CODING Q&A

Coding for 'Feared Complaint,' Facility E/M Codes, and Nuances in Complexity of Medical Decision-making

DAVID STERN, MD, CPC

Q. We recently coded a visit for a young woman who thought—although she had no symptoms or foreign-body sensation—that there was a tampon left in her vagina. On pelvic exam, however, no retained tampon was found.

What ICD-9 code is appropriate? Should the physician still diagnose this as a foreign body in the vagina?

- Question submitted by Japhlet Aranas, Resurrection Healthcare, Illinois

A. One should not choose a specific diagnosis (ICD-9) code unless that diagnosis is actually confirmed by history, by exam, or by further testing. If the physician is unable to diagnose a specific condition, then you should generally code for the symptom(s) or complaint(s).

Since this patient did not have a vaginal foreign body, it is not correct to code for a vaginal foreign body.

If the patient did complain of a foreign body sensation in the vagina, then the best code for this complaint may be 789.9 (other symptoms involving abdomen and pelvis).

This patient, however, was completely asymptomatic, so the correct code would be V65.5 (person with feared complaint in whom no diagnosis was made).

If the patient had complained of actual symptoms, you could have coded for both codes. ■

Q. We are coding our physician charts with E/M codes 99281–99285. When we met with the hospital about our coding, they were concerned that the physician E/M codes (99281–99285) are not always the same codes that they are billing for the facility E/M code (99281–99285) for any specific visit.

Should the hospitals that we staff always bill the same E/M code for the facility as we are coding for the physician services? Does it make any difference, if our physicians are not employed by the hospital?

- Question submitted by Nancy Henry CPC, CEDC, Marshall Emergency Services Associates, PSC, Cincinnati, OH

A. Yes, this is confusing, as the same codes (with completely different definitions) are used on both the CMS-1500 (physician billing) and the UB-04 (facility billing). Thus, the visit is billed for one E/M code from the hospital and another E/M code (which is frequently a different E/M code) from the physician group.

The specific E/M level appropriate for the professional component of the visit is intended to communicate the level *of physician services* for any specific visit.

The E/M for the professional component is determined by the 1995 or 1997 CMS evaluation and management algorithms.

The specific E/M level appropriate for the facility component of the visit is intended to communicate the level *of facility services* for any specific visit.

The E/M for the facility component is determined by an algorithm that the hospital can determine itself will produce a bell-shaped curve distribution of codes. Because the codes are billed under completely independent algorithms, it is not surprising that these algorithms will often result in different specific codes for the same visit. The method does not change, whether or not the physicians are employed by the hospital.

Note: The same answer applies to urgent care centers that are affiliated with a hospital and have selected to bill visits (using E/M codes 99201-99215) on both the CMS-1500 form and the UB-04 form. ■

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Q. I am a certified coder, and I currently work for an urgent care center. The coders code all charts. If the chart is not signed or is missing information, the chart is coded and put on hold. Recently, however, our administrator has begun releasing claims before the chart is signed. I was wondering what would happen if the charts were billed to a payor before they were signed by the provider. If we started doing this, I fear that this might jeopardize my coding certification. I want to do what is right, and I do not want to jeopardize my coding certificate.

- Question submitted by certified coder, Maryland

A. I sense that you are a diligent and compulsive coder. When it comes to coding and billing charts, you are correct that it is most compliant to code and bill charts after they are signed by the provider. It sounds to me, however, as though you are describing the following situation:

- The patient has been seen and treated.
- All documentation is on the chart (except a provider signature).
- Changes to provider documentation and/or to provider coding is extremely unlikely and rare.
- You have no doubt about the identity of the rendering provider.
- There is a system in place to make sure that the rendering provider will sign the chart.
- If the provider makes any changes that will result in a change in appropriate codes, the claim will be re-billed.

Assuming this situation exists, I have never heard of anyone losing coding certification for billing in this manner. This should not be considered specific legal advice, however, so if you wish a legal opinion on this issue, I would encourage you seek legal counsel. ■

Q. As our medical group opened two urgent care sites within the past six months, I found your UCAOA webinar quite interesting and very helpful. We do have templates in our electronic health record, which the physicians are using. These templates makes it very easy to document a detailed (or comprehensive) history and physical exam.

My concerns are with the Complexity of Medical Decision-making (CMDM).

1. **Level of Diagnoses/Treatment Options: In the number of diagnoses or treatment options section, do you think that the first time any patient is seen in our urgent care center that the diagnosis would fall in one of the following categories?**
   - **New problem (to examiner); no additional work-up planned (worth 3 points)**
   - **New problem (to examiner); additional work-up planned (worth 4 points)**

Would the choices be limited to just these two choices even when the patient presents with minimal respiratory symptoms, and the physician examines the patient, determines that it is a simple cold, and does not order any antibiotics nor any additional studies? The physician then discharges the patient with instructions encouraging rest, increased fluids, and follow-up with a family physician if symptoms worsen or don't improve within a stated period of time.

Technically speaking, it would be a "new problem to the examiner" in the diagnosis section. But in the risk section, it falls in the low level of risk category, so would it really be a self-limited or minor problem?

2. **Determining established patient E/M code: For an established patient visit, if the history and exam components are both either detailed or comprehensive (because we use templates) and if the level of medical decision making is straightforward or low, then is it really appropriate to code a 99214 or 99215? I know the rules say that you can, but if the level of complexity of decision-making is to be taken into consideration, how would you justify this on an audit?**

- Question submitted by Romaine T. Suminski, Interventional Coder/Reimbursement Audit Specialist, Saint Vincent Medical Group, Erie, PA 16502

A. Let's look at the answer to each of your questions about E/M CMDM separately:

1. *Level of Diagnoses/Treatment Options:* In the Marshfield Clinic point-scoring system that you are using to determine the complexity of medical decision-making for a new patient, there are three choices to select from for the level of diagnosis or treatment options for a new patient:
   - New diagnosis, additional workup planned
   - New diagnosis, no additional workup planned
   - Minor diagnosis

   The level of risk should be determined independently from (although may be similar to) the level of diagnosis or treatment options. Minor diagnoses may be defined (my definition) as those diagnoses that need no more than over-the-counter medications and are only seen by the physician to give reassurance or to confirm that the diagnosis is truly a minor illness. Thus, the patient visit that you describe would be scored with a minor diagnosis, which is weighted with just one point in the Marshfield Clinic point-scoring system.
2. *CMDM and determining the established patient E/M code:* There is significant confusion about what is appropriate to document on any given patient visit. The overarching rule for documentation is to document any item that was performed because there was medical necessity for performing that specific item. It is not appropriate to perform or document any specific item simply "because we use

"On a new patient E/M code, the code can never be higher than the level of CMDM."

templates;" instead, each item should be performed and documented because it was appropriate to the patient visit.

In the urgent care setting, however, patients are generally unknown to the rendering provider. Even where the patient has been seen previously by the specific provider, the provider has not taken responsibility for the ongoing care of the patient, so much of the history may change from visit to visit in an urgent care center.

Since patients are not truly "established" with an urgent care physician in the same sense that they are "established" in the practice of a primary care physician, there is usually a medical necessity for obtaining a comprehensive history on most urgent care patients—even patients seen in the urgent care center within the past three years.

For so-called "established" patients, if the physician actually performs and documents a detailed or comprehensive level of history and physical exam and if there was a medical necessity for the elements to be documented in the history and physical, then coding these levels of CMDM would be appropriate.

On a new patient E/M code, the code can never be higher than the level of CMDM. Per CPT guidelines on an established patient visit, however, the lowest element of history, physical, and CMDM is not considered in determining the final code.

CMS, however, has encouraged practices to use the CMDM as a general guideline for determining the level of E/M code. In response, some practices have chosen to limit the E/M code level (on codes 99211-99215; or only on 99214 and/or 99215) selected on an established patient visit to the level of complexity of medical decision making. This is a conservative approach, but it is not required by E/M coding guidelines, as published by CMS. ■

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