# Navigating the Physician Services Maze



*by Margaret A. Skurka, MS, RHIA, CCS*

---

As HIM professionals know, accurate and complete documentation is critical for providing care and supporting reimbursement. This is particularly true-and yet particularly problematic-in the area of E/M coding. Medical practices report and are paid for their services using E/M coding, yet there are many points of confusion surrounding the process. Mastering these fine points can help HIM professionals assist physician practices in improving their documentation, optimizing reimbursement, and ensuring that they are in compliance with guidelines. This article highlights some common pitfalls and examples for correct coding.

## Three for the Price of One

Contributing to the current confusion over E/M codes is the fact that currently three variations of the Health Care Financing Administration's and American Medical Association's documentation guidelines are circulating. One set was published in 1995 and another in 1997. In June 2000, a new set of guidelines was published in draft form. Currently, physician practices may use either the 1995 or the 1997 version of the guidelines. The guidelines have not become an official part of the CPT manual as of the 2001 edition, so they continue to remain a payer-specific issue. Eventually, after field testing and acceptance by all parties, the latest version is expected to replace the others.

So physicians need to be familiar with both the 1995 and 1997 guidelines to select the set that works best for the practice. It is also important to be aware of the proposed 2000 guidelines, as a version of these is expected to be adopted in the future.

## Hot Spots to Watch

Here are some areas that could be potential sources of confusion:

*Office Visit Reporting*
Codes for physician office visits are subdivided into new patients and established patients, and each category has five levels. "Coding for New Patients" and "Coding for Established Patients" [available in PDF format] illustrate the E/M codes for physician office reporting with the application of the documentation guidelines.

*Consultations*
Consultations are a potential source of confusion. According to CPT, a consultation is defined as a type of service provided by a physician whose opinion or advice regarding evaluation or management of a specific problem is requested by another physician or other appropriate source. Four types of consultations are available for the physician.

Confusion over code selection occurs between new patients, patients whose attending physician has requested advice from a consulting physician, and patients specifically referred to a physician for evaluation and treatment. Many focused reviews have been performed because of potentially erroneous consultation coding and documentation.

For example, a consultation requires that physician A request the advice or opinion of physician B. Physician B must see and evaluate the patient, then provide the written consultation information back to physician A. If the patient is merely referred to a specialty physician, the requirements for a consultation, according to CPT guidelines, may not always be met and the wrong code could be submitted.

If it is the patient or the patient's family decision to request a consultation, that may be a confirmatory consultation or a new or established patient visit. Physicians increase their audit risk for inappropriate use of consultation codes, because a consultation

service is generally reimbursed at a higher rate to compensate for the extra work involved in rendering an opinion and communicating the findings back to the requesting physician.

*Hospital Visit Code Selection-Inpatients*
For hospitalized patients, physicians must select one of three codes for the admission day, one of three codes for subsequent hospital days, and one of two codes for the discharge day.

For the discharge day, an entirely different selection methodology is employed. In selecting discharge day codes, time is the deciding factor between the codes. Discharges that typically take 30 minutes or less are assigned one code, and discharges of 30 minutes or more are assigned another code. The codes represent the total duration of time spent by a physician for final hospital discharge of a patient.

The codes represent discharge activities. Physicians are allowed to total up the time spent on any given day, even if the time is not continuous. If a patient is both admitted and discharged on the same day, a different set of codes (99234-99236) are reported.

Documentation appropriate to each discharge level used, either 99238 or 99239, is required. Time is the factor used in the selection of the two codes, but documentation of all the physician did for the patient is critical to support the amount of time spent.

*The Emergency Department*
The CPT system defines an emergency department as "an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day." The emergency department (ED) follows the same format as the physician office visits in that five levels of codes are available for physician use. No distinction is made between new and established patients. Urgent care facilities would not qualify as emergency departments and physicians therefore must instead use the office/outpatient facility codes. ED visit codes range from CPT codes 99281 to 99285. These codes move from straightforward medical decision making through areas of low, moderate, and high complexity. Documentation requirements increase with each level. In general, higher levels of care are provided to patients who are subsequently admitted or transferred.

*Critical Care Services*
Critical care is direct care delivered by a physician for a critically ill or injured patient, usually, but not always, rendered in an area such as an ICU, CCU, or a pediatric intensive care unit (although it may be rendered in an emergency department). In CPT, these services are completely time based. The actual time spent with the patient is the basis for selecting the most appropriate code reflecting the services rendered. The high complexity definition is assumed to cover the assessment of all possible body system failures or vital organ failure. Physicians report one service or the other-a code from the critical care series or the ED visit series, but not both for the same episode of care.
It is key for physicians not to separately bill for services included within a critical care CPT code. It is assumed that physicians are performing activities such as interpreting cardiac output measurements, reviewing information stored in computers, and assessing ventilator management as well as performing vascular access procedures, for example, as a part of the critical care services. Audit problems emerge when the physicians or facility bill these services incorrectly.
To avoid these issues, the actual time spent with the individual patient should be recorded in the patient's record. This represents good documentation practice, providing adequate documentation supporting the selected CPT code. In addition, physician documentation should extend beyond traditional activities conducted at the bedside to time spent with family members and time spent at the nursing unit with other clinical staff.

## The Time Factor

Since 1992, time has been a key factor in assisting physicians in selecting the most appropriate level of E/M service. The times associated with each code are averages, not absolutes. The physician should always refer to the acuity level of the patient and the amount of documentation completed in selecting the most appropriate code, not specifically the time involved to provide the service.

Face-to-face time spent with the patient is the guideline for office encounters and unit/floor time (time on the inpatient nursing unit) is acceptable for inpatient encounters. The inpatient guideline encompasses a more global definition of time that is

advantageous to the physician in raising the level of care.

Remember, a physician is allowed to use time to his/her advantage. In the event that counseling or coordinating care has encompassed more than 50 percent of the patient's visit, it may be used to select the code to report.

As always, document the extent of the counseling or coordination of care in the record by recording the time spent.

## Other Codes

Other sections of the E/M section will be used as appropriate to the setting. Use caution, however. Reimbursement may be inappropriate if the wrong category is used to report services and the risk of abusive billing practice audits increased. Additional categories include:

- neonatal intensive care
- nursing facility services (also used in skilled care beds within a hospital, such as "swing beds")
- domiciliary, rest home, or custodial care services
- home services
- prolonged services
- case management services
- care plan oversight services
- preventive medicine services
- newborn care
- special evaluation and management services
- other evaluation and management services

## Current Documentation Requirements

When completing HCFA documentation, E/M codes are used and specific requirements for each level of service are defined. Three key components-patient history, the physical exam, and medical decision making-are required.

Patient history requires obtaining a variety of data from the patient and documenting related patient assessment activities. Additional documentation elements are required to support the movement from one level of history to a higher level of history. The patient or an office assistant may gather a portion of the history for physician review as long as physician involvement is documented.

Similarly, for the physical exam, levels move from problem focused to expanded problem focused, detailed, and comprehensive. As with histories, additional documentation is required to support and validate the use of each level of code.

The medical decision-making component is the most significant and the most difficult for a non-physician reviewer to assess, because it reflects the complexity of the process and may not always be clearly documented in the record.

This component of an E/M code represents the physician's documentation of significant patient care process components. It includes diagnoses, management options, the amount of data to review, the risk of complications, morbidity, and mortality. It also addresses the well-known "medical necessity" issue.

The decision-making component includes provisional or working diagnoses, which is the diagnosis the physician is intending to "rule out." Take care to avoid using these working diagnoses in the actual final diagnoses listed for the patient encounter.

## Comparing the 1995 and 1997 Documentation Guidelines

Both the 1995 and 1997 version of the documentation guidelines have similar requirements for the history component of the requirements. There are specific requirements for documentation of the patient history. The chief complaint and history of the present illness should always be recorded; other elements, such as a problem pertinent system and past, family, and social history, are required depending on the level of the visit.

The two sets of guidelines differ more significantly regarding the physical exam section. The 1995 guidelines include a lot of detail for the general multi-system exam and less detail for single system exams. Requirements are not always clear. There are four levels of physical exam-problem focused, expanded problem focused, detailed, and comprehensive.

In the 1997 guidelines, there is a general multi-system exam and 10 specific single system exams. A varying number of "bullet points" or exam elements are needed to move from one level to another.

The two versions don't differ significantly, however, in the medical decision-making section. Both employ four levels of decision making ranging from straightforward to high complexity. A list of examples of items within each level is provided, but it is often open to interpretation.

## The 2000 Version of the Documentation Guidelines

The proposed 2000 regulations have many improvements but have not been field tested as of this writing. In the history area, requirements regarding history of present illness are clearer, and recognition in the requirements of medication monitoring is explicit. In the review of systems section, there are fewer requirements required to meet a certain level. Examples of acceptable and unacceptable notations are provided.

There is no difference in the requirements for the past, family, and social history from the earlier renditions of the requirements.

Much progress has been made in the physical section in that these draft guidelines allow the physician to tailor the documentation to the exam being performed. There are now three levels of exams, rather than four. For documentation purposes, problem focused and expanded problem focused examinations are similar and are designated as a "brief" examination. Vignette examples will be helpful, and there are no bullet points, which should help keep irrelevant facts from being recorded.

In the medical decision making section, there are now only three levels-low, moderate, and high complexity. Again, the physician should tailor the documentation to the assessment and the plan of treatment, and examples are included.

## The Audit Process

The Office of Inspector General (OIG) recommends that all physician practices develop audit policies and procedures and conduct claims submission audits, baseline audits, and periodic audits. A feedback system must be developed in the event the audit process finds documentation and billing errors, so that corrective action may be taken.

During an E/M review process, it is never useful to merely indicate that some codes were "too high" or "too low." Instead, show how increased history, increased physical documentation, or additional documentation of decision-making make it necessary to move patients to higher code levels. This gives physicians more specific guidance on areas may not be well documented in the record.

## Performing Your Own Audit

When performing an internal audit, it's helpful to have consistent parameters. For example, reviewing 10 records per practitioner is sufficient to establish documentation patterns. If you are performing a re-audit six months or one year later, look at the results of the first audit and select cases accordingly. If a physician scores particularly well in the first audit, you can review fewer cases the next time around, perhaps five to seven.

If a physician scores poorly in the first audit and corrective action has been taken, you should again review 10 records. Be sure to select records documented after the corrective action or educational process has taken place.

All of these processes are part of the cycle of improving the quality of your coded data. This data, in turn, will be integrated with financial data to produce information needed to make important decisions about patient care and profitability of providing selected health services. For these reasons, accuracy and completeness are essential, and they begin with documentation in the medical record.

## The Importance of Being Cautious

The more a medical practice understands and abides by documentation requirements and CPT principles, the more it minimizes the risk of adverse consequences from external review. But because of concerns about "upcoding" of physician service levels, it helps to be cautious. Here's a list of problems that may cause a focused payer review:

- Using the same code over and over. A physician can easily trigger an audit by using the same level of code repeatedly-for example, using 99213 for office visits, 99223 for hospital admits, and 99244 for office consults. A pattern such as this is easy to detect and shows the physician is not discriminating within the coding system
- Inconsistencies within partners in a group. A statistical comparison of partners in a practice shows inconsistent physician education about coding guidelines.
- Upcoding/undercoding. In some instances, physicians consistently tend to select higher-level codes. This presents data that is hard to believe and may trigger an audit or review. Two codes the federal government will focus on are 99214 (established patient office visit, level 4) and 99233 (subsequent hospital care, level 3, highest level). It is critical that organizations review their current use of these codes for appropriateness. Undercoding may not trigger an audit but results in lost revenue and creates data quality concerns. For example, some physicians use lower-level codes because they do not want to "bother" with the documentation requirements of the higher levels. This presents a false picture of patient severity and the associated physician work and may actually decrease reimbursement amounts in the future.
- Modifiers. Using modifiers correctly can help support documentation and claims in unusual or specific circumstances. When they are used incorrectly-e.g., to force a claim to pass edits in place to reject services-modifiers can create a compliance liability. In the physician setting, modifier -25 is especially problematic because it may allow payment for a visit and a procedure when the two services are really not distinct from each other.
- Diagnoses issues. Using nonspecific diagnoses or terminology increases the risk of audit for providing unnecessary services. Encourage physicians to use specific diagnoses and document all complications and comorbidities when completing a patient record and ordering specific tests or treatments

## For Further Reading

Compliance Program Guidance for Individual and Small Group Physician Practices, available at www.dhhs.gov/progorg/oig/modcomp/index.htm.

Documentation Guidelines for Evaluation and Management Services, for 1995, 1997, and 2000 are available online at www.hcfa.gov/medicare/mcarpti.htm.

American Medical Association. Physicians' Current Procedural Terminology. Chicago, IL, 2000. Available at www.ama-assn.org/ama/pub/category/3672.html.

"Diagnostic Coding and Reporting Guidelines for Outpatient Services (Hospital-based and Physician Office.)" Available from the National Center for Health Statistics at www.cdc.gov/nchswww/data/icdguide.pdf.

Skurka, Margaret A. Health Information Management, Principles and Organization for Health Record Services. Chicago, IL: American Hospital Publishing, 1998.

Additional graphics are available in PDF format by clicking here.

Web extra: Sample audit forms for E/M coding and emergency services coding are available here.

You can download Adobe Acrobat by going to http://www.adobe.com/products/acrobat/main.html

---

*Margaret A. Skurka (mskurk@iun.edu) is professor and director of the health information management programs at Indiana University Northwest in Gary. She is the current past president of the AHIMA.*

*This article is based, in part, on a presentation made at the 2001 Annual Conference of the Healthcare Information and Management Systems Society.*

---

**Article citation**:
Skurka, Margaret A. "Navigating the Physician Services Maze." *Journal of AHIMA* 72, no.7 (2001): 51-58.

---