CODING Q&A

Medical Necessity in E/M Coding, Part 3: Correctly Coding the Physical Exam

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Some coding auditors do not understand the urgent care setting. As a result, they have been inappropriately downcoding evaluation and management (E/M) levels—not based on levels of documentation, but rather on whether the documentation is supported by their "view" of medical necessity, even though these auditors have usually never been providers and lack clinical experience.

In this situation, the best defense is a strong offense. This column reviews medical necessity and level of physical exam for two conditions commonly seen in urgent care centers: sore throat and chest pain. The goal is to clarify the logic underlying medical necessity documentation. These examples are given so that providers and coders may apply similar logic to the documentation of other complaints that are commonly evaluated in urgent care.

Q. Which elements and systems are appropriate for a provider to perform and document in the physical exam for a patient presenting with a chief complaint of a sore throat?

A. When a patient presents with a sore throat, it is appropriate to document the following items:

- **Constitutional:** vital signs and general appearance.
- **Ear/Nose/Throat:** presence or absence of pharyngeal erythema or swelling, tympanic erythema or bulging, etc.
- **Skin:** presence or absence of exanthema or other rash. Concurrent inflammation of the skin and pharynx is frequently seen with scarlet fever, scarletina, measles, etc.
- **Psychological:** mood and affect. These are always appropriate to observe and document, as they have a bearing on the accuracy of the history and the ability of the patient to comply with physician instructions.
- **Eyes:** presence or absence of icterus. Jaundice is an indication that the patient may be suffering from hepatitis, which may indicate that infectious mononucleosis may be the cause of the sore throat.
- **Neck:** presence or absence of nuchal rigidity. Signs of meningeal inflammation may indicate concurrent viral or bacterial meningitis, which may have the same etiology as a pharyngitis.
- **Lymphatic:** presence or absence of palpable lymph nodes. Cervical lymphadenopathy is commonly seen with pharyngitis, especially when caused by group A streptococci. Diffuse lymphadenopathy is more common with infectious mononucleosis.
- **Respiratory:** presence or absence of respiratory distress and/or adventitious lung sounds. Findings here may indicate concurrent asthma, pneumonia, croup, or epiglottis, all of which would be more common in a patient with a complaint of a sore throat.
- **Musculoskeletal:** gait and station. The ability to stand and walk normally tells the physician a great deal about any patient's condition.
- **Cardiovascular:** presence or absence of a murmur. A cardiac murmur may indicate concurrent endocarditis or may be a result of previous rheumatic fever caused by group A streptococci. ■

Q. Which elements and systems are appropriate to perform and document in a physical exam for a patient

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presenting with a chief complaint of chest pain?

A. When the patient presents with chest pain, it is appropriate to document the following items:

- **Constitutional:** vital signs and general appearance
- **Ear/Nose/Throat:** presence or absence of oral mucosal pallor. Pallor may be consistent with anemia, which may exacerbate or precipitate cardiac angina.
- **Skin:** presence or absence of rash or petechiae, which should raise suspicion of endocarditis or pericarditis.
- **Psychological:** mood and affect. The rationale for documenting psychological status for chest pain is the same as for sore throat (see the previous page).
- **Eyes:** presence or absence of icterus. Jaundice may result from heart failure. Blockage of biliary ducts may produce chest pain with jaundice.
- **Neck:** presence or absence of signs.
- **Lymphatic:** presence or absence of palpable lymph nodes. Lymphadenopathy may indicate a localized or systemic inflammatory process or carcinoma, either of which may be a clue to the cause of the chest pain.
- **Respiratory:** presence or absence of respiratory distress and/or adventitious lung sounds. Findings here may indicate concurrent asthma, pneumonia, heart failure, or one of many other chest conditions.
- **Musculoskeletal:** gait and station. The ability to stand and walk normally tells the physician a great deal about any patient's condition.
- **Cardiovascular:** any patient with chest pain should have a complete cardiovascular system exam.

Under the 1997 Medicare E/M documentation guidelines, either a sore throat or chest pain only qualifies for a detailed physical exam, which would support a 99203 or 99214 CPT code. If the 1995 E/M guidelines are used, documentation of each physical qualifies as a comprehensive physical exam, which would support a 99205 or 99215 CPT code.

This is not to suggest that a 99205 or 99215 code is always appropriate for these complaints. Complexity of medical decision making (CMDM) is likely to support a 99205 or 99215 code for a chief complaint of chest pain. However, a single chief complaint of sore throat (without evidence of acute epiglottitis or another more serious condition) would at most support a moderate level of CMDM consistent with a 99203 or 99214 code.

Documentation of the physical exam, which is driven by medical necessity, may produce a comprehensive exam for many common medical problems, especially when coded using the 1995 guidelines. This is especially true in urgent care, where unexpected findings are more likely to be discovered because a provider often has not previously examined the patient.

Providers should ensure that coders are familiar with both sets of guidelines so that the practice can receive full credit for the work performed. Providers who use an EHR that performs automated E/M coding should know which set of guidelines is being used; almost all EHRs use the 1997 guidelines, which tend to reduce the level of E/M codes for a significant proportion—often more than 30%—of patient visits.

If your EHR does use the 1997 guidelines, consider hiring a coder to recode all visits according to the 1995 guidelines. Although manually recoding visits is costly, the substantial increase in revenue often justifies the investment. ■