CODING Q&A

Rule Number One: Code for Services Rendered

DAVID STERN, MD, CPC

Q. Which CPT codes can be used for diagnosis codes 786.50 (unspecified chest pain) and 414.9 (chronic ischemic heart disease-unspecified) to maximize a Medicare patient bill?

A. The basic rule of coding is that you should code for the services rendered, not to "maximize a patient bill." In other words, you should code the best codes that indicate the actual services that were performed. For these codes, you could code for a cardiac bypass surgery or a simple E/M; it would just depend on what services you had rendered. You both maximize coding compliance and revenue when you make sure that all codes for services rendered are included in the claim.

Q. Is there any legal or ethical reason why an emergency department should not re-code an emergency visit as an urgent care visit based on the final diagnosis and/or time involved in treating the patient who presented himself to the ED?

A. The coder should apply the best code that describes the service. E/M code sets are based on the place of service. If the service was rendered in a hospital ED, then the coder should use E/M codes (99281-99285) that are designated for services rendered in a hospital ED. It is not appropriate to change to another E/M code set (eg, 99201-99215 for office or other outpatient visit) simply because of the level of service.

For example, it would not best describe the services in your case to say, "Office or other outpatient visit for the evaluation and management ...," which is part of the description of the E/M codes used for urgent care services. Rather, the best description for the services rendered is, "Emergency department visit for the evaluation and management of a patient ...," which is part of the description of E/M codes used for visits to a hospital ED.

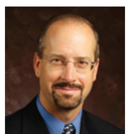
In this case, the place of service determines the code set to be used. The level of service rendered will determine the appropriate code within that code set.

Q. I am confused about a common billing issue. A medical doctor (not an ophthalmologist) is billing CPT Code 92002 when a patient presents to urgent care for an eye injury such as ICD-9 918.1. Is this appropriate? Based on the description of CPT code 92002, it appears that an ophthalmologist should be performing this service. Wouldn't an E&M code 99202-99205 be more appropriate?

A. CPT codes are based on the service rendered, not necessarily on the specialty of the physician. If a general surgeon or a family doctor delivers a baby, she can code for delivering the baby. If an urgent care physician performs the services described by 92002 ("Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient"), then he can submit a claim for 92002.

The medical record should indicate that a proper level of evaluation and management occurred. For 92002, the intermediate eye examination codes require an external ocular and adnexal examination, whereas the comprehensive examination (92004) requires, in addition, gross visual fields, basic sensorimotor evaluation, and an ophthalmoscopic examination.

Medicare carriers have mandated specific elements to be documented to qualify for these codes. Most carriers list 10 elements, requiring at least three elements to qualify for 92002 and at least eight elements to qualify for a comprehensive examination. Simple eye exams with less than three elements should be coded with the regular E/M codes 99201-99215.



David E. Stern is a certified professional coder. He is a partner in Physicians Immediate Care, operating 18 clinics in Illinois, Oklahoma, and Nebraska. Dr. Stern was a Director on the founding Board of UCAOA and has received the Lifetime Membership Award of UCAOA. He serves as CEO of Practice Velocity (*www.practicevelocity.com*), providing software solutions to over 750 urgent care centers in 48 states. He welcomes your questions about urgent care in general and about coding issues in particular.

Note: CPT codes, descriptions, and other data only are copyright 2011, American Medical Association. All Rights Reserved (or such other date of publication of CPT). CPT is a trademark of the American Medical Association (AMA).

Disclaimer: JUCM and the author provide this information for educational purposes only. The reader should not make any application of this information without consulting with the particular payors in question and/or obtaining appropriate legal advice.