service performed (e.g., straightforward, low, moderate, or high complexity).

Table 1 Structure of the E&M Coding Section

Category	Subcategory	Code Range
Office/outpatient services	New patient	99201–99205
	Established patient	99211–99215
Hospital inpatient services	Initial observation care	99218–99220
	Initial hospital care	99221–99223
	Subsequent hospital care	99231–99233
	Office consultation	99241–99245
Consultations	Initial inpatient consultation	99251–99255
	Follow-up inpatient consultations	99261–99263
	Confirmatory consultations	99271–99275

Data adapted from E&M Coding for Interventional Radiology. Medical Learning, Inc.; 2004.

A new patient is one who has not received any professional services within the past 3 years from a provider or another provider of the same specialty belonging to the same group practice. If a patient sees a physician of a different specialty within a multispecialty group, each first face-to-face encounter in a different specialty is considered new. For new patients, all three key components must be documented to the level-of-service specifications outlined in the specific E&M code; for established patients (follow-up visits), only two of the three key components must be documented to the specified level.

In many E&M subcategories, the CPT code description includes a suggested amount of time typically spent face-to-face with the patient and/or family. However, this is only intended for use as a tool to assist in code assignment, which should not be determined by time unless counseling and/or coordination of care constitute > 50% of the visit (see below). Note that Medicare will not reimburse for time spent with the family without the presence of the patient, except in the case of inpatients.

Face-to-face time refers to the time the interventionist (but not ancillary staff) spends directly with the patient. Some inpatient E&M codes list unit/floor time as a time factor component. When these codes are used, time the interventionist spends discussing the clinical case with the family or other professionals, reviewing records, and writing/reviewing chart notes is considered as part of that time.

The requirement of two or three key components can be waived when counseling and coordination of care represent > 50% of the time the physician spends face-to-face with the patient. Time spent on the phone discussing the patient with the family may be considered counseling time only if the patient is present while the call is conducted. When reporting the level of service based on counseling and coordination of care, the specific activities undertaken and the amount of time spent must be documented, which can be achieved in two ways. A provider can document both the amount of time spent counseling and the total amount of face-to-face time, or document that > 50% of the visit was spent on counseling and document the total amount of time of the encounter.

DOCUMENTING E&M SERVICES

Before services and procedures can be translated into codes and a claim filed with the payer, the services or procedures performed must be documented. Comprehensive documentation informs billers and coders which service or procedure was performed and why it was medically necessary. Proof of medical necessity is an integral line of defense against claim delays and denials, as well as allegations of fraud and abuse.

Furthermore, prior to reimbursing for a service or procedure, Medicare and third-party payers frequently require information to justify its medical necessity. The medical record therefore must include information about the patient's symptoms or conditions, any coexisting or complicating conditions, and physician decision making.

A well-documented medical record will allow an individual who does not know the patient to determine the following: the patient's chief complaint; services or procedures performed (CPT code assignment, based on documented assessment or plan) and why (ICD-9-CM code assignment); the final diagnosis or suspected conditions (ICD-9-CM code assignment); and the treatment plan (typically documented in progress notes).

The medical record should be complete and legible. Documentation of each patient encounter should include the following: the date, an appropriate history and physical exam, results of laboratory and imaging studies, and an assessment and plan for care, including reasons for tests, as well as discharge planning and instructions to patient when appropriate. All entries should be signed.

In addition, within the medical record, past and present diagnoses should be accessible and relevant health risk factors identified. Patient progress, including response to treatment, changes in therapy or diagnosis, and patient noncompliance, should be documented. The written plan for care should include treatments and medications (specifying dosage and frequency), referrals and consultations, patient and family education, and specific instructions for follow-up.

Documentation of the three key components of the E&M service (history, physical examination, and medical decision making) should be sufficiently thorough to indicate the intensity level of each component. In addition, the time spent with the patient should be included when > 50% of the encounter was spent in counseling and coordination of care. The ICD-9-CM, CPT, and HCPCS codes reported on the health insurance claim form or billing statement should reflect the medical record documentation.

Most physicians use a problem-oriented approach to their notations in the medical record. The most common style, the "SOAP note," breaks the components of each clinical encounter into four categories.

- "Subjective" documents the history of patient's illness and patient's current perception of his status, along with any new complaints, issues, or questions.
- "Objective" includes the physical examination, laboratory, and imaging data.
- "Assessment" uses the gathered data to formulate a working differential diagnosis.
- "Plan" includes both diagnostic tests and therapeutic plans.

The last two sections are often lumped together into a problem-based list. Notes may be handwritten or dictated or a preprinted progress note may be filled in.

LEVELS OF CARE, CODE COMPONENTS AND THEIR ELEMENTS

The narrative description of most E&M codes includes components that help establish the level of service that was provided. There are three key components and four contributory components. The key components (history, examination, and medical decision making) are the most important for code selection within a subcategory, which depends largely upon the amount and intricacy of these components. The four contributory components are counseling, coordination of care, nature of the presenting problem, and time.

The nature of the presenting problem is not a measurable documentation requirement. However, it serves as a starting point for providers to begin an evaluation and therefore is felt to determine the necessary documented history components and areas or systems to examine and to lead to treatment plans. Standards of care suggest a certain complexity of work must be performed to appropriately diagnose and treat a given presenting condition. For example, for a patient presenting with a minor ankle sprain, the expected level of service performed would be lower than that for a patient presenting with severe chest pain with shortness of breath.

Each encounter requires specific types of information, and each type must be documented to a different degree of detail. This information determines the level of care. For most E&M codes, there are five levels of care, ranging from level 1 (the least complex and time-consuming) to level 5 (the most complex and time-consuming), with reimbursement increasing accordingly. To support a given level of care, there must be documentation that the patient received these services and that justifies their medical necessity.

Each of the three key components in the E&M codes will have different levels of service documented depending on clinical complexity of the patient. For example, the provider can obtain four levels of history (Table 2): problem-focused, expanded problem-focused, detailed, and comprehensive. The level of detail of the

history obtained will depend upon the nature of the presenting problem. To qualify for a given level of history, all four elements in the table must be met at the level specified. The seemingly generic terms such as *problem-focused*, *detailed*, and *comprehensive* are in fact descriptors that have very specific requirements as outlined in the CMS documentation guidelines (<http://www.cms.hhs.gov/medlearn/emdoc.asp>).

By the CMS guidelines, it is permissible for portions of the history, the review of systems, past, family, and social history to be obtained by ancillary staff or from a patient-completed questionnaire. The physician must review the information form with the patient, make any necessary changes, and document that the information was reviewed with a notation confirming or supplementing the information.

If the physician is unable to obtain a history from the patient or other reliable source, the physician must document the patient's condition or other circumstances that preclude obtaining the history. In such a situation, the entire history component is considered comprehensive. The level of physical examination and medical decision making will determine the overall level of service.

The physical examination and medical decision making each also have four levels of associated service with different documentation requirements. For medical decision making, complexity is measured, in turn, by three factors: the number of diagnoses and management options; the number or complexity of medical records, diagnostic tests, and other information that must be considered; and the risk of patient morbidity or mortality based upon the presenting problem, diagnostic tests ordered, or treatment options selected.

When, during an E&M encounter, patient counseling or coordination of care accounts for > 50% of the patient face-to-face time, the requirement for documenting the three key components is waived, and time becomes the main factor in selecting the correct level of service. The E&M code chosen then depends upon the "typical time" for a code as noted in its CPT description. Document the total length of time spent and that > 50% of the visit was providing counseling and coordination of care and describe the counseling or activities necessary to coordinate the patient's care.

Table 2 Levels of History

Level of History	Chief Complaint	History of Present Illness	Review of Systems	Past, Family, or Social History
Problem-focused	Documented	Brief	N/A	N/A
Expanded problem-focused	Documented	Brief	Problem-pertinent	N/A
Detailed	Documented	Extended	Extended	Pertinent
Comprehensive	Documented	Extended	Complete	Complete

Data adapted from E&M Coding for Interventional Radiology. Medical Learning, Inc.; 2004.

COVERAGE AND REIMBURSEMENT

The payment process is governed by numerous government rules and regulations and takes into account factors such as the location of service, the correct code choice, and appropriate documentation and claim-form completion. Elements affecting coverage and reimbursement include medical necessity, ICD-9-CM diagnosis codes, restriction on CPT code usage, modifiers, policies regarding major and minor surgeries, the use of physician extenders, and guidelines stemming from CMS's Correct Coding Initiative.

Even if a service is covered and the documentation supports the codes, many third-party payers may not pay for the service if the associated ICD-9-CM diagnosis code(s) do not fall within the list of diagnoses, created by the payer, which are considered appropriate for that particular procedure. Denial for lack of medical necessity can result in time-consuming appeals or needless write-offs and loss of anticipated revenue. Several steps can be taken to prevent such denials.

First, ensure that all necessary information is obtained from the referring provider. Create an incoming referral form and train staff to obtain the information needed to satisfy medical necessity according to the insurer guidelines. Second, track services that have medical necessity or frequency limitations. Draw attention to these services on your encounter form, indicating that these services require a waiver of liability for noncoverage due to medical necessity before the service is rendered. Ancillary staff must be aware of these policies so that they can obtain the waiver of liability form. Third, Medicare never covers certain services and the patient will always be responsible for payment. Although a waiver of liability form is not required for such services, it may be prudent to make sure the patient understands that payment for these services will be their responsibility. Finally, read your Medicare carrier bulletins, which provide information about special coverage instructions, including conditions that substantiate the medical necessity of services. Access all pertinent information from your state Medicare carrier's website, especially for all local medical review policies.

THE GLOBAL SURGICAL PACKAGE

All services integral to accomplishing a procedure or service are bundled into the reimbursement for that procedure. These services are considered components of the global surgical package and should not be coded separately. Such services include: routine preoperative care (most payers exclude the consultation/visit in which the decision to perform the procedure was made and will allow reimbursement for that encounter); the procedure itself; any component procedures (e.g., the incision or

closure of an open procedure); and all routine post-operative care.

Fortunately many of the procedures performed in interventional radiology, including many vascular procedures, have a "0-day" (or no) global period and therefore any E&M services performed following the procedure, such as daily rounds, is reimbursable. On the other hand, some procedures such as TIPS, inferior vena cava filter placement, and gastrostomy tube placement have 10- or 90-day global periods meaning that any E&M service performed either 10 or 90 days (depending on the length of the global period) are included in the global services for a particular code and are not reimbursable.

WORKING WITH NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

For NPPs, such as physician assistants and nurse practitioners, additional guidelines pertain above and beyond those for physicians. The Medicare program covers NPP services so long as these services are medically reasonable and necessary, meet Medicare and state requirements, and fall within the scope of services the NPP is licensed to perform. However, to receive reimbursement for covered services, the NPP must meet Medicare, state, and local hospital bylaw requirements, including educational requirements.

The two major factors governing coverage of a NPP services are federal and state policy and the site of service. Federal and state guidelines define the types of services that NPP may perform. Medicare covers NPPs services as long as the service is a covered physician service. However, provisions of state law that regulate the NPP's scope of practice prevail over Medicare, with Medicare and third-party payers following whichever law is more stringent. For interventional radiology, the limitations on sites of service will rarely have a negative impact, as NPPs are able to provide services in the clinical settings where interventional radiology physicians typically practice.

All services provided by the NPP must be "supervised" by the physician. Physician supervision, however, has different meanings depending upon the site and the location. The state in which the NPP is licensed regulates the degree of supervision required for specific sites and services. As always, documentation of supervision is required. Most physicians countersign the medical record, and some states actually mandate the practitioner's countersignature.

CONCLUSION

The practice of interventional radiology will continue to evolve into a true clinical practice with interventional

radiology physicians and NPPs spending more time with the patient making clinical decisions. The services provided in the clinical setting are reimbursable. In fact, for other medical specialists to provide E&M reimbursable services and then not bill for them would be considered absurd. A real challenge for the clinical interventional radiologist will be to understand and then implement a new and somewhat foreign accounting system for E&M reimbursable services. Nonetheless, interventional radiology physicians across the country have and continue to develop E&M systems that financially support the clinical efforts required to

develop and sustain a viable competitive interventional radiology practice.

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