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2017 – November Run Through a few Typical Cases and Grade the Care You Provide

Reviewing nearly 400 medical records a month gives us a keen insight into how our colleagues perceive the value of what they are providing to their patients. What is so concerning to us is the undervaluing of what these doctors do by the doctors themselves. We'll see doctors perform great clinical assessments and provide outstanding care, but routinely under-grade the visit by two levels (equaling ~$60 in reduced reimbursement). Doing this just once a day can affect the practice's NET by nearly $15,000 a year. Simply by understanding the coding process, you can have a significant impact on the bottom line. One way to become comfortable coding for medical care is by running through several "typical" cases we see every day. You will need to list the normal history process, physical exam testing, and an average medical decision-making for this type of case and then grade the exam based on the 1997 Documentation Guidelines. Let's run through a routine case we all see, a subconjunctival hemorrhage.

CC/RFV	Pt reports very red eye upon waking.	
HPI	Right eye, noticed 2 hours ago, new condition, tried "Red-out" drops, slightly gritty	5 HPI + 2 ROS + 1 PFSH **Detailed Hx**
ROS	+HTN, +osteoarthritis	
Past Hx	+Cataracts	
Physical Exam	VA, IOP, EOM, Ocular Adnexa, Cornea, Bulbar Conjunctiva, Palpebral Conjunctiva, Anterior Chamber, Orientation, Mood	10 exam elements **Detailed Exam**
MDM	Primary Dx: Subconjunctival Hemorrhage Plan: Pt educated on condition, artificial tear PRN for grittiness, recommended monitoring BP at home and notifying PCP	1 Dx + 3 Management options + Low MDM (1 self-limiting prob.) **Low Complexity**

As you can see above, this is a pretty basic exam…a short and directed history related to the CC/RFV. The physical exam contains a fairly focused effort on just the problem. And finally, the MDM is appropriate to the findings. I don't think anything listed here is excessive, and I suspect many of you would feel a few more physical exam elements may be prudent. But, if we grade this based on the exam above, this short visit earns a 99214! I'm not joking. It may sound absurd to grade a "subconj heme" as a level 4 established patient, but the documentation supports it based on the 1997 Documentation Guidelines.

Some doctors may do a shorter history than we listed above; let's say they only documented a few HPI elements and didn't review any ROS elements or do a PFSH. This would pull the history down to Problem Focused. Then maybe they only did VAs, EOMs, Bulbar Conjunctiva, Cornea, Ocular Adnexa, Orientation and Mood. That makes the physical exam Expanded Problem Focused. And finally, the MDM would be the same. If we reduced both the Hx and the physical exam by one level each, we still earn a 99213.

And if we evaluate this on the 92000 side, we have a History, General Medical Observation, External Ocular Exam, Other Diagnostic Procedures as indicated, and an Initiation and/or Diagnostic Treatment Program. This allows the exam to earn 92012.

I use this example, because we will routinely see a simple diagnosis like this one graded as 99212, resulting in the practice losing tens of thousands of dollars a year. Doctors appear to feel that because the final diagnosis is "easy" and of low risk, the exam cannot earn a very high level. Simply looking at the grading process shows how these routine cases meet the requirements of higher reimbursing visits.

I hope this exercise demonstrates the value to grading a few typical exams and seeing where they fall. By having a general idea of how these visits code, it will make you more confident in accurately coding for the excellent care you provide every day.