CODING Q&A

Evaluation and Management: Coding Details

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The urgent care practitioner may not live by coding alone, but proper reimbursement depends on it. To that end, Dr. David Stern, a certified coder who is in great demand as a speaker and consultant on coding in urgent care, will offer answers to commonly asked questions in every issue of *JUCM*.

In this, our inaugural issue, he tackles the key issue of evaluation and management (E/M) coding.

Q. Why is the (E/M) code important in urgent care?

A. Because the majority of urgent care revenue is derived from E/M codes (mostly codes 99210-99215), accurate E/M coding is the most important coding variable in urgent care revenue. Inaccurate E/M coding is, also, the number-one reason that urgent care centers run into compliance issues with payors and regulatory agencies.

Q. I see that the Centers for Medicare and Medicaid Services (CMS) lists two sets of guidelines, 1995 and 1997, for coding E/M codes. Which one should I use? May I use either? May I use both?

A. You can use either. CMS has instructed its auditors to code the chart using both E/M guidelines and to use whichever set of results is most in the physician's favor. Thus, you may use either set of E/M guidelines to code any given chart; however, you may not mix and match the aspects of each set of guidelines to code a given chart. In other words, you may not use the level of history from the 1997 Guidelines and the level of physical exam from the 1995 Guidelines to determine the E/M level for a single visit.

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Q. What are the major differences between the 1995 and 1997 guidelines for E/M coding?

A. The major difference between the two guidelines lies in the documentation of the physical exam. The 1995 guidelines are more imprecise. For example, they allow the physician (and the auditor) to choose their own definitions of a "detailed" examination of an organ system. On audit, this vagueness often leads to differences of opinion—even among expert coders—on the appropriate level of exam on any given chart. The 1997 guidelines are much more explicit, listing specific elements and specific counts of these elements that count toward each specific level of physical examination.

Q. For E/M coding, can I count the same item in both the History of Present Illness (HPI) section and the Review of System (ROS) section?

A. Yes. Although some coders avoid this and call it "double dipping," CMS actually allows the provider to get credit for the same documented elements in both the HPI and ROS. For example, if you document "fever" in the ROS, you can also count "fever" toward the "related symptoms" in the HPI. A well-documented chart, however, rarely needs to nab elements from other sections to justify a specific coding level.

Note: Auditors for some payors do reject the CMS standard and will not credit the physician for the same information in both the HPI and ROS, so some practices have decided to accept a few lower E/M code levels by adopting a policy of no "double dipping" for all claims. This helps avoid nuisance problems with payor audits.

Q. If I do count the same item in both the HPI in the ROS section, do I need to document the item twice?

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CODING Q & A

A. No. It does not matter where the information is located, as long as it is documented somewhere on the chart.

Q. **May I count the same item toward two different elements in the HPI?**

A. No. For example, if the patient tells you that the cough is produced when "lying down," this element cannot count toward both "context" and "modifying factors" of the HPI.

Q. **What if the item is documented in the section labeled Past Medical History (PMH); can I still count it toward ROS or HPI**?

A. Absolutely. Coders should not be bound to any of the labels on your chart template. For example, if the date of last menses is listed in the PMH, this item may be used to count toward the genitourinary section of the ROS; or, if the patient is complaining of amenorrhea, this item could be used as documentation of duration in the HPI. Note: It is still best to try to document the appropriate information needed for each code in the appropriate section, as many auditors for payors may lack the clinical acumen to recognize such fine distinctions.

Q. **What is the so-called "bell curve" for E/M codes for urgent care centers?**

A. There is no specific bell curve (percentage distributions of 99201-99205 and 99211-99215) published for urgent care centers. CMS has published the bell curves for many other specialties, and these all tend to be quite similar, with peaks on 99203 and 99213 in most specialties.

For two reasons, however, urgent care physicians may be undercoding and losing significant revenue if they emulate these bell curves.

First, urgent care centers see patients with new problems which may increase the complexity of medical decision making.

In addition, many studies of physicians find that 30% to 50% of charts are undercoded by at least one level.

Thus, following the bell curve of other practicing physicians may simply be emulating their patterns of undercoding, resulting in reduced revenue for the urgent care practice in 30% to 50% of patient visits. ■

COMING NEXT MONTH

Next month in Coding Q & A: Get the low-down on the newer code S9088, "Services provided in an urgent care center."