Uncovering the Right Code

By Barbara J. Cobuzzi, MBA, CPC

In light of the expansion of Medicare's Recovery Audit Contractor program, physicians are taking a second look at their coding practices. Don't make the mistake of undercoding because you think it is the safe way to go. If you document well, and let the nature of the presenting problem (NPP) become the prevailing criterion for selecting an E&M code, you should be able to defend any audit that comes your way.

Start where all E&M services begin, with the chief complaint. When gathering a history it is clinically appropriate to conduct a comprehensive history for a new patient, even one who presents with a simple problem. This allows you to insure that this problem is truly straight forward; or you may uncover complicating factors such as comorbid conditions, familial history, medications that may affect the problem, etc.

Performing a comprehensive history for even a seemingly small problem can help you conclude whether the chief complaint is truly small, or if the NPP has been complicated by some aspect of the history. There is a reason why the history has three elements: history of present illness; review of systems; and past family and social history — and all three are required to determine the NPP.

The next two steps build on the first. Based on the chief complaint, the history, and ultimately the NPP, you will then decide how extensive an exam is needed. For a straight forward, simple problem, the exam will match it, and will only need to be either a problem-focused or expanded problem-focused exam. Even though a comprehensive history may have been performed and documented, the NPP will lead you to a limited exam, thus limiting the level of the E&M service performed and documented for that encounter.

Had the comprehensive history uncovered a slightly more complex presenting problem, you may have determined it was necessary to perform a more detailed exam. By doing this, you are setting up the service for a higher level E&M code based on the more complex presenting problem.

And finally, had the problem been determined to be very complex, you would have determined that a comprehensive exam was necessary for this encounter.

This leads you to the medical decision making element of the E&M service. Often the medical decision making calculation does not align with the NPP, especially for established patients with chronic illnesses. Because these patients may not be able to support a high number of diagnostic management options or diagnostic testing, it is difficult to justify a higher level of medical decision making. However, the NPP — for example the management of diabetes, HIV, Lupus, or other chronic conditions, particularly when they may not be totally in control — can support a level four follow-up visit from a medical necessity standpoint.

So, even though the medical decision making component by itself can only support a low E&M code due to the familiarity of the patient's case, performing and documenting a comprehensive interval history and a detailed exam (medically necessary for the nature of these presenting problems) supports the level four established patient. This is why it is so important to consider the NPP and not just the medical decision making element of the E&M calculation.

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