E/M Options in the Outpatient Arena

by Lolita M. Jones, RHIA, CCS

Under the Medicare ambulatory payment classification (APC) system, hospitals must establish criteria for mapping the medical care rendered in the emergency department and hospital-based outpatient settings to appropriate CPT medical visit codes. Do you know how to establish a sound rationale for mapping these codes? Failure to do so can result in compliance risks, so it's best to understand the principles at work. Once you've put a methodology in place, you'll reduce compliance risk and get your bills out on time. In this article, we'll look at examples of mapping logic and tips for better coding for care rendered.

Six APC Medical Visit Groups to Know

In developing medical visit APCs based on CPT procedure codes only, the Health Care Financing Administration (HCFA) collapsed 31 CPT codes that define clinic and emergency visits into six groups, three each for clinics and the emergency department. Many of the CPT codes are, in fact, evaluation and management (E/M) codes. The final APC groups and 2001 rates for emergency visits and hospital-based clinic visits are:

- APC 0610, Low-Level Emergency Visits: 99281, 99282 (national payment rate $66.46)
- APC 0611, Mid-Level Emergency Visits: 99283 (national payment rate $104.65)
- APC 0612, High-Level Emergency Visits: 99284, 99285 (national payment rate $158.21)
- APC 0600, Low-Level Clinic Visits: 99201, 99202, 99211, 99212, 99241, 99242, 99271, 99272 (national payment rate $48.61)
- APC 0601, Mid-Level Clinic Visits: 92002, 92012, 99203, 99213, 99243, 99273, G0101 (national payment rate $49.60)
- APC 0602, High-Level Clinic Visits: 92004, 92014, 99204, 99205, 99214, 99215, 99244, 99245, 99274, 99275, G0175 (national payment rate $82.23)

Note that codes 92002, 92004, 92012, and 92014 classify ophthalmological medical examination and evaluation services, while code G0175 classifies an interdisciplinary team conference with the patient present.

HCFA Regulations for Hospital Outpatient E/M Coding

In its final APC regulations, published in the April 7, 2000, Federal Register, HCFA noted that while "HCPCS codes appropriately represent different levels of physician effort, they do not adequately describe nonphysician resources." However, the regulations continue, the same concept can be applied to each code in terms of the differences in resource utilization. "Therefore," the rules state, "**each facility should develop a system for mapping the provided services or combination of services furnished to the different levels of effort represented by the codes.**"[1]

The regulations state that each facility is accountable for following its own system for assigning the different levels of codes. "If the services furnished are documented and medically necessary and the facility is following its own system," the regulations say, HCFA "will assume that the facility is in compliance with these reporting requirements as they relate to the clinic/emergency department visit code reported on the bill." They add that "therefore, [HCFA] would not expect to see a high degree of correlation between the code reported by the physician and that reported by the facility."

HIM professionals will note that this notice does not define "facility." Thus, there is no policy that prohibits integrated delivery systems from developing different sets of mapping logic for each hospital within the delivery system. In addition, there is no policy that prohibits a single hospital from developing different sets of mapping logic for each hospital-based clinic within the hospital.

Options for Mapping Levels of Care to E/M Codes

When mapping levels of care to E/M codes, consider these options:

Nursing acuity: Consider mapping medical services rendered to the appropriate E/M code by using nursing acuity levels. In this logic, a hierarchy is developed to assign a value or points to the patient care services provided by nurses during a medical visit or assessment.

Diagnosis-based system: This option involves assigning a predetermined E/M code based on the patients' diagnoses or reasons for visit. For example, an emergency or clinic patient seen for acute bronchitis is automatically assigned to a level three E/M code.

Mirroring professional component codes: Some hospitals may elect to "mirror" on the UB-92 claims E/M codes reported by physicians on HCFA 1500 claims. If this is the mapping logic of choice, consider these issues:

- **Intensity of facility component services**: The codes assigned by physicians may or may not consistently represent the intensity of services rendered by all of the healthcare professionals who provided medical care. For example, a low-level visit for a physician may in fact represent a high-level visit for nursing professionals involved in the encounter or visit
- **"New" versus "established" patients**: The definition of "new" versus "established" is not the same for physicians under the Medicare physician fee schedule and hospitals under the APC system. Under APCs, the meaning of "new" and "established" pertains to whether or not the patient already has a hospital medical record number. For physicians, a new patient is one who has not received any professional services from the physician or any other physician of the same specialty in the same practice group, within the past three years. Under APCs, the following codes specifically reference "new" and "established" patients: 9921-99215, 92002, 92004, 92012, 92014
- **Limited follow-up care**: HCFA did not propose (nor did it include in the final rule) provisions for a global period for hospital outpatient services analogous to the global period affecting payments for professional services made under the Medicare physician fee schedule. HCFA did not include "limited follow-up services" in its packaged groups under the APC system because of the difficulty of matching the costs of these services with their associated primary encounter. For now, hospitals are to bill follow-up care, such as suture removal, using an appropriate HCPCS code. However, for many follow-up encounters, the physician will not have an opportunity to assign a code and bill for the actual follow-up care rendered

Tips for Hospital Outpatient E/M Coding

Here are some tips for hospital outpatient E/M coding:

Map to an E/M code the initial medical assessment of an outpatient before he/she starts a specific diagnostic or therapeutic regimen, such as the assessment of a patient before:

- diabetic counseling
- rehabilitation therapy
- wound/ostomy care
- incontinence care
- pain management therapy

The reporting of an E/M code may be the hospital's only opportunity to be compensated for these encounters or visits-when the regimen has not yet begun.

Make sure that there is documentation in the record to support any E/M code reported for such an encounter. A dictated report or a standard form may facilitate the capture of comprehensive documentation.

Map to an E/M code **medical care that is rendered to an outpatient in the "holding area," when surgery is cancelled**. Such cancellations cannot be reported with the intended procedure code appended to a reduced service/discontinued procedure modifier -52, -73, or -74. In order for one of these modifiers to be appended next to the intended procedure code, the patient must be physically in the room where the procedure was going to be performed when the surgery is cancelled.

For example, a medical assessment of a patient in the "holding area" may take place after the surgery has been cancelled. The reporting of an E/M code may be the hospital's only opportunity to be compensated for the medical care rendered in the "holding area." Make sure that there is documentation in the record to support any E/M code reported for such an encounter in the "holding" area.

Finally, organizations should develop a comprehensive work plan for implementing and maintaining medical visit mapping logic. Sample Work Plan," offers some representative goals and objectives for such a plan. Once you have a plan, these tips and ideas should help you on your way to an E/M mapping strategy.

Note
1. Federal Register 65, no. 68. (April 7, 2000): pp. 18448-18541.
References
"APC Institute: Outpatient Compliance Action Plan," educational manual, Lolita M. Jones Consulting Services, Fort Washington, MD, 2001.
Federal Register 56, no. 227 (1991).

Sample Work Plan

A work plan for your organization's medical visit mapping logic can be a useful tool. Here are some sample goals and objectives for such a plan:
Goals
According to this work plan, this organization aims to:

- develop a system for mapping the medical services rendered in the emergency and hospital-based clinics to the different levels of effort represented by the medical visit codes included in the APC system. These medical visit codes will directly impact the hospital's reimbursement for medical services rendered to Medicare patients
- incorporate input from both the HIM and clinical staff in developing the mapping logic

  o develop a mapping system that reasonably relates the intensity of hospital resources to the different levels of E/M codes
- develop a system for the hospital to document the medical services furnished during the medical visit
- develop a system to ensure that the hospital will follow its own mapping system for assigning the different levels of E/M codes

Objectives and Plans

According to this work plan, this organization will:

- identify the patient care services commonly provided during emergency department and hospital-based clinic medical visits
- identify the resource intensity of the services commonly provided during medical visits
- refine an existing or develop a new form that will allow the clinical staff to document the care provided to patients during medical visits/assessments
- refine or develop guidelines for completion and permanent filing of the form
- develop "tentative" mapping logic for assignment of the E/M codes to medical visits
- "pilot test" the "tentative" mapping logic for a minimum of two weeks, documenting feedback received from the physicians, nurses, coding specialists, and other staff who will use the mapping logic for clinical or charging/billing purposes
- revise the mapping logic as appropriate, based on the feedback received from staff during the "pilot test" period

- file in the compliance department a copy of the facility's written mapping logic for the medical visit level codes
- provide training to the appropriate staff in the required medical record documentation needed to support the facility's mapping logic
- use actual hospital medical records in the training handout as examples of each medical visit level based on the facility's mapping logic; obliterate all patient identifiers
- file in the compliance department a copy of the "medical visit documentation training" curriculum and attendee sign-in sheets
- audit a random sample (on a regular basis) of emergency department and hospital-based clinic(s) medical records to confirm that the medical record documentation supports the medical visit level codes assigned
- ensure that the audit sample contains records for each individual responsible for documenting to support the level of medical visit care (e.g., physicians, nurses)
- file in the compliance department, a copy of the audit findings
- implement a corrective action plan if adverse findings are revealed during the audits
- file in the compliance department a copy of the corrective action plan and the results of the follow-up audits after the plan was implemented

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