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Level of Care Coding Tips to Boost Revenue and Mitigate Risk

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If physicians don't document elements (history, exam, and medical decision-making [MDM]—or time spent counseling and coordinating care) for each E/M level adequately—or the elements they document don't make sense given the patient's presenting problem (e.g., performing a comprehensive exam for a patient with a sinus infection)—payers and auditors may down-code the service or even conduct a more in-depth audit that could expose additional documentation vulnerabilities, she adds.

It's equally risky to report the same E/M level for all patients with the same diagnoses (e.g., diabetes or congestive heart failure) without first considering medical necessity—a trap into which many physicians fall because they assume all patients with the same diagnoses generally require the same work.

History

When billing a level 4 or 5 new patient E/M code (i.e., 99204 or 99205), remember to document one specific item from the past medical history (i.e., illness, operations, injuries, treatments, medications, or allergies), one specific item from the family history (i.e., medical events or hereditary diseases that place the patient at risk), and one item from the social history (e.g., use of tobacco, drugs, or alcohol).

Also document a review of systems that relates directly to the problem identified in the history of the present illness (HPI) in addition to a review of all additional body systems, says. Physicians frequently forget to include all of these elements, often leading payers to down-code these services to a level 2 or 3 on post-payment review, she adds. That means physicians could lose as much as $133 per encounter.

Similarly, when billing a level 3 new patient E/M code (i.e., 99203), don't forget to document one specific item from either the past, family, and/or social history that's directly related to the problem in the HPI. Omitting one or more of these details usually prompts payers and auditors to down-code the service to a level 1 or 2 on post-payment review. Revenue loss in this case could be as much as $64 per encounter.

Be as descriptive as possible when documenting the HPI. Specify the location, quality, severity, timing, context, modifying factors, and associated signs and symptoms that are significantly related to the presenting problem. These descriptors help physicians gain points when choosing an E/M level.

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Don't repeat the same HPI for every visit. This is true even for follow-up appointments related to chronic conditions. Payers want to see what's new with the patient—for example, new pain, new flare-ups, new concerns, or new lab results—or some acknowledgement that the patient has been stable and symptoms are controlled. The same repetitive HPI could be a red flag that a physician is cloning their documentation.

Exam

Only review body areas or organ systems that affect MDM for the current encounter. Most subsequent visits, for example, don't require a multi-system exam even though it's very easy in an EHR to pull this information forward from the initial visit. Doing so inflates the E/M level and could expose a physician to audit risk.

Explain negative findings. Documentation should reflect the following: For example, what did the physician specifically ask the patient about each body system, and how did they respond? How did this contribute to the physician's overall assessment and evaluation? In the examination, what element of the organ system did the physician evaluate, and why?

Physicians who don't explain their analysis in the context of the patient's complaints often end up with (level 4s and 5s with mostly negative findings and no explanation of why the physician performed certain services) that tend to raise a red flag with payers and auditors.

Know whether your Medicare Administrative Contractor uses the 1995 or 97 E/M guidelines. These guidelines differ in their options for the exam component of the E/M level. More specifically, the 97 guidelines provide additional options for single organ system exams, allowing providers to report higher-level services for intensive, problem-specific examinations. Once you know which of the guidelines your MAC uses, ensure your EHR vendor incorporates them into any templates you use.

MDM

Know how payers calculate the MDM. This includes the number of diagnoses and management options considered, the amount and/or complexity of data reviewed (e.g., urinalysis, EKG, lab results, or additional workup planned), and the risk of complications, morbidity, or mortality. Therefore, documenting each of these elements is critical because it can help justify a higher-level E/M code.

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Know how your Medicare Administrative Contractor interprets MDM. Contractors publish frequently-asked questions and other guidance describing what they look for in terms of all E/M documentation, including MDM. For example, some MACs define 'additional workup' as any service that's performed outside of the current encounter while others state it's any work that goes beyond the E/M service—even when the physician performs it during the current encounter.

Time

Document the total time (in minutes) spent face-to-face with the patient and/or family during the visit, and specify how much time (in minutes) was spent counseling the patient and/or family or coordinating care.

Summarize specific details of the conversation with the patient and/or family (i.e., what was discussed with patient and/or family and why).