

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Check the Notes Before Submitting a High-Level ED Code

Keep upcoding to a minimum with this expert advice.

The popular E/M code 99285 (Emergency department visit for the evaluation and management of a patient...) continues to be on many claims reviewers' target lists due to its higher than average error rate. A great way to confirm that your emergency department (ED) coding is accurate - and steer clear of auditors in the process- is to review your physician's documentation before submitting claims to your payers.

A reader recently submitted the following question: "One of our physicians codes all trauma and myocardial infarction cases as 99285 because of the emergent nature of the patients' conditions. How do we handle this?" We sat down with some emergency coding experts to get the answer to these questions - read on for the scoop.

Don't Assume Trauma Equals High Level

"While many times it is likely a trauma will result in a higher level, an E/M level should never be assumed just on presenting condition alone or 'typical' practice," says **Elaine Dunn, DHA, RRT, RPSGT, CPCO**, vice president of revenue integrity and centralized coding with Change Healthcare in Alpharetta, Georgia. "Each encounter has to be assessed against CPT® guidelines for the appropriate level, with supporting documentation present."

For professional billing, the complexity of the patient history, exam, and medical decision making (MDM) all factor into determining the indicated level, Dunn notes. "Providers should be documenting their clinically relevant data for each key component as well as the resources expended in each of these core E/M elements, then the encounter reviewed holistically to assign the correct level. Again, the core tenets of the CPT® level must be met and using default codes based on presenting condition alone can very well lead to a failure to align practice, documentation, and compliant billing."

Read Note to Check Level

If there's any suspicion or belief that a physician might be selecting a particular code due to a patient's condition or status, then you should immediately check that provider's notes.

"Our coders always code directly from the note," says **Marie Franklin, MBA, CPC**, national director of coding, education, and audit with AdvantEdge Healthcare Solutions. "What's really important is that the provider documents the supporting medical necessity for the presenting problem."

She points to Medicare's E/M tool as a way to check whether the physician's note justifies the code selected. "You'll have to evaluate all three sections: history, exam, and MDM," Franklin notes.

First, you'll review the number of diagnoses/conditions that the provider has to consider. "The physician may not be managing those conditions or diseases, but he has to consider those in decision making, so it's important for him to document the relevance of those conditions," she notes.

In addition, you'll review any additional tests or labs ordered/reviewed and what the physician found due to those diagnostics. "Rather than just documenting 'Looked at lab' or 'reviewed X-rays,' document how that was pertinent to today's episode so it's clear why that was important as part of the decision making," she adds.

The third part of the MDM is the table of risk, which outlines the risk of complications and/or morbidity or mortality, she

says. Putting it all together, you'll determine whether the MDM is straightforward, low complexity, moderate complexity, or high complexity. Code 99285 requires a high complexity MDM (in addition to a comprehensive history and a comprehensive examination).

It is also quite possible that trauma or myocardial infarctions could qualify for the critical care code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes), so coders should check for valid critical care attestation statement with time spent in providing critical care series for that patient, or make sure that physician gets training on when critical care would be an appropriate alternative to reporting 99285.

Reviewers Are Watching - You Should, Too

Carriers are buckling down on the medical necessity of all ED visits, Franklin says. "That's one thing I've been educating ED providers regarding clinical documentation improvement," she adds. "Just because you order a test and you elaborate on it, coders are not clinicians - we can't take the jump to say, 'I assume the physician ordered this test due to the following reasons...'. So providers must be thorough in documenting."

This not only helps you code the notes accurately, but it also ensures that the patient gets the best care possible. "If the patient goes elsewhere for care and a new practitioner requests the medical records, it could very well impact future care if our physician forgot to document something," Franklin says.