Are you undercoding too much?

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Getting fairly reimbursed for physician services in your practice comes down to selecting the right Medicare evaluation and management (E/M) codes. In a recent benchmark survey completed by the Renal Physicians Association, nephrologists used the 99213 E/M code (otherwise known as a level 3 visit) to bill for 43% of established patients seen in the office. During the same period, they selected the 99214 code for only 37% of these encounters. This might seem like a reasonable coding pattern, but if you take the time to examine the cognitive labor required to deal with a typical nephrology patient, it is hard to overlook the possibility that many nephrologists are selling themselves short when it comes to charging for intellectual services.

Nephrologists need to learn when it is appropriate to bill using a 99214 code instead of a 99213 code. When you consider the fact that a 99214 code pays over 50% more than a 99213 code, it becomes obvious that this is not just an academic distinction.

Consider the following example: You see an established patient with diabetic nephropathy in the office. The creatinine has gone from 1.5 mg/dL to 1.7 mg/dL. Blood pressure is 140/80 mm Hg. You increase lisinopril from 10 mg to 20 mg per day and schedule a follow-up appointment in three months with labs. The entire encounter takes about 10–15 minutes, including documentation time.

How would you code for this visit?

This seems like a fairly straightforward encounter. Not surprisingly, most nephrologists would choose to bill this visit using the 99213 code. This level of care has a certain intuitive appeal because it is in the middle of the coding spectrum. It is tempting to use this code for patients perceived as "routine." This would be a big mistake. This approach to E/M coding may feel right, but it is inherently irrational because of the subjectivity involved. If you look at the medical decision making required for the hypothetical encounter above, it is clear that the clinical scenario is more consistent with the 99214 level of care.

The use of an objective point system (developed by the Centers for Medicare & Medicaid Services and distributed to all Medicare carriers) could help physicians quantify their medical decision making more objectively. This approach takes into consideration the number and nature of the diagnoses addressed, the data reviewed by the physician, and the patient's risk of morbidity and mortality. Points are added up for each category and the overall level of complexity of medical decision making is determined by plugging the data into a table.

Creating a point system

Looking at the hypothetical encounter above, the first thing to do is see how the points would add up for the diagnoses addressed. This can be done by referring to Table 1.

It is easy to see that our patient adds up to a total of at least four points. Two points come from suboptimal controlled hypertension (established problem, worsening), and two points for diabetic nephropathy (established problem, worsening).

Data review

The next step is to see how many points you would get for reviewing the data (see Table 2).

For our hypothetical office visit, we would only qualify for one point in this category for reviewing or ordering lab tests.

Patient risk

The last component of medical decision making to address is the risk to the patient. This is quantified by referring to Table 3 (p. 58). Of all the components used to calculate medical decision making, medical risk is the one that is most frequently underestimated by physicians. It is important to remember it only takes one element of risk in any of the categories of presenting problems, diagnostic procedures, or management options to qualify for any given level of risk. Also, the E/M guidelines explicitly state that the highest risk present determines the overall level of risk for the encounter.

TABLE 1. PATIENT PROBLEM POINT SYSTEM

Problems	Points
Self-limited or minor (maximum of 2)	1
Established, but stable or improving	1
Established and worsening	2
New problem, with no additional work-up planned (maximum of 1)	3
New problem, with additional work-up planned	4

Understanding CPT coding: *When adding up the "problem points" in this table to determine reimbursement, use the categories listed. "New problem, with no additional work-up planned (maximum 1)," for example, means that a practitioner can only count one new patient problem during each encounter toward the total points. If there were two new problems with no additional work-up planned, you could not use both of these new problems to total up the points (because of the "maximum 1" rule). Another example: If you had one "new problem with no additional work-up planned" and one "self-limited or minor" problem, your total problem points would be four (three points for the new problem, with no work-up planned and one point for the self-limited or mild problem).* —P. Jensen

TABLE 2. REVIEWING THE DATA

Data Reviewed	Points
Review or order clinical lab tests	1
Review or order radiology test (except heart catherization or echocardiogram)	1
Review or order medicine test (PFTs, EKG, cardiac echo or catherization)	1
Discuss test with performing physician	1
Independent review of image, tracing , or specimen)	2
Decision to obtain old records	1
Review and summation of old records	2

TABLE 3. E/M GUIDELINES TABLE OF RISK

Risk	Presenting problems	Diagnostic procedures	Manage options selected
Minimal	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis	• Laboratory tests • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound/Echocardiogram • KOH prep	• Rest • Gargle • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, e.g. well controlled HTN, DM2, cataract • Acute uncomplicated injury or illness, e.g., cystitis, allergic rhinitis, sprain	• Physiologic tests not under stress, e.g., PFTs • Non-cardiovascular imaging studies with contrast, e.g., barium enema • Superficial needle biopsy • ABG • Skin biopsies	• Over-the-counter drugs • Minor surgery, with no identified risk factors • Physical therapy • Occupational therapy • IV fluids, without additives
Moderate	• One or more chronic illnesses, with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem, with uncertain prognosis, e.g. lump in breast • Acute illness with systemic symptoms, e.g., pyelonephritis, pleuritis, colitis • Acute complicated injury, e.g., head injury, with brief loss of consciousness	• Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test • Diagnostic endoscopies, with no identified risk factors • Deep needle, or incisional biopsies • Cardiovascular imaging studies with contrast, with no identified risk factors, e.g., arteriogram, cardiac catheterization • Obtain fluid from body cavity, e.g., LP/thoracentesis	• Minor surgery, with identified risk factors • Elective major surgery (open, percutaneous, or endoscopic), with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids, with additives • Closed treatment of fracture or disclocation, without manipulation
High	• One or more chronic illness, with severe exacerbation, progression, or side effects of treatment • Acute or chronic illness or injury, which poses a threat to life of bodily function, e.g., multiple trauma, acute MI, pulmonary embolism, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness, with potential threat to self or others, peritonitis, ARF • An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss	• Cardiovascular imaging, with contrast, with identified risk factors • Cardiac EP studies • Diagnostic endoscopies, with identified risk factors • Discography	• Elective major surgery (open, percutaneous, endoscopic), with identified risk factors • Emergency major surgery (open, percutaneous, endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate, or to de-escalate care because of poor prognosis.

If you apply these rules of risk to our example encounter, it is clear that this visit easily qualifies for moderate risk. This level of risk is based on "prescription drug management" (since we adjusted the dose of the lisinopril) or "one or more chronic illnesses with mild exacerbation," which describes our patient's hypertension and diabetic nephropathy. Once you have added up the diagnosis and data points, and quantified the level of risk, the overall level of medical decision making is calculated by plugging this data into the risk table.

TABLE 4. LEVEL OF COMPLEXITY

Overall medical decision making	Problem points	Data reviewed points	Risk
Straightforward complexity	1	1	Minimal
Low complexity	2	2	Low
Moderate complexity	3	3	Moderate
High complexity	4	4	High

Two out of three elements are required to qualify for any given level of complexity. In order to qualify, it is necessary to meet or exceed the criteria for only two out of three of the elements in the table. So, in our example, the encounter qualifies for medical decision making of moderate complexity because of four diagnosis points and moderate risk. The data points only qualify for straightforward complexity, but that's acceptable because you only need two out of three to make the grade.

This exercise demonstrates that our hypothetical encounter qualifies for moderate medical decision making. If you look at any standard E/M reference, you will find that this degree of complexity of medical decision making corresponds to a Level 4 office visit, otherwise known as a 99214 code. What is striking about this clinical scenario is its benignity. This acuity of care would seem to describe the vast majority of "routine" office patients in a typical nephrology practice. Why then is 99213 code used so much more often than 99214 code? The reason may be that physicians haven't taken the time to learn how to recognize the value of their own cognitive labor. It may seem a little complicated, but once you go through the steps of calculating the medical decision making a few times, repetitive patterns will start to emerge.

Document it!

It is important to realize that there is more to E/M coding and documentation than just the medical decision making. Each encounter has very specific requirements for the documentation of the history and/or physical exam, depending on the level of care selected. Calculating the medical decision making gives physicians enough clinical traction to choose an appropriate target code to fit the medical circumstances of the encounter. After the level of care has been selected in this manner, the documentation of the history and/or physical exam can be performed in a prospective and purpose-driven manner to ensure these elements are congruent with the E/M guidelines.

A happy side effect of letting the medical decision making be your guide when it comes to E/M coding is that this approach removes a large burden of subjectivity from the physician. When you use this E/M coding strategy, it is the patient—not the physician—who ends up choosing the level of care. The objective clinical parameters used to calculate the medical decision making are largely beyond the control of the examining physician, which adds an insulating layer of impartiality to the process. This unrecognized complexity of medical decision making represents an untapped reservoir of potential reimbursement.

This is not a question of bilking Medicare or somehow trying to "game the system." It is simply a matter of taking full credit for the intellectual services you rendered as defined by the E/M guidelines. Allowing the medical decision making to lead the way is the only path to true E/M compliance. ◆