Coding Consistency

EVALUATION AND MANAGEMENT (E&M) CODING CHALLENGES

By Holly Louie, RN, CHBME

Unlike surgical specialties that have hundreds of CPT codes to choose from, E&M services are limited to a handful of choices. They all have the same key components and the same basic rules. To the uninitiated, therefore, it may seem that coding these services should be easier. In reality, accurate coding for E&M services is one of a coder's greatest challenges.

Numerous studies have demonstrated that the most proficient coders frequently disagree on the correct code. The reasons for this coding inconsistency are numerous: medical decision making involves subjectivity, medical necessity is interpreted differently, physicians "overdocument," and payor interpretations and instructions regarding the most basic concepts are inconsistent.

To further compound the confusion, there are really three sets of E&M documentation and coding guidelines: the CPT book and two significantly different guidelines published by CMS. The CMS guidelines are commonly referred to as the 95 and 97 guidelines and have been widely adopted by commercial payors. Although the American Medical Association (AMA) collaborated with CMS (then HCFA) in the development of the E&M documentation guidelines and published the guidelines in *CPT Assistant*, the CPT manual does not incorporate either set in totality. CMS published a third set of guidelines in draft format that were ultimately dropped and the AMA formally withdrew from participation in a fourth set.

It is important to note that the CPT manual was developed by physicians for physicians. While basic documentation guidelines are set out and supplemented by clinical examples, the CPT guidelines are based on the premise that the physician knows what needs to be documented both for patient care and to communicate with medical professionals. CMS, as well as other payors, believe very specific elements must be documented to support medical necessity and that a counted scoring methodology is necessary to review E&M coding accuracy.

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While this *may* result in some level of coding consistency, the real result is that the methodology reduces the complexity of patient care and physician knowledge, expertise, and communication to a mathematical formula. Physicians believe both the 95 and 97 guidelines require documentation of information that is irrelevant to the care of the patient. This article focuses on some of the common coding dilemmas when applying CPT guidelines and Medicare carrier interpretations of the 1995 E&M guidelines.

What is the proper documentation for past, family, social history (PFSH)? To many physicians, stating that the family history is "noncontributory" or that the past history is "negative" is appropriate and conveys the necessary information to other health care providers. To a Medicare carrier, these comments are deemed to be equivalent to "not documented" and no credit is given in a review. Explaining to physicians why modifying the statement to say "The patient has never had any previous illness or hospitalization" is acceptable, while saying "negative" is not, is a tough job since they state the same thing. CMS recognized and corrected this issue with later interpretations, but will not apply it to the 95 guidelines.

Where do you count allergies? In questions and answers with CMS, physicians were told that allergies could be considered past history OR part of the review of systems. Currently, some carriers have written that comments such as "No known allergies" or "Allergic to penicillin" cannot be considered part of the review of systems and are always past history. Unfortunately, the written guidance has not always been formally published by the carrier.

What is a complete physician examination? Although both CPT and the E&M Documentation Guidelines describe a complete examination as eight or more organ systems, many payors have allowed a mix and match of anatomic areas and organ systems. Other carriers

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adhere to the organ system requirement. Some payors will count specific comments as an organ system, i.e., "no cervical lymphadenopathy" for the lymphatic system and others will only give credit if the "complete" system is assessed.

The Emergency Medicine caveat: When coding emergency department E&M codes, the coding guidelines permit coding the highest level of service, *without* documenting the required key components, *within the constraints imposed by the patient's condition.* In other words, it is recognized that emergencies take precedence over the need to capture information. This caveat does not extend to any other E&M codes. This failure to recognize other specialties that frequently treat patients in the emergency department, but must report services using another category of E&M codes, such as hospital admission, results in the same situation having completely different coding rules.

What can we do? E&M coding is a continued focus of CMS, the Office of Inspector General (OIG) and commercial payor fraud units. To protect your company, know what your payors' policies are; write for clarification if you are not sure. Make sure your coders know when payor rules conflict with CPT. Review coding patterns and pay special attention to those that are identified by CMS as having a very high error rate in reviews. Many carriers publish the result of their reviews and audits on their Web site to assist you in accurately coding based on the medical record documentation. ▲

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