Coding the limited level of service

Code the level of service provided, not the time spent with the patient, and be sure that the diagnosis matches the level of service

[*This article first appeared as part of the "Levels of Service" series in the monthly newsletter* CPT Coding for Physician Reimbursement.]

THE LEVELS OF SERVICE series concerns the codes included in the CPT system that account for variations in skill, effort, time, responsibility and expertise — important factors in physician reimbursement.

Levels of service codes use the terms minimal, brief, limited, intermediate, extended, comprehensive, or complex to specify the extent of examinations, evaluations, treatment, counseling, conferences with or concerning patients, preventive pediatric and adult health supervision and similar services.

Of the seven levels of service, limited is used most often. Insurance companies carefully monitor its use, and may down-code the service unless you provide adequate justification.

The March issue of *CPT Coding for Physician Reimbursement* discussed brief level of service. This series is not to be considered as a replacement for CPT guidelines. It is intended only to provide additional insight into reimbursement for levels of service.

The third level of service, limited, is used to describe services pertaining to the evaluation of a circumscribed acute illness or to the periodic re-evaluation of a problem.

A limited level of service must include the following:

✔A moderate or limited examination of the affected area

✔A review of the pertinent past history that affects the treatment

✔The ordering and evaluation of appropriate tests

✔The adjustment of any therapeutic management

✔The discussion of test results and/or therapeutic management of the patient

Consider specifying limited level of service for a regular or routine new patient visit when testing is required to verify a final diagnosis. This level can also be used for a routine follow-up visit if a history and examination is performed and if additional information is identified that will change the therapeutic management of the patient. The physician may use moderate or limited judgment in establishing the diagnosis or treatment.

A limited level of service can be provided in the following locations: physician's office; patient's home; hospital; emergency department; skilled nursing facility that provides convalescent, rehabilitative or long-term care; or nursing home that provides domiciliary or custodial care.

Of the seven levels of service, limited is used most often. Most insurance companies carefully monitor its use. In many instances, insurance companies will down-code, from limited to brief, if the diagnosis does not justify the use of limited level of service.

The most effective way to ensure proper third-party reimbursement and avoid down-coding is to include all pertinent diagnoses on the claim. [*The Medical System can help; see "A Point About Pointers" on page 5.*] Inform the carrier of the signs, symptoms, and conditions that made the visit and tests necessary. List on the claim the actual diagnosis along with any V codes and E codes necessary to report extenuating circumstances surrounding the visit. Providing specific information can ensure optimal reimbursement.

Monitor the explanation of medical benefits (EOMB) and the submitted claim to determine if the insurance company has down-coded this level. If it has, provide the carrier some justification that a limited level of service was performed.

While some relative value studies include a time factor formula as a guideline for selecting a level of service, the CPT manual is careful to avoid using any such criteria. It is important to code the level of service provided to the patient rather than the length of time spent with him.

Refer to the introduction to the CPT code book for additional information regarding limited level of service.

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Coding for late effects

To code the service correctly, you must be able to distinguish between the residual condition and its cause

[*This article first appeared in the ICD-9-CM coding series of the monthly newsletter* St. Anthony's ICD-9-CM Coding for Physician Reimbursement.]

Most patients who seek medical attention recover from their episodes of acute illness or injury. However, some patients may experience temporary or permanent healthcare problems — known as residual conditions — after the acute period has ended. Coders can use the ICD-9-CM coding system to locate late effect codes that identify the cause of a residual condition.

The residual effect, or late effect, of an illness or injury is of indefinite duration, generally occurring one year after the acute phase of the illness or injury has ended.

The following terms, when documented in the medical record, may describe a late effect: old, following, late, non-union, residual, malunion, due to an old injury, due to previous illness, due to a previous illness or injury that occurred one year or more prior to the current encounter.

Some examples of late effects are:

- Nonunion of fracture, left ankle
- Scarring due to a third-degree burn, right leg
- Hemiplegia following cerebrovascular accident 14 months ago
- Back pain due to lumbar strain from a previous motor vehicle accident

To select the correct code, the coder must be able to distinguish between the residual condition and its cause. In the above examples, the residual conditions are indicated by the terms nonunion, scarring, hemiplegia and back pain. The terms that identify the causes of the residual conditions are fracture, burn, cerebrovascular accident, motor vehicle accident and lumbar strain.

Assigning the codes

Follow these steps to accurately assign late effect codes:

Step 1. Select a code to indicate the residual condition (the condition that causes the patient to seek treatment). This code is found in the Alphabetic Index under the specified condition and is sequenced first on the claim. If the residual condition is not specified in the medical record and the information cannot be obtained from the physician, code only the cause of the late effect. In this situation only, the last effect code would be sequenced first.

Step 2. Select a code to indicate the cause of the late effect. The cause is the original illness or injury that is no longer present in an acute state. This code can be found in the Alphabetic Index under the main term Late.

Step 3. Select an E code to indicate the external cause of the original illness or injury. These codes are located in the Index to External Causes in the Alphabetic Index, under the main term Late effect of.

Step 4. Verify all code assignments in the Tabular List. Carefully read the notes advising the coder on the proper use of each code.

Properly applying the definitions and coding principles of residual conditions and the causes of late effects will help ensure appropriate reimbursement. In addition, accurately assigning and sequencing the codes, as well as linking diagnostic and procedure codes, will result in positive cash flow.

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Plastic surgeon nets $52,800 by using accurate codes

A patient visits a plastic surgeon for surgical intervention due to extensive scarring and limb contractures. Third-degree burns to the patient's shoulder and upper arms occurred in a fire 16 months before the visit. As a result, the patient has a limited range of motion. The surgeon performs debridement and grafting to a 40-centimeter area to release the contracture and remove the scarred tissue. Sequencing the code for the residual condition, which prompted the patient to seek treatment, prior to the late effect code will result in appropriate payment. In this example, correct diagnostic and procedure coding increases the estimated allowable by $550 per case.

Incorrect coding ✗	**Correct coding ✓**
ICD-9-CM codes	**ICD-9-CM codes**
906.7 Late effect of burn of other extremities	709.2 Scar conditions and fibrosis of skin
709.2 Scar conditions and fibrosis of skin	906.7 Late effect of burn of other extremities
E929.4 Late effects of accident caused by fire	E929.4 Late effects of accident caused by fire
CPT Codes	**CPT Codes**
15220 Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq. cm or less	15220 Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq. cm or less
	15221-51 each additional 20 sq. cm.
	15000 Excisional preparation or creation of recipient site by excision of essentially intact skin (including subcutaneous tissues), scar, or other lesion prior to repair with free skin graft (list as separate service in addition to skin graft)
Estimated allowable per case: $850	Estimated allowable per case: $1,400
Estimated payment per year*: $81,600	Estimated payment per year*: $134,400

Increase in revenue from correct coding: $52,800 per year*

*based on two cases per week for 48 weeks

Coding, *continued*

Quick Tips

✔ TAKE YOUR TIME STARTING UP and shutting down your system. It's better to leave your system running than to turn it off and on again during the day. If you do reset your system by turning it off then on again, be sure to wait at least 20 seconds before turning the power back on. Your hard disk uses mechanical heads to read data from the disk; when you turn the power off, it takes the heads 15-20 seconds to "park." If you restart before the heads are fully parked, they could jerk back and forth across the disk, damaging your information.

✔ WHEN BRINGING UP your system, your computer may stop at this statement:

COPY \FF.TXT PRN

This means your computer is having trouble getting your printer's attention. Simply turn the printer off, then back on.

✔ "POWERING" THROUGH INSURANCE QUESTIONS . . . Many customers find they don't have to answer all of the questions asked by the system when adding or changing insurance information on an account. If that's the case for you, you'll find a feature called "power return" a big time-saver. To use the power return, simply answer all of the insurance questions you need to answer, then hold down the Control key and press Return. The system will automatically skip the remaining insurance questions, using the default values where necessary.

✔ MAILING INSURANCE FORMS . . . Customers often call to ask about printing address labels for insurance companies, to make mailing insurance forms easier. Our recommendation is that you use "window" envelopes; by folding the insurance forms properly, you can have the insurance company address show through the window. This saves using any labels at all, and is a faster means of processing the forms. P