When Guidelines Depend on the Setting: Comparing, Contrasting Facility Reporting and Professional Fee Coding

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Coding for facility and professional services on the same encounter can be confusing. This article outlines the differences in guidelines between the two coding types.

The Setting Factor

Over and over, coding professionals have been told that they can code "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out" conditions. This guideline is true for certain settings such as acute care facilities, short-term facilities, long-term care, and psychiatric hospitals. However, a coder coding a physician service may not apply this rule, even if a physician provides the service to an inpatient admission.

Take for example a patient admitted to a facility with a first progress note diagnosis of shortness of breath, rule out pneumonia. The coder reporting the professional fee would not be able to code the diagnosis of pneumonia, but he or she would need to code shortness of breath. Shortness of breath is the sign or symptom known. The diagnosis of pneumonia could be coded by the hospital inpatient coder, as long as the diagnosis was not ruled out throughout the hospitalization.

If this same documentation was applied to a hospital outpatient setting, such as a patient in observation, then the diagnosis of pneumonia would not be coded by either the coding professional reporting the professional fee or the hospital outpatient service.

The coding professional would need to know this guideline, as most books or encoders do not distinguish the "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out" rule.

The third quarter 2000 Coding Clinic validates this guideline, stating, "When coding for physician services whether provided in the hospital inpatient setting or in the physician office, coders should be guided by the Diagnostic Coding and Reporting Guidelines for Outpatient Services (Hospital Based and Physician Office)."

Evaluation and management coding is another area where the guidelines differ between facility coding and professional fee coding. Professional fee coding and reporting follow the established documentation guidelines set forth by the Centers for Medicare and Medicaid Services (CMS). There are two sets of documentation guidelines a physician may follow, the 1995 or 1997 guidelines.

Both sets are similar in requirements with the exception of the examination section, and as coding professionals know, physicians may use either set. Facilities may report the same evaluation and management codes but are not required to follow the same documentation guidelines that have been established for professional fee coding.

While CMS is working on establishing facility guidelines to report evaluation and management codes, the codes should be reported based on facility-developed guidelines while physicians use the 1995 or 1997 guidelines. It is important that coding professionals know the type of setting (i.e., the facility or the physician's fee) for the codes being reported.

Modifier Usage

Modifier usage also differs for professional fee coding and facility coding. Certain modifiers only apply to hospital outpatient settings, such as 73, Discontinued outpatient procedure prior to anesthesia administration, and 74, Discontinued outpatient procedure after anesthesia administration. Professional fee coding would report modifiers 52, Reduced services, or 53, Discontinued procedure, for the same service in which the hospital would report 73 or 74 depending upon the documentation.

Modifier use also differs in evaluation and management codes. For example, necessary professional services may report modifiers 21, Prolonged evaluation and management services, and 24, Unrelated evaluation and management service by the same physician during a postoperative period.

Facilities may not report either modifier. The postoperative period is defined differently for facilities and professional services. Most third-party payers define postoperative days for providers as 0, 10, or 90 days; facilities only have to be concerned with outpatient visits that occur on the same day.

V Codes

Reporting V codes to third-party payers is a common challenge in both facility and professional fee coding. Coding professionals have heard repeatedly that they can't use V codes because the claims won't get paid.

V codes, however, are valid codes, and when used correctly they result in paid claims. The ICD-9-CM Official Guidelines for Coding and Reporting feature a table that describes when V codes should be used as the first listed diagnosis only, an additional diagnosis only, or a combination of both first listed or additional diagnosis.

For instance, if a patient is seen on an outpatient basis in follow-up for a knee replacement, the code V43.65 (knee joint replacement) should not be listed as the first diagnosis. Rather, V54.81 (aftercare following joint replacement) is the correct first diagnosis, as supported by the guidelines. The code V43.65 would be added to the encounter as an additional diagnosis. This encounter should be covered by the third-party payer. Coding professionals should reference the ICD-9-CM guidelines for further information regarding V codes.

Coding professionals thus must be acutely aware of the setting they are coding for, as the guidelines differ from setting to setting. And, of course, no matter the setting, good documentation and ongoing education are essential to good coding.

Documentation must support all diagnosis and procedure codes reported. Documentation must be legible; if you can't read it, third-party payers likely will not be able to read it either, and the claim may be denied.

Continuing education for coders is a must, as new codes and guidelines are created every year. Coding professionals should take the time to review the established coding guidelines and familiarize themselves with new ones. Education is never wasted and could save valuable time correcting errors on the back end.

References

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