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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Want To Make $43 More Per E/M Visit?

4 steps help you avoid unnecessary downcoding

If you underestimate your physician's medical decision-making, you might report a level three E/M when he actually performed a level four -- that's a loss of approximately $43 for a new patient visit and $33 for an established patient.

Problem: You must evaluate three components -- history, exam and medical decision-making -- before you can select the appropriate E/M code . The E/M's history and exam components are generally straightforward and easy to assess from the physician's documentation. When physicians come to the medical decision-making component, however, they often rule out diagnoses, evaluate complicating factors and choose care management options without documenting everything in the patient's chart, says **Curt Udell, CPAR, CPC, CMPA,** senior advisor at **Health Care Advisors Inc** in Annandale, Va.

This lack of straightforward information makes selecting a code difficult for coders. This is especially true in certain specialties, such as cardiology and endocrinology, where much of the physician's work involves ruling out diagnoses and managing patients with complicated conditions.

Solution: CPT lists four levels of decision-making: straightforward, low complexity, moderate complexity and high complexity. You must consider three elements when you evaluate the physician's level of decision-making:

The number of diagnoses or management options,

The amount and/or complexity of data to be reviewed, and

The risk of complications and/or morbidity or mortality.

These three elements have certain requirements to meet in order to qualify for each of the four different levels of decision-making. CPToutlines these requirements in Table 2 in the Evaluation and Management Services Guidelines. To qualify for a given level of decision-making, the physician must meet or exceed the requirements for two of the three elements, according to CPT.

You can accurately assess the level of decision-making if you find a description of the patient's condition in the physician's chart, inform your physicians of necessary documentation tips, and familiarize yourself with the three elements of decision-making outlined in CPT's Table 2, entitled "Complexity of Medical Decision Making." Follow these four steps for success:

1. Look for a description of the patient's condition(s) in the documentation that will indicate the status and

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seriousness of the diagnosis. Simple, one-word descriptors such as "stable," "worsening" or "new" may be all you need to discern how time-consuming and serious a patient's condition is, explains **Maggie Mac, CMM, CPC, CMSCS, CCP, ICCE,** administrator at **Bay Area Women's Care** in Clearwater, Fla. New or worsening conditions typically involve more time and risk, whereas stable conditions may have little or no effect on the visit.

For example: If your physician documents an established patient with type II, uncontrolled diabetes who has "stable" renal complications (250.42) and "worsening" glaucoma (250.52, 365.44), you know the renal complications are not a serious issue during the visit but that the glaucoma is significant. The term "worsening" implies that the physician must review more data, consider more management options and evaluate more risk of complications. So, using CPT's Table 2 and reviewing your physician's documentation, you may decide the amount and/or complexity of data to be reviewed was moderate and the risk of complications was moderate. This would lead you to determine moderate complexity decision-making, which qualifies the visit for a level four E/M (99214), as long as the visit meets the other required components for the code.

2. Check for a connection between the patient's conditions and the decision-making process. Physicians'decision-making documentation often lacks an explanation of how the diagnoses influence the management options, says Mac, who is also a private medical practice consultant. You don't want to count additional diagnoses toward a higher level of decision-making if no information shows that the physician considered these conditions when planning his treatment, she adds.

For example: Atype II, uncontrolled diabetic patient has renal failure (250.42) and hypertension (403.91, Hypertensive renal disease; with renal failure). Your endocrinologist documents that he treats the patient's hypertension by ordering tests and adjusting medications. He also documents that an evaluation of the patient's renal complications influences his treatment decision because he has to consider possible drug interactions before changing the patient's medications. This provides a clear connection between both of the patient's conditions and the decision-making. You could assume this visit involved multiple diagnoses and management options, and this may lead to moderate complexity decision-making if the history and exam are appropriate.

3. Count rule-outs if the physician orders tests. Some people say you should not "count rule-outs in the diagnostic process of decision-making," Mac explains. However, if the physician orders tests to help him rule out a particular diagnosis, that qualifies the condition as a serious consideration, and you can count it toward the number of diagnoses and management options, she says.

Remember: You cannot link the actual "rule-out" or suspected ICD-9 code to tests the physician ordered to rule out a particular diagnosis. Instead, be sure to code the symptom(s) that prompted the test or, if possible, an actual diagnosis that the test reveals.

For example: Apatient presents with short stature and delayed puberty. The endocrinologist may document that he rules out hypothyroidism (244.9) immediately, but desires a hormone stimulation test to check for growth hormone deficiency. Although growth hormone deficiency is still a diagnosis in the rule-out stage, it qualifies as a condition under serious consideration and you can count it when determining the level of decision-making. Be sure to link the visit to the presenting symptoms, such as delayed puberty (259.0, Delay in sexual development and puberty, not elsewhere classified), and not to the suspected diagnosis of growth hormone deficiency.

4. Inform physicians about proper documentation. The better physicians document their decision-making processes, the more likely they are to get paid for the true level of service they perform. If lack of information makes selecting the appropriate level of decision-making difficult for you, ask your physicians to start providing more detailed notes. Physicians should include the definition of conditions (are they acute, chronic, recurrent, stable, worsening, exacerbated by another problem, etc.) and the way in which these conditions influence the treatment plans, Udell advises.

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