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"My Usual New Patient Visit is 99204", Part 1

This is a frequent comment from specialty providers and, in some situations, primary care providers as well. Beginning with this edition, we plan to take an in depth look at this specific code, reviewing requirements applicable to both primary care and specialty care.

In this month's edition, we're looking at the history component of 99204. Subsequent editions will review the exam and decision making requirements.

Providers understand that 99205 requires "everything" – that is, a comprehensive history, a comprehensive exam, and high complexity decision making. Many providers think that 99204 requires "less than that" but are vague on what that really means.

In reality, the code 99204 has the same history and documentation requirement as 99205. The only difference between the key component requirements for both codes is the level of medical decision making.

Required history inclusions for 99204 are as follows:

History
<ul style="list-style-type: none"> • Chief Complaint • ≥4 HPI or the status of 3 chronic conditions • minimum 10 ROS • 1 element each: past, family & social history

On many occasions, the 99204 isn't substantiated at audit. It may be the right level of service, based on the nature of the presenting problems, but does not have sufficient supporting documentation for that code level. The following section lists common 99204 history component documentation errors.

Scenario	Problem
Chief complaint/HPI documentation by someone other than the billing provider	Per Medicare, the billing provider is responsible for the documentation of this information and the work RVU is adjusted to take this into account
Vague chief complaint (i.e., "multiple problems")	When the chief complaint is vague, it may be difficult to identify what and how many conditions should be taken into consideration. It may also be difficult to support medical necessity.
"Get Established"	There is no code for "get acquainted" visits. If a patient doesn't present to have problems addressed, then the service is generally some form of preventive encounter.
"ROS: See HPI"/ Repetitive ROS	Documentation guidelines state that the HPI and the system review can both be in the same paragraph, but if there's not enough documentation to independently support both, then the system review is likely to come up short. For example, if you talk about the patient's "nausea" in the HPI, "nausea can't also be a system review.

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Scenario	Problem
"10 point system review..."	The word "point" isn't synonymous with "system". For example, "nausea" and "vomiting" could be two separate "points" of ROS, but they don't represent two "systems". If 10 systems have been reviewed, the better statement is "10 system review of systems..."
Less than 10 systems reviewed	The requirement for 99204 is a minimum of 10 systems – if less are documented, the code is reduced to a lower level.
Status of 3 chronic conditions + ROS	1997 guidelines allow for documentation of a detailed HPI by documenting the status of 3 chronic conditions. System review is counted separately from that. Any system review documented toward the status of a chronic condition is part of the HPI. Additional documentation needs to separately support system review.
Inconsistent HPI and ROS	This sometimes occurs in an EHR environment where the program can assist the provider by documenting a negative system review with a click of a button. If the HPI says the patient has headaches, and the ROS says "denies headaches", this is sufficient to cause for the entire note to fail audit and a carrier is not obligated to pay the claim.
"All systems are negative"	Well, no, probably not. The patient has some kind of problem or they wouldn't be in your office, so at least one system has to be positive.
"Family History: Noncontributory"	Medicare doesn't accept this statement as sufficient to cover family history. It's not clear if the family history has been obtained and is non-contributory, or the provider decided in advance that it wouldn't be relevant to the presenting problem so didn't obtain it. A better statement is "Family history obtained and is noncontributory", if this is an accurate statement.
Family History not documented	This omission is probably the single biggest reason history documentation doesn't fully support high level codes.
Patient-completed Health History Form	If your patient fills out a form with health history information, you may reference this information in your note, but there must be documentation that you have reviewed the information and agreed with it or amended it.

Next Edition: 99204 Examination Guidelines

Medicare Conversion Factor

The "Continuing Extension Act" signed by President Obama on 4/15/10 further delays the implementation of the 21% conversion factor reduction until 5/31/10. If a "fix", either temporary or permanent, is not determined by that date, it is likely that Medicare will again hold payments for the first 10 working days in June waiting for the next congressional action toward resolution.

Workers Comp Corner: Update

The Division of Workers' Compensation (DWC) has issued an important statement which says that the Labor Code provisions for medical treatment cannot be applied to medical-legal services. Claims administrators had requested an opinion from the DWC amid a controversy regarding the growing usage by carriers of medical provider network (MPN) or preferred provider organization (PPO) discounts, on medical-legal cases. California physicians have been alarmed because of carriers' increasingly more frequent and aggressive usage of questionable discounting of provider fees, citing the provisions of Labor Code section 5307.11 as their legal justification for using the contract rates. Labor Code section 5307.11 specifically states that providers, employers and carriers may contract for rates different than those found in fee schedules adopted and revised pursuant to Labor Code section 5307.1, the official medical fee schedule (OMFS). However, the medical-legal fee schedule (MLFS) is set forth in Labor Code section 5307.6, not 5307.1, and therefore services rendered under its provisions would not be subject to the contracting provisions described in section 5307.11. This opinion has given encouragement to providers, because unless a medical-legal provider and the payor have made a specific written agreement regarding medical-legal service payment at rates different than the MLFS, MPN or PPO discounts are **not applicable**.

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