

# Coding from the Trenches



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**W**hen billing for patient visits, providers must make sure they can properly include the complexity required for the level of healthcare service indicated. As a physician who is in the daily trenches of patient care and has achieved coding and auditing certification, it becomes critical but stressful to ensure all my bases are covered on each and every patient I treat.

## SAMPLE ENCOUNTER

I am about to be done for the day. I need to get to a meeting and I have one more patient to see. Mrs. Jones is my partner's regular patient but Jill is tied up and the front has asked me to see her. I say yes and, due to my schedule, I hope it will be a quick in-and-out visit. After seeing Mrs. Jones, I dictate her note in a hurry and rush to my meeting. The following is the documentation of my encounter:

- **Chief Complaint:** *Mrs. Jones is a 35-year-old lady who comes in today for a cough.*
- **History of Present Illness:** *Mrs. Jones has been coughing for four days. The cough is productive of sputum with effort. Walking up stairs makes the cough worse. The cough is getting worse, so she came to the doctor.*
- **Review of Systems:** *General: No fever; Cardiovascular: Chest pain with inspiration; Gastrointestinal: No nausea, no vomiting.*

- **Social History:** *No smoking, recent air travel.*
- **Exam:** *The patient is in no acute distress today. The lungs are noted to have some expiratory wheezes.*
- **Impression:** *Acute Bronchitis. The patient is to take Keflex 500 mg bid for the next 10 days. If she continues to worsen and notes no improvement, she should return to the clinic or emergency room as the condition warrants.*

*Electronically signed by Shelton Hager, MD*

A quick note for what appears to be a quick and routine encounter. A detailed history is recorded, which is only half of the necessary information required for an established patient "detailed" visit or a 99214. Upon auditing, a valid chief complaint is identified and four History of Present Illness (HPI) elements were documented (Duration, Associated Signs & Symptoms, Context, and Severity), scoring the HPI as Complete. Three body systems were found for a detailed review of systems and one element of PFSH (Past/Family/Social History) was reported for a Detailed PFSH. (A detailed history is scored as the lowest documented component within the history portion of the note, which is used to determine the overall level of service.) The Physical Exam is documented with only two identified body systems, neither of which has any "detailed" content. I diagnosed acute bron-

chitis and prescribed an antibiotic. Medical decision-making is low complexity (new problem, no additional work-up and prescription management) and the level of service is an expanded problem-focused exam 99213.

The medical necessity is the determining factor in coding and is based on the patient's presenting problem. This patient presented with an acute uncomplicated problem (according to the documentation) and would therefore be classified as a low-risk patient, making the billable level of service a 99213.

## TRUE STORY

Now, let me tell the true story of Mrs. Jones.

The history information recorded is accurate but in retrospect is lacking some key components. I checked Mrs. Jones' problem list and she has a history of a heart attack. I questioned her further and she told me it was secondary from a pulmonary embolism she had in the past. This information completely changed the focus of my visit and my initial thoughts of her condition. Further questioning found the airline travel was a trip to Hawaii. Mrs. Jones commented that she had noticed her right leg being swollen during and after the return flight.

Inclusion of this information in the already recorded history would not change the level of service based on the documentation content, but would have a healthy boost in the medical complexity of the visit. The documentation is not in-

## SPECIAL FEATURES

creased because while we now have the inclusion of past medical history and social history, there is still no family history to meet the necessary requirements. Further, the review of systems was not enhanced enough to include the required systems for a comprehensive history. The physical is the same as above, so there is no change to the level of service based on the exam.

The medical decision process is more intensive. You have new elements in your medical decision-making – cough, leg swelling and a personal history of pulmonary embolism – but it is up to the physician to draw a road map for the auditor to the identified. I treated her with an antibiotic, explaining that this is probably acute bronchitis, and documented the plan of care this way in the medical record. However, what is not documented is that I ordered a CT chest pulmonary protocol to rule out an occult pulmonary embolism. It was my job to make the thought process clear and the medical necessity evident and, according to the documentation of the encounter, this complexity was not made evident. By incorporating this additional information I would have been able to bill a higher level, better document the patient's actual condition of care, and have a more complex encounter.

### SUPPORTING A 99215

What would it have taken to increase this visit to a Level 5 visit 99215? Based on medical necessity, would a 99215 have been supported? The documentation needed would be:

1. Seven additional systems for the review of systems
2. Inclusion of the discussed Past Medical History and Family History
3. Physical exam: This portion of the documentation would not have to change as an established patient only needs two of the three documentation components (history/exam/medical decision making). However, a 99215 level of service would need eight body systems for the exam.

The medical necessity that justifies complex medical decision-making is intense and hopefully rare in an outpatient setting. Mrs. Jones' case at her current state does not meet the intense level of severity. Remember the buzz words, "threat to life or bodily function," as this is the founding basics of the Level 5 encounter. Mrs. Jones is being evaluated for a condition that could lead to threat to life or bodily function; however, she does not pose this threat at this time. Having this knowledge, the amount of documentation to increase to a 99215 is not needed, since this patient would not satisfy the complexity standards.

It is imperative that providers document what is needed from a legal liability standpoint, while maintaining what is needed for documentation content and supporting the complexity involved with the patient's episode of care. It is a balancing act, which is best begun by ensuring that all physicians have the ability to properly identify the level of service needed according to the patient's condition on the date of service of the encounter. +

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