

Improve Coding Accuracy to Rightsize Reimbursement (and Revenue!)



It's no wonder your clinicians are more expert at performing physical rather than fiscal exams... and rightfully, thankfully so. Years of medical training and practice have given them the knowledge, skills, and clinical gestalt to heal and protect.

For all their focus on doing no harm to patients, however, the same cannot be said of the way many physicians and advanced practice clinicians were taught to treat revenue. All too often, urgent care center finances suffer at the hands of gifted clinicians who are unknowingly improperly charting and/or undercoding.

EB Medicine recommends the same approach that produces skilled clinicians – training them to evaluate and use evidence and apply best practices in clinical decision making – to drive better coding outcomes at the hands of your providers. In this whitepaper, we view current guidelines through the lens of real and relevant cases. The clinicians in our scenarios model best practices and highlight opportunities to modify behavior through education – a realistic goal – for the sake of improving coding/charting and optimizing reimbursement.

Read on to consider how much your center and/or system can gain by investing in evidence-based clinical education and behavior-changing coding and charting training.

**Fiscal Exam Findings
Reveal ROI for Coding
& Charting Education**



Rightsizing reimbursement is a learned behavior, an acquired skill. Without focused on-the-job training, clinicians are guaranteed to make mistakes, leaning toward undercoding. And because codes and rules change every year, their need to get up to speed never ends. That's why each monthly issue of EB Medicine's *Evidence-Based Urgent Care* features "Charting & Coding" cases and guidance, right alongside our chief-complaint-specific medical content, to train your team to code with confidence.

The following cases focus on common chief complaints seen and/or procedures performed in urgent care. These "fiscal exams" identify routine coding and charting ills and prescribe treatment to yield more healthy reimbursements. The scenarios follow the course of true-to-life patient encounters to show how coding and charting runs directly in parallel with medical decision making. The tables accompanying each case highlight the costs of subpar coding and charting practices and count the rewards – in real revenue – of doing it right.

Rightsizing Reimbursement: Strep Pharyngitis/Pharyngitis



Case Presentation: A 6-year-old girl presents with a sore throat. Symptoms began 2 days ago. Pain is of moderate severity. Fever is absent. Other associated symptoms have included pain while swallowing, swollen glands, and the feeling that her right tonsil is swollen. Fluid intake is good. There has not been contact with an individual with known strep. Current medications include ibuprofen.



Clinician Perspective: The PA seeing the patient is thinking, "This will be a simple visit. Sore throat: I will check for strep and COVID since we still are seeing some COVID+ patients." Mom, who is in the room, tells the PA she is concerned about her child because "she hardly ever gets sick." Fifteen minutes go by, and just as your PA suspected, the rapid strep test is positive. He says to himself, "Good! I knew this was a simple visit. Level 3 all day." He prescribes amoxicillin. Mom and daughter head to the pharmacy as the PA rushes to close out the chart. On to the next patient.



Coding Pitfall: Not so fast. While many if not most clinicians would reflexively deem this a Level 3 visit, strep pharyngitis in the pediatric population very often meets the criteria for a Level 4 visit with the proper documentation. Here's how we get there:

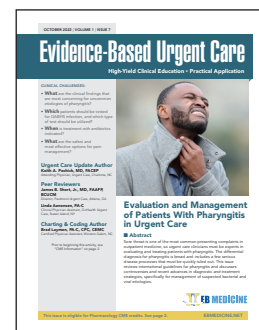
- Problems Addressed category: Acute, uncomplicated illness or injury (Level 3)
- Complexity of Data category: Two POCTs (COVID and strep), plus history reported by an independent historian (Level 4)
- Risk of Complications category: Prescription management (Level 4)



Rightsized Coding Conclusion: Per the American Medical Association's Elements of Medical Decision Making definitions, this encounter met Level 4 criteria in 2 of the categories (Data and Risk), so the correct E/M code is 99204. (See Table 1, page 11.)

Fiscal Exam #1: Estimated Revenue Increase from Rightsized Coding of Strep Pharyngitis/Pharyngitis

# of strep pharyngitis in pediatric patients diagnosed per year per clinic	502
Average reimbursement rate for a Level 4 visit	\$271.51
Average reimbursement rate for a Level 3 visit	\$182.29
Lost revenue per patient encounter	\$89.22
Estimated percentage that are undercoded	70%
Estimated total patient encounters undercoded	351
Potential total revenue increase per year per clinic	\$31,352
10-clinic system	\$313,520
20-clinic system	\$627,040
50-clinic system	\$1,567,595
100-clinic system	\$3,135,191



Rightsized Coding Revenue Impact: Based on the all-too-common scenario of undercoded pediatric pharyngitis patient encounters, above is an estimate of revenue at stake, for loss or gain, depending on decisions your clinicians are making at the point of care. (Note: The number of strep cases, the average reimbursement rates [from all payors], and estimated percentage of undercoded charts are based on a large urgent care system's comparables.)

In this scenario, a single clinic stands to gain more than \$30,000 per year from reimbursement optimization for this one common diagnosis. Multiply that across 10 clinics and the dividends add up to more than \$300,000; a 100-clinic system could see well over \$3 million more in a year.

Corresponding Evidence-Based Urgent Care issue:

Evaluation and Management of Patients with Pharyngitis in Urgent Care
(4 AMA PRA Category 1 Credits™ and 4 AOA Category 2A or 2B credits.)

Covered in This Issue: This issue of *Evidence-Based Urgent Care* reviews the evidence-based recommendations for the evaluation and management of pharyngitis in the urgent care setting, including:

Key Clinical Decision Points

Source: *Evidence-Based Urgent Care*, October 2022

	Elements of Medical Decision Making informed by this training		
	Complexity	Data	Risk
What are the key history and physical examination findings that can help to distinguish viral pharyngitis from GABHS pharyngitis or other etiologies?	●		
Which clinical findings raise suspicion for more dangerous etiologies of sore throat? How should those etiologies be managed?	●		●
When is testing for GABHS indicated, and which type of test is most appropriate?		●	
What are the potential complications of GABHS pharyngitis?			●
When are antibiotics needed?			●
What are the best options for pain control in acute pharyngitis?			●
Do corticosteroids have a role in the management of pharyngitis?			●

Rightsizing Reimbursement: Sexually Transmitted Infections



Case Presentation: A 24-year-old female presents to the clinic with chief complaints of lower abdominal pain, vaginal discharge, and dysuria. She states her symptoms started 4 days ago and are progressively worsening. Two weeks ago, her boyfriend broke up with her, but a week ago, they had sexual intercourse. She has never had an STI in the past. She has taken OTC acetaminophen for the abdominal pain but it did not help. LMC was 3 weeks ago with no abnormalities.



Clinician Perspective: The NP starts thinking about the differential diagnosis. Could this be an ectopic pregnancy? STI? She plans to order a urinalysis, pregnancy test, and a vaginal swab to check for gonorrhea, chlamydia, vaginal candidiasis, trichomonas, and bacterial vaginitis. She will perform a pelvic exam. This could be complex! Okay, pregnancy test is negative. While the urinalysis appears to show a UTI, the wet prep is negative for a vaginal yeast infection, trichomonas, and bacterial vaginitis. The NP suspects chlamydia and/or gonorrhea and adds a urine culture to the order set. "Phew! That is a lot of data," she thinks. She discusses her findings with the patient, gives an injection of Rocephin® for gonorrhea, and prescribes Macrobid® for the UTI and doxycycline for chlamydia. The patient tearfully leaves as the NP scrubs up to prepare for what's next.



Coding Pitfall: The wide differential for lower abdominal pain, plus overlapping symptoms, complicate medical decision making. Narrowing the possibilities to suspected STI(s), doesn't simplify matters. Complexity only escalates and data accumulates when, at a minimum you do a pelvic exam, order multiple POC tests and analyze results, draw blood and send for lab work, and write prescriptions for prophylactic antibiotics. Clinicians have a lot going on to manage STI patients, and they should account for it in the charts to ensure full reimbursement.



Rightsized Coding Conclusion: Per the Elements of Medical Decision Making, this encounter met Level 4 criteria in all 3 of the categories (Complexity, Data, and Risk), so the correct E/M code is 99204. (See Table 1, page 11.)



Rightsized Coding Revenue Impact: STIs, with proper documentation, usually meet criteria for a Level 4 visit; however, many clinicians mistakenly assign a Level 3 code. The following example accounts for potential unrealized revenue from undercoding of encounters by patients diagnosed with one or more STIs. (Note: The number of STI cases, the average reimbursement rates [from all payors], and estimated percentage of undercoded charts are based on a large urgent care system's comparables.)

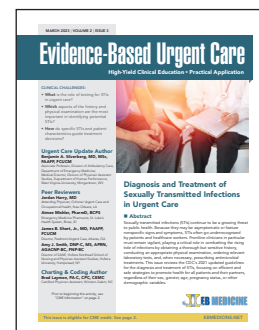


Evidence-Based Urgent Care is an excellent, well-designed educational resource. It serves both to confirm my current practice and to make sure I am aware of the latest updates and new thinking. The section on medicolegal pitfalls is indispensable!"

BENJAMIN SILVERBERG, MD, MSC, FAAFP, FCUCM
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MEDICAL DIRECTOR, DIVISION OF PHYSICIAN ASSISTANT STUDIES, DEPARTMENT OF HUMAN
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Fiscal Exam #2: Estimated Revenue Increase from Rightsized Coding of Sexually Transmitted Infections

# of sexually transmitted infections diagnosed per year per clinic	185
Average reimbursement rate for a Level 4 visit	\$271.51
Average reimbursement rate for a Level 3 visit	\$182.29
Lost revenue per patient encounter	\$89.22
Estimated percentage that are undercoded	50%
Estimated total patient encounters undercoded	93
Potential total revenue increase per year per clinic	\$8,253
10-clinic system	\$82,529
20-clinic system	\$165,060
50-clinic system	\$412,643
100-clinic system	\$825,285



The high prevalence and rising rates of STIs in the United States represent a significant economic burden on the healthcare system, and, closer to home, your center's revenue if clinicians don't understand how to optimize reimbursement. Let's say newcomers to your staff err on the side of caution in half of STI patient encounters, coding the visit at a Level 3 versus Level 4. Their uncertainty, which is commonplace especially for trainees and beginners, could cost more than \$8,000 per year for each clinic in your system.

Corresponding Evidence-Based Urgent Care issue:

Diagnosis and Treatment of Sexually Transmitted Infections in Urgent Care
(4 AMA PRA Category 1 Credits™ and 4 AOA Category 2A or 2B credits.)

Covered in This Issue: Urgent care clinicians can play an important role in identification and management of STIs. This issue of *Evidence-Based Urgent Care* reviews the evidence-based recommendations for the evaluation and management of STIs, including:

Key Clinical Decision Points Source: <i>Evidence-Based Urgent Care</i> , March 2023	Elements of Medical Decision Making Informed by this training		
	Complexity	Data	Risk
What is the best way to obtain a thorough but sensitive history in a patient with suspected STIs?	●		
What are the physical examination findings associated with chlamydia, gonorrhea, syphilis, bacterial vaginosis, donovanosis, lymphogranuloma venereum, genital herpes, human papillomavirus, and trichomoniasis?	●		
What are the incubation periods and windows for common STIs?	●	●	
What should be considered in selecting the appropriate test type? What difference do these factors make? Suspected STI(s)? Test availability? Patient presentation? Local disease prevalence?	●	●	
When should partner therapy be offered? Expedited?			●

With STIs on the rise as a public health threat, now is the time to educate clinicians on how to accurately document and code to ensure rightsized reimbursement. Clinical decisions may be clouded and confounded by overlapping symptoms, the call for rule-out testing for asymptomatic patients, and/or alignment of timing of lab tests with likely windows for detection.

Rightsizing Reimbursement: Influenza



Case Presentation: A 44-year-old woman presents with a complaint of a nonproductive cough. The current episode started yesterday. Her history reveals possible exposure to COVID 3 days ago at work. Associated symptoms include fever, dyspnea on exertion, malaise/fatigue, body aches, nasal congestion, and nausea. Pertinent negatives include no chest pain, headaches, or orthopnea. Her symptoms are alleviated by OTC cough suppressant. There is no history of COPD. Temperature is 102.7°F with a heart rate of 124 beats/min and a respiratory rate of 24 breaths/min. SpO₂ is 95% on room air.



Clinician Perspective: The patient's temperature is high, and her heart rate and respiratory rate are elevated. "She is really sick!" thinks the PA reviewing the patient's chart. She wonders: "Can I treat her as an outpatient or does she need inpatient care?" A subsequent chest x-ray does not show pneumonia. The patient is positive for influenza B, negative for COVID. The PA concludes that the patient is clear to go home, as long as she promises to follow up with her regular physician in the next few days, especially if she doesn't feel better. She receives a prescription for Tamiflu® because she is in the 24- to 48-hour window for symptom onset. The PA messages the patient's primary care provider through the EMR.



Coding Pitfall: Just because an RITD yields rapid results – positive for influenza this time -- doesn't necessarily mean it's a simple, straightforward case. Often there are other factors that raise risk and/or complicate clinical decision making. In this case, the patient's high fever and tachycardia met criteria for acute illness with systemic symptoms and led the PA to probe further.



Rightsized Coding Conclusion: Per Elements of Medical Decision Making, this encounter met Level 4 criteria in 2 of the categories (Complexity and Risk), so the correct E/M code is 99204. (See Table 1, page 11.)



Rightsized Coding Revenue Impact: Influenza, with proper documentation, is usually a Level 4 visit; however, most clinicians will only code it a Level 3. The following example quantifies potential unrealized revenue from improper documentation of visit for this common diagnosis. (Note: The number of influenza cases, the average reimbursement rates [from all payors], and estimated percentage of undercoded charts are based on a large urgent care system's comparables.)

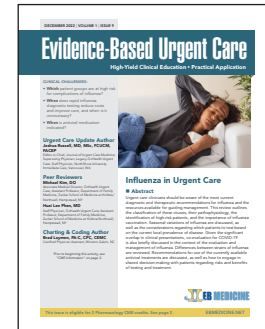


Evidence-Based Urgent Care is a concise but in-depth review of urgent care presentations that can be problematic. It fills a gap for much-needed urgent care education."

JOHN KULIN, DO, FACEP
CEO, URGENT CARE GROUP OF NEW JERSEY

Fiscal Exam #3: Estimated Revenue Increase from Rightsized Coding of Influenza

# of pneumonia/influenza diagnosed per year per clinic	512
Average reimbursement rate for a Level 4 visit	\$271.51
Average reimbursement rate for a Level 3 visit	\$182.29
Lost revenue per patient encounter	\$89.22
Estimated percentage that are undercoded	17%
Estimated total patient encounters undercoded	87
Potential total revenue increase per year per clinic	\$7,765.71
10-clinic system	\$77,657.09
20-clinic system	\$155,314.18
50-clinic system	\$388,285.44
100-clinic system	\$776,570.88



The revenue at risk from honest mistakes and undercoding of influenza patient encounters corresponds to the severity of the annual outbreak. Make sure clinicians have the knowledge to rightsize reimbursement before the next flu season.

Corresponding Evidence-Based Urgent Care issue:

Influenza in Urgent Care (4 AMA PRA Category 1 Credits™ and 4 AOA Category 2A or 2B credits.)

Covered in This Issue: This issue of *Evidence-Based Urgent Care* reviews the evidence-based recommendations for the evaluation and management of influenza, including:

Key Clinical Decision Points

Source: *Evidence-Based Urgent Care*, December 2022

	Elements of Medical Decision Making Informed by this training		
	Complexity	Data	Risk
What are the most common symptoms of influenza in both adults and children?	●		
Which patient groups are at high risk for complications from influenza?	●		●
What are the current recommendations for influenza vaccination?	●		
What impact does community prevalence of influenza have on testing decisions?		●	
What are the indications for initiation of antiviral medication?			●
When are antiviral medications an appropriate option for patients?			●
How should I appropriately document a patient encounter for ILI or confirmed influenza?	●		



These short, concise CME case studies are clinically helpful and easy to complete during a busy clinical day or after work. I highly recommend them."

SCOTT PRYSI, MD
MEDICAL DIRECTOR, DOCTORS ON DUTY MEDICAL CLINICS

Rightsizing Reimbursement: Laceration Repairs



Case Presentation: A 47-year-old man presents to the clinic with lacerations to the head and the left elbow. He complains of a headache and left elbow pain. The injury was accidental. The patient tells you he cut himself when he tripped over an extension cord and fell in his garage about 2 hours ago. The patient applied direct pressure to control the bleeding. No LOC, CP, SOB, or dizziness.



Clinician Perspective: The PA watches this patient walk into the room with bloody bandages on his head and left elbow. He seems to be walking fine and is alert. The PA does an initial triage of the patient's injuries. The scalp laceration is about 3 cm long and not deep. The left elbow laceration is about 5 cm long and muscle is visible upon inspection. Thirty minutes later, the PA placed 4 interrupted simple sutures in the scalp laceration and a multiple-layer closure with 4 subcuticular sutures and 7 interrupted sutures in the left elbow. The PA also does a thorough neurological examination. After 45 minutes, the patient is discharged and the PA is summoned to take the next patient. He hurriedly jots down notes with plans to fill in the blanks and complete the chart at the end of his shift.



Coding Pitfall: All laceration repair notes should include the repair complexity (simple, intermediate, complex), wound location, and wound length. When multiple wounds are repaired, add together the lengths of all wounds in the same classification and from all anatomic sites that are grouped together into the same code descriptor. Do not add lengths of repairs from different groupings of anatomic sites, which is a common mistake. This patient encounter had 2 lacerations of differing complexity (1 simple and 1 intermediate) and should have 2 procedure codes. Many clinicians would add the lengths of the 2 lacerations and choose the "simple" procedure code, which is incorrect. A neurological exam was also performed, so the clinician would code an E/M code (99202-99215) with a modifier 25, as this is separate from the laceration repairs.



Rightsized Coding Conclusion: Per the Elements of Medical Decision Making, this encounter met Level 4 criteria in 2 of the categories (Complexity and Risk), so the correct E/M code is 99204. **(See Table 1, page 11.)** The patient chart also should include a modifier 25 and 2 procedure codes.

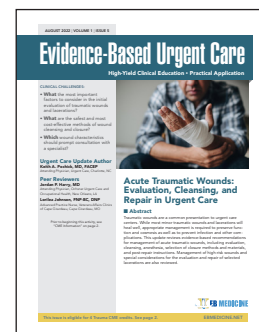


Rightsized Coding Impact: Many wounds in the urgent care intermediate level complexity, but these are often incorrectly coded as simple lacerations. Clinicians may fail to document the length, complexity, and/or location of the laceration, all of which contribute to the correct code selection. Such misclassification can cut reimbursement rates significantly, resulting in unrealized revenue. (Note: The number of simple/intermediate lacerations, the average reimbursement rates [from all payors], and estimated percentage of undercoded charts are based on a large urgent care system's comparables.)

In addition to revenue increases from improved documentation, providing comprehensive training for clinicians on wound care will result in fewer unnecessary referrals to the ED and additional revenue for your clinics.

Fiscal Exam #4: Estimated Revenue Increase from Rightsized Coding of Laceration Repairs

# of lacerations coded as simple per year per clinic	52
Average reimbursement rate for a simple laceration	\$204.65
Average reimbursement rate for an intermediate laceration	\$297.81
Lost revenue per patient encounter	\$93.10
Estimated percentage that are undercoded	50%
Estimated total patient encounters undercoded	26
Potential total revenue increase per year per clinic	\$2,421
10-clinic system	\$24,210
20-clinic system	\$48,420
50-clinic system	\$121,050
100-clinic system	\$242,100



Corresponding Course & Issue:

The Laceration Course (8 AMA PRA Category 1 Credits™ and 4 AOA Category 2A or 2B credits.)

Acute Traumatic Wounds: Evaluation, Cleansing, and Repair in Urgent Care (4 AMA PRA Category 1 Credits™ and 4 AOA Category 2A or 2B credits.)

Covered in this Course & Issue: *The Laceration Course*, an in-depth wound closure procedural education video program, and this issue of *Evidence-Based Urgent Care* review the evidence-based recommendations for wound closure, repair, and care, including:

Key Clinical Decision Points

Sources: *The Laceration Course* and *Evidence-Based Urgent Care*, August 2022

	Elements of Medical Decision Making Informed by this training		
	Complexity	Data	Risk
What are the key factors to consider in the initial evaluation of traumatic wounds and lacerations?	●		
What are the safest and most cost-effective methods of wound cleansing and closure?	●		
Given various patient presentations, what are the appropriate wound closure methods?			●
When are prophylactic antibiotics indicated?	●		●
How should clinicians accurately document comprehensive physical examination findings and procedure notes?	●		
Which wound characteristics should prompt consultation with a specialist or transfer to a higher level of care?	●		●
What are possible complications to consider, and how should the treatment approach be modified if complications transpire?	●		●



When purchasing *The Laceration Course*, I was primarily thinking about the procedural aspect of closing wounds... [but] many of the reasons I recommend it are related to what I learned about coding and documentation. The course includes many documentation tips that will protect me and my practice from lawsuits and coding pearls that will likely cover the cost of the course in a very short time."

DON JESKE, FNP-C

Summary

Because of the compounding effect, it doesn't take long for correct coding (or honest mistakes) to boost (or bust) the bottom line. When integrated into their medical decision making, coding education for clinicians yields a quick and direct return on investment.

In every issue of *Evidence-Based Urgent Care* and in all of EB Medicine's courses, clinicians get clear, practical, and easy-to-implement recommendations for improving patient care and optimizing reimbursement. With a group subscription, you can be assured your entire team has the training and support needed to provide the best clinical care and yield positive patient and financial outcomes.

Interested in learning more about how EB Medicine can improve clinician confidence, knowledge, skills, and documentation? Visit www.ebmedicine.net/groups, call us at 678-366-7933, or email groups@ebmedicine.net.

Charting & Coding Excerpt From a Recent Issue:

Evidence-Based Urgent Care

High-Yield Clinical Education • Practical Application

Pharyngitis (with or without other symptoms of upper respiratory infection) is among the most frequent presenting complaints seen in the UC setting. The common ICD-10 codes for pharyngitis are J02-J03. All diagnoses should be as specific as possible. When the exact organism is known, the primary diagnosis should reflect this specificity.

Table 1. Simplified Elements of Medical Decision Making^a

MDM Level ^b	Problems Addressed	Complexity of Data	Risk of Complications	E/M Service Codes
Level 2: Straightforward	Minor/self-limited	Minimal/none	Minimal risk	99202 99212
Level 3: Low	1 stable chronic illness 1 acute, uncomplicated illness 1 acute, uncomplicated injury	At least 1 of these: 2 data sources (eg, ordering or reviewing tests) - Independent historian	OTC medication management	99203 99213
Level 4: Moderate	1 or more chronic illnesses with exacerbation 2 stable chronic illnesses 1 undiagnosed new problem 1 acute illness with systemic symptoms	At least 1 of these: 3 data sources (eg, ordering or reviewing tests); can include independent historian - Independent interpretation of test results - Discussion of management or test interpretation	- Prescription drug management - Significant social determinants of health	99204 99214
Level 5: High	- Severe illness with exacerbation - Threat to life or bodily function	At least 2 of these: 3 data sources (eg, ordering or reviewing tests); can include independent historian - Independent interpretation of test results - Discussion of management or test interpretation	Severe without emergent treatment	99205 99215

^aBased on data from: American Medical Association. CPT® evaluation and management (E/M) office or other outpatient (99202-99215) and prolonged services (99354, 99355, 99356, 99417) code and guideline changes. Accessed March 10, 2023. Available at: <https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-codechanges.pdf> CPT is a registered trademark of the American Medical Association. Copyright 2023 American Medical Association. All rights reserved.

^bLevel is based on meeting 2 out of 3 elements of medical decision making.

Abbreviations: E/M, evaluation and management; MDM, medical decision making; OTC, over the counter.

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The American Medical Association created a medical decision-making grid to provide guidance on the selection of evaluation and management (E/M) codes. A simplified version of this guidance is provided in **Table 1, page 11**. The appropriate E/M code for patient encounters for pharyngitis will be dependent on the age of the patient; which laboratory tests were ordered, reviewed, and analyzed, if any; and whether management involves either OTC or prescription medication.

- **Age of the patient.** The Center for Medicare Management guidelines do not state a specific age when an “independent historian” can be used, but the independent historian requirement is met if a parent or caregiver is providing a history in addition to the history supplied by the patient due to “developmental stage.” For example, a 2-year-old patient is unable to give a history of their present illness, so an independent historian would be needed. Most children aged >12 years are able to give a history of the present illness. However, if a child aged >12 years cannot elaborate with specificity on the history of the illness, a parent or caregiver must step in to add details to present the illness in the correct state; this would also fulfill the independent historian requirement.
- **Laboratory tests.** Common laboratory tests ordered in the UC setting for pharyngitis include POC NAAT or RADT for GABHS, COVID-19 testing, and the Monospot test. Less common tests include complete blood count and swabs for gonorrhea, chlamydia, and herpes.
- **Management.** For the Risk of Complications category, OTC medication documentation falls in the Low Level (Level 3). Prescription medication management falls in the Moderate Level (Level 4). (See Table 1.)

Key Points

- In the Problems Addressed category, most encounters for pharyngitis will meet the criteria for Level 3 as “1 acute, uncomplicated illness or injury.” It is possible a child with a high fever; systemic symptoms such as headache, gastrointestinal complaints, or rash; and negative POC test results for GABHS, COVID-19, and mononucleosis could meet the criteria for Level 4 as “1 acute illness with systemic symptoms.” (See Table 1.)
- In the Complexity of Data category, most encounters for pharyngitis will meet the criteria for either Level 3 or Level 4. Level 3 criteria are satisfied when the clinician orders POC testing for GABHS and COVID-19, as this would involve ordering 2 unique tests. Level 4 criteria would be met if the patient is a young child who is unable to give an adequate history of present illness and an independent historian is used to provide information, and the clinician orders POC testing for GABHS and COVID-19; this would count as 2 unique test orders and an independent historian. Another common scenario would be the ordering of 3 unique tests (eg, GABHS, COVID-19, and mononucleosis). (See Table 1, page 11.)
- In the Risk of Complications category, most encounters for pharyngitis would meet the criteria for Level 3 (if managed with OTC medication) or Level 4 (if managed with prescription medication). (See Table 1, page 11.)



Coding Challenge: Pharyngitis in Urgent Care

Challenge yourself! Determine the correct evaluation and management (E/M) service code for this urgent care encounter:

Subjective

24-year-old female who complains of a sore throat. Symptoms began 2 days ago. Pain is of moderate severity. Fever is absent. Other associated symptoms have included pain while swallowing, swollen glands, and feeling that her right tonsil is swollen. Fluid intake is good. There has not been contact with an individual with known strep. Current medications include ibuprofen.

Current Outpatient Medications:

- Norethindrone-ethinyl estradiol-ferrous fumarate (LOESTRIN® FE) 1-20 mg-mcg per tablet; 1 tablet, oral, daily
- OTC ibuprofen

No Known Allergies

Objective

- BP 147/87 (BP location: left arm; patient position: sitting)
- Pulse 101
- Temp 99.5 °F (37.5 °C) (Tympanic)
- Resp 16
- Ht 5' 5" (1.651 m)
- Wt 250 lb (113.4 kg)
- LMP 08/24/2022
- SpO₂ 99%
- BMI 41.60 kg/m²
- General Appearance: Alert, cooperative and no distress, obese
- Head: Normocephalic
- Eyes: PERRLA EOMI
- Ears: Clear without erythema
- Nose: Without congestion or drainage
- Throat: Marked erythema, tonsillar hypertrophy, 2+, exudates present and mucous membranes moist
- Neck: Supple with mild tender bilateral anterior cervical nodes
- Lungs: Clear to auscultation bilaterally
- Heart: Normal, regular rhythm, S1, S2 normal, no murmur, click, rub or gallop
- Skin: Skin color, texture, turgor normal. No rashes or lesions

Recent Results (from the past 14 hours)

- POCT CoVid-19 nucleic acid
 - Collection Time: 08/24/22 9:52 AM
 - Negative
- POCT Strep Nucleic Acid
 - Collection Time: 08/24/22 9:53 AM
 - Positive
- POCT INFECTIOUS MONONUCLEOSIS ANTIBODY
 - Collection Time: 08/24/22 10:52 AM
 - Negative

Assessment

- Strep Pharyngitis, Primary: J02.0

Orders this encounter:

- POCT CoVid-19 nucleic acid
- POCT Strep nucleic acid
- POCT Infectious mononucleosis antibody

Plan

1. Discussed diagnosis with patient. Stressed fluid hygiene hydration. Push comfort measures. Follow-up with PCP in 3 to 4 days if not improved or sooner if worsen.
2. Medication changes and new medications: Augmentin 875 mg BID for 10 days. OTC NSAID PRN pain.
3. Follow up in about 1 week, or if symptoms worsen or fail to improve, or with PCP.

CHALLENGE: What is the appropriate E/M code for this encounter?

Let's consider this patient encounter using the Elements of Medical Decision Making to find the appropriate level of service:¹

Number and Complexity of Problems Addressed

The patient complaint is pharyngitis. This falls under "acute, uncomplicated illness or injury," which is **Level 3**.

Amount and/or Complexity of Data to be Reviewed and Analyzed

In this case, the clinician ordered a POCT strep test, a COVID test, and a Monospot. This meets the criteria for Category 1 (ordering of each unique test x 3) in **Level 4**.

Risk of Complications and/or Morbidity or Mortality of Patient Management

Augmentin® was prescribed. Prescription drug management meets the criteria for **Level 4**.

Two of the 3 Elements of Medical Decision Making must be met when choosing your level of service. This encounter met Level 4 criteria in 2 of the categories (Data and Risk), so the correct E/M code is 99204.

¹ American Medical Association. CPT® evaluation and management (E/M) office or other outpatient (99202-99215) and prolonged services (99354, 99355, 99356, 99417) code and guideline changes. Accessed September 10, 2022. Available at: <https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-codechanges.pdf>

Want More Coding Challenges?

Challenge yourself! Determine the correct service code for both common and high-risk UC encounters by viewing the Coding Challenge on our Free Online Access Medical Education platform by clicking FOAMed at www.ebmedicine.net.

Profitability Rests in the Hands of Your Clinicians

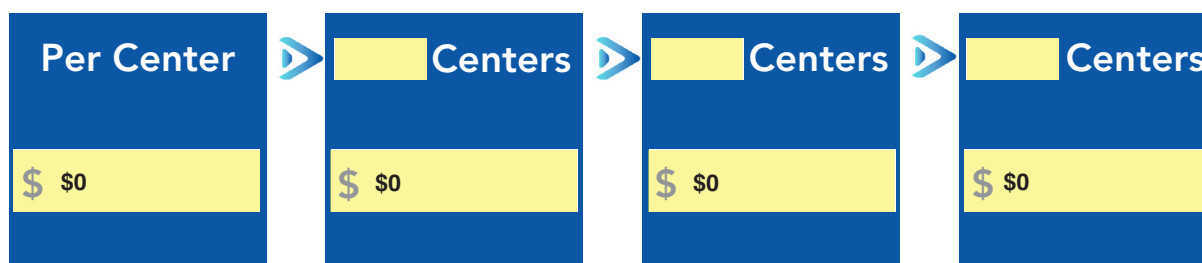
Is unrealized revenue affecting your bottom line more than you think?

Clinician knowledge, confidence, and accuracy have a direct impact on your organization's financial health. Even for common conditions, incorrect documentation and coding can result in significant lost revenue. Many visits that should qualify as Level 4 are frequently down coded to Level 3—whether due to incomplete documentation, uncertainty, or lack of training. This calculator will help you estimate the impact on your urgent care clinics. And EB Medicine's **Upskill Academy** can provide your clinicians with the knowledge they need to improve decision making and reimbursement rates.

Use this calculator to estimate the impact of undercoding on your organization.

Fill in the blanks for a common diagnosis in your healthcare system.
First calculate the unrealized revenue per center. Then multiply by the number of centers in your system.

Estimated Revenue Increase from Rightsized Coding of (diagnosis)		
# of	diagnoses annually, per center	
Average reimbursement rate for a Level 4 visit	\$	
Average reimbursement rate for a Level 3 visit	\$	
Lost revenue per patient encounter undercoded	\$	\$0
Estimated percentage that are undercoded	%	0%
Estimated total patient encounters undercoded		0
Potential Unrealized Revenue Due to Undercoding		
Reset Form		Per Center \$ \$0



For a digital version of this calculator, visit www.ebmedicine.net/urgent-care-groups.

We're Here to Help.

Contact us at **groups@ebmedicine.net**, and one of our team members will contact you to explore how we can help transform your practice into a leader in urgent care.



Dana Stenzel

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