Dangerous E/M Coding Practices: Identifying and Remedying Common Sources

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Code assignment for physician evaluation and management (E/M) services is inherently problematic because of the multiple coding rules and reporting guidelines that must be applied and the subjectivity of the codes. Consistent E/M coding practices are critical in the physician practice setting. The lack of good E/M coding practices is dangerous, as it may result in codes that don't accurately reflect services provided and place the reporting provider at risk for allegations of fraud or abuse.

Dangerous E/M coding practices result from misunderstanding CPT E/M codes and code categories or problems with the code reporting process (e.g., workflow issues that result in errors due to miscommunication). This article lists dangerous physician E/M coding practices in both of these categories and provides recommendations for avoiding trouble.

Misuse of E/M Codes

E/M service codes were designed to reflect the nature of physician work for a particular type of service. Thus the E/M section of CPT is divided into categories and subcategories in an attempt to capture the varied work a physician may perform based on the place of service, the patient's status, or other factors. Appropriate use of E/M codes first requires a full understanding of the code categories and subcategories as well as the CPT coding guidelines. Second, appropriate reporting of E/M services requires an understanding of current payer reporting requirements.

The following examples reflect some of the common misuses of E/M codes that may result in coding patterns that could be suspect for fraud or abuse.

Reporting the wrong category or subcategory of E/M service. This would result if a consultation category is reported when there has been a full transfer of care, for example. Consultation services should reflect a physician providing expert advice to another healthcare provider. A specialist who takes over the portion of the patient's care related to his or her specialty is not functioning as a consultant. Physician practices should provide ongoing training on the definitions and guidelines for E/M categories of care. Staff should be aware of the specific documentation guidelines for consultation services.[1]

Indiscriminate use of E/M code levels. For example, consistently reporting a level three on every patient seen in the clinic is inappropriate. The E/M code levels are intended to reflect physician work, which will naturally vary depending on the patient's presenting problem and severity of illness. Coding professionals should educate physicians on the amount of work reflected in the code levels, using case examples from their patient population as illustrations. Coding professionals should also perform ongoing auditing, with subsequent feedback to providers, applying the Centers for Medicare and Medicaid Services' documentation guidelines.[2]

Inappropriate manipulation of E/M codes for reimbursement purposes. An example is manipulating preventive (versus problem-oriented) codes to take advantage of health plan coverage. Some health plans cover one preventive medicine visit per year. Patients with this type of coverage may specifically request that a visit be billed in this manner. Other patients, who have only problem-oriented coverage, may specifically request problem-oriented visit codes be submitted. However, the E/M code assigned should reflect the type of service that is actually provided based on the patient's need on the day of the visit, recognizing that this may vary from a preventive medicine visit scheduled weeks earlier.

Physician practices should establish policies and procedures for E/M coding, based on coding guidelines and reporting requirements. They should investigate payer reporting requirements for encounters that include both preventive care and problem-oriented care (split bill versus majority of service time) and establish procedures to implement those requirements as well as consistent policies and procedures for resolving patient inquiries.

Reporting E/M codes when no reportable E/M service is provided. Take for example a family practice physician who stops in the medical or surgical unit to say hello to a patient who has been under his care for several years, though he is not the physician of record for the current hospitalization. It is not uncommon for a primary care physician to visit his or her patients in the hospital when he or she is not the attending physician. Though these visits are a common courtesy and reflect quality care, if no examination, history, or medical decision making is performed, they are not a reportable E/M service.

Medicare payments for procedures, which include anticipated pre- and postprocedural E/M services, are another example. A separate E/M code should only be reported, with modifier 25, when significantly separate E/M services are provided. According to a recent Office of Inspector General report, Medicare should not have allowed payment for 35 percent of claims using modifier 25 in 2002 because "the E/M services were not significant, separately identifiable, and above and beyond the usual preoperative and postoperative care associated with the procedure; or because the claims failed to meet basic Medicare documentation requirements."[3]

Practices should provide ongoing training on E/M services for providers as well as coding and billing staff. Staff should know which services are specifically included in a procedure and what constitutes a separately reportable E/M service. Organizations should also periodically audit for appropriate use of modifier 25.

E/M Coding Process Issues

As the previous examples illustrate, multiple coding rules and reporting guidelines must be applied for correct physician reporting of E/M services. An efficient E/M coding process is critical to facilitate application of the myriad rules and guidelines. In contrast, an inefficient process can lead to miscommunication, which may result in coding errors.

The following examples reflect some of the common E/M coding process issues that may result in coding patterns that could be suspect for fraud and abuse.

Insufficient input in E/M code level selection. This might occur when coders assign E/M codes based on documentation and the physicians who provided the E/M service are not involved in E/M code selection at all. E/M codes should reflect the level of service that is provided, thus it is unwise to assign code levels without the care provider's input. Some aspects of the medical decision-making portion of the E/M code in particular are only known by the care provider. The E/M codes are specifically designed to be applied by the provider. Practices should establish a concurrent process for E/M code selection that includes the actual care provider and provide ongoing education and feedback to providers on E/M code levels and practice profiles.

Insufficient E/M tracking mechanisms. Take for example an organization that has no systematic process to track global periods associated with procedures. Payer guidelines specify that E/M codes should not be submitted for routine follow-up care within a global period. A tracking process is needed to determine which visits fall within a global period so that modifiers can be applied if the E/M care is unrelated to the procedure.

Another example is a patient who is classified as new without access to the patient's appointment history. Assigning patients as new or established based on whether or not the patient looks familiar to the physician can result in errors. The coding workflow should include a process to verify the patient's status.

Physician practices should establish a workflow that allows for verification of E/M categories, tracking of global periods, and monitoring for compliance.

Manufacturing documentation to support E/M code levels. Compelling a physician to document additional E/M elements to support an E/M code level is problematic. For example, coding professionals should provide feedback to a provider when documentation is insufficient to support the code level assigned. AHIMA's standards of ethical coding state that coding professionals are expected to query physicians for clarification and additional documentation prior to code assignment when there is conflicting or ambiguous data in the health record.[4] The key issue is the manner in which this is done. Physician queries must not lead the physician to document additional E/M elements that may not have been performed.

Physician practices should develop a policy and procedure for addressing insufficient E/M documentation that is consistent with E/M documentation guidelines and best practices.[5]

Inappropriate use of electronic E/M documentation tools. Take for example an electronic E/M visit template that automatically populates all systems on an exam as normal, requiring the physician to change or delete normal entries. This process may result in documenting something the physician didn't actually do. E/M codes are designed to measure physician work. It is work for a physician to examine the neck and declare it normal. If the computer enters this automatically it may imply the physician examined the neck when the physician didn't.

Coding professionals should follow best practices for maintaining a legally sound electronic health record.[6] Avoid documentation by default. Tailor E/M documentation systems to allow the provider to intentionally create documentation reflecting the services he or she provided.

Notes

1. Resources on consultation E/M services include the CPT codebook, which includes instructions just prior to code 99241, and CPT Assistant 9, no. 6 (1999): 10.

2. The documentation guidelines are available for download from the Medicare learning network. The 1995 Documentation Guidelines for E/M Services are available at www.cms.hhs.gov/ MedlearnProducts/downloads/1995dg.pdf. The 1997 guidelines are available at www.cms.hhs.gov/MedlearnProducts/downloads/MASTER1.PDF.

3. Department of Health and Human Services, Office of Inspector General. "Use of Modifier 25." November 2005. Available online at http://oig.hhs.gov/oei/reports/oei-07-03-00470.pdf.

4. AHIMA. "Standards of Ethical Coding." *Journal of AHIMA* 71, no. 3 (2000): insert.

5. Prophet, Sue. "Developing a Physician Query Process." *Journal of AHIMA* 72, no. 9 (2001): 88I-M.

6. AHIMA e-HIM Work Group on Maintaining the Legal EHR. "Update: Maintaining a Legally Sound Health Record--Paper and Electronic." *Journal of AHIMA* 76, no. 10 (2005): 64A-L.

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