CODING Q&A

Deciphering Payor Language and Other Challenges

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Q. Many procedures, such as injections and fracture care, are reported to patients as "surgery." Patients sometimes accuse us of false billing, as they don't consider these procedures to be a "surgery." How can we fix this problem?

A. All third-party payors have installed computer software programs that have code descriptions loaded for each CPT code. Many of these code descriptions are hard to understand, and sometimes they are not truly accurate.

Getting payors to come up with more accurate and patient-friendly code descriptions is likely to take many years. When patients express concern, you will need to educate them to them on this issue.

You may want to give your staff a script to follow. An example script might be, "Although many procedures are not accurately described as 'surgeries,' the insurance company may have that word loaded into their software program. They often use the term 'surgery' for many procedures that do not involve a trip to an operating room nor a skin incision."

You may even offer to read or mail the patient the actual description from the CPT manual, as published by the AMA.

Q. My new urgent care will be performing multiple procedures, including suturing lacerations, conscious sedation, and casting fractures. Since I am not a specialist, should I use different codes to report procedures performed in an urgent care center?

A. All physicians use the same CPT, ICD-9, and HCPCS codes for the same procedures, diagnoses, and supplies.

However, some payors do pay more for the same procedure—or even the same evaluation-and-management (E/M) codes—if the procedure (or E/M) is performed by specialty physicians. Medicare pays the same amounts for a procedure, regardless of the specialty the physician. With other payors, it is not uncommon to offer a fee schedule at a 20% to 30% premium for specialty physicians.

Some urgent care centers have become accredited through UCAOA and have been able to obtain contracts as physicians specializing in urgent care medicine. However, they often encounter significant obstacles in receiving recognition as specialty physicians by payors.

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Q. Do I have to use a preventive-care E/M code for a patient visit when the patient does not have a chief complaint? An example would be a patient who has hypertension but does not have any symptoms.

A. A chief complaint is required for physician office E/M codes (99201-99205). For the asymptomatic patient, you can simply note the problem; for example, "Patient presents for a chief complaint of hypertension...."

Q. How would I document a history of present illness (HPI) for a patient who has an asymptomatic problem, such as hypertension or elevated blood sugar? How could I document the duration, location, modifying factors, associated symptoms, quality, timing, context, and severity?

A. Per the 1995 or 1997 E/M coding guidelines, you can note when the problem first started (i.e., duration); under the associated symptoms, you could note that the problem is currently asymptomatic.

Under 1997 E/M coding guidelines, you can get credit toward the HPI in past medical history under the chronic/ inactive problems. If you note one chronic/inactive problem and its status, you get credit toward a brief HPI. If you note at least three chronic/inactive problems and the status of at least three

Continued on page 36.

CODING Q&A

chronic/inactive problems, you get credit toward an extended HPI.

Q. Can I use the established patient E/M code 99211 for medication refills performed by a nurse?

A. A medication refill by itself is not a separately coded service. If you only provide a simple medication refill, then no E/M code is appropriate. If the clinical staff provides an additional, medically necessary E/M service beyond the medication refill, you may use code 99211.

Make sure that the clinical staff documents the actual E/M service in the chart. A simple note with the patient vitals and documentation of the refill is not adequate, as you must specify the additional E/M service that was provided.

For example, it is appropriate to document side effects of a medication, the clinical staff's discussion with a physician, and the recommendation for follow-up.

Q. Is it ever appropriate to bill a level-IV E/M code for a visit that does not have a documented physical exam?

A. In some circumstances, it may be appropriate to code a 99214 without a physical exam, as an established patient E/M is based on the three elements of the E/M—i.e., history, physical exam, and medical decision-making—but with the established patient E/M, the lowest of the three elements is dropped and the next highest element determines the actual code.

Thus, it is possible to drop the physical exam from the E/M algorithm and document only the history and medical decision-making; the code is determined by the lowest level of the history and medical decision-making.

With a new patient E/M, however, the lowest element is *not* dropped from the algorithm; instead, the lowest element of the history, physical exam, and medical decision-making actually determines the level of code.

In other words, when basing the E/M code on these three elements, it is not possible to compliantly code a level-IV new patient E/M code (99204) without documenting a physical exam.

It may, however, be compliant to code a level-IV new patient (or established patient) E/M without a physical exam if more than half of the total face-to-face time between the patient and the provider involved counseling and/or coordination of care. If coded by time, the total face-to-face time of a 99214 is 25 minutes; the total face-to-face time for a 99204 is 60 minutes.

Make sure that you document the total face-to-face time, and specify that more than half of the time was devoted to counseling and/or coordination of care. In addition, make sure you describe the nature of the counseling. ■

OCCUPATIONAL MEDICINE

"When was the last time that you…" or "What do you think is the best solution to the problem that I just described?").

- **Show appreciation.** Let your audience know how appreciative you are at both the beginning and end of your presentation. Be certain that the appreciation is stated from the heart (say something like, "I never take for granted that busy people such as yourselves can find the time to hear what I have to say; it means a great deal to me. Thank you.").

Finally, some quick tips to drive these points home:

- **Rearrange the room if necessary.** Make the room comfortable for *you*. Rearrange tables, put people closer to one another, narrow your sight line, etc., so the atmosphere supports your objective as a speaker.
- **Repeat questions from the audience and keep your answers brief.** In addition to ensuring that every member of the audience hears every question, repeating each question gives you time to think. It also clarifies things for your audience. And keep your answers brief; they may be of interest only to the person who asked the question.
- **Never turn you back to your audience.** Never turn around to look at a screen or walk into an audience to make a point.
- **Repeat key points.** Key points are far more important than non-key points. Always repeat them.
- **Don't fear silence.** Nobody likes a motor mouth. Give your audience a chance to catch their breadth. Silence is golden.
- **Alter your pitch.** Audio record and listen to your next presentation. Are there periods in which you speak louder than normal and others softer than normal? There *should* be.
- **Vary the speed of your delivery.** Likewise, speed should be continuously adjusted throughout a presentation.
- **Pause before and after important points.** Pauses reinforce what you just said. What better time than before and following key points?
- **Act and look confident.** If you enjoy speaking and are well prepared, you should be confident. Makes certain that this confidence comes across.
- **End with an emotional story.** We live in an emotional world in which good deeds vastly outnumber bad ones, even though the bad ones tend to be repeated at least as often as the good ones. Hook on to a positive, emotional story and retell it. ■