

# Physician

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Capturing all appropriate revenue is a more daunting task than ever for medical practices. Multiple pressures make it crucial to the economic health of all health care providers not to leave “money on the table” through coding inaccuracies, while also maintaining compliance. While it is impossible to account for all potential lost revenue (e.g., by not billing consultations), a recent evaluation and management (E/M) analysis for a provider group of 20-plus showed they appeared to be leaving \$1.1 million on the table. Because of the potential impact of both compliance and revenue issues, close internal monitoring of code categories is strongly recommended.

Internal monitoring, providing physicians with feedback and education on coding, paying extra attention to certain codes, and ensuring coding compliance can help practices succeed—even during an economic downturn.

## Internal monitoring

Virtually all third-party payers (government and non-government) monitor physician coding habits. So if an outside entity is already monitoring your practice’s coding habits, should you? *Yes*. Most successful practices provide internal monitoring both to be compliant and to realize the benefits from a revenue perspective.

The single most valuable tool in internal monitoring is

an E/M analysis. Once the templates for E/M tracking are built and populated, it is easy for organizations to annually update utilization internally (although many of the most successful practices update their utilization more frequently).

Internal monitoring typically looks at E/M codes for office visits, hospital services and consultations for the period to be included in the review (e.g., year-to-date 2009), with corresponding fees for each of these codes and Centers for Medicare & Medicaid Services (CMS) national normative data for each specialty. For some specialties, a narrower focus may be appropriate (e.g., for hospitalists, the focus may be confined to hospital admissions and inpatient consultations). For practices with limited resources, this can make their internal monitoring efforts more efficient and effective.

A realistic amount of resources should be provided for internal monitoring, based

## Holding the (bottom) line

*Accurate coding compliance can help maintain your practice’s economic health*

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on availability of staff, budget, internal expertise, etc. As a rule of thumb, one FTE per 50 physicians works for monitoring and education.

What might your internal monitoring turn up? Here are some typical observations:

- Low or no use of a particular category of service or code by one physician, compared to others within the group (e.g., the new patient category, 99201–99205).
- All hospital discharges coded as 99238 (“hospital discharge, 30 minutes or less”), meaning perhaps the physician is unaware of code 99239 (“hospital discharge, more than 30 minutes”). On the other hand, high use of code 99239 would prompt the question, “Does the documentation reflect that in excess of 30 minutes was spent on the discharge management?”
- Disparity in coding patterns within the same specialty (e.g., one physician using a code 30 percent of the time, while another used the same code 60 percent of the time).

- Some physicians using a favorite code (e.g., the norm for code 99213 is 52 percent, and a physician uses it 93 percent). This finding may not only affect revenue, but may also raise a red flag that invites outside scrutiny as a statistical outlier.

Internal monitoring may also help answer the following questions:

- Is there use or abuse of modifiers (e.g., use of modifier –25 without a significant, separately identifiable E/M)?
- Do diagnoses support all services provided?
- Does the documentation support the level of service billed?
- Do nurse visits (i.e., 99211) have adequate supporting documentation?
- Are handwritten notes legible?
- If an EHR is being used, does the documentation accurately reflect what took place on that date?

## Physician feedback and education

*“No one ever told me that!”*

If this is a frequently heard comment in your practice, it’s time to think about how feedback and education on coding and documentation are provided to physicians. In successful practices, it’s understood that a clear, consistent plan for feedback will result in complete, accurate charge capture and better supporting documentation—both of which

ultimately help the bottom line.

### **Frequency of feedback.**

The frequency of feedback on coding and documentation should be based on the physicians' needs, as demonstrated by internal monitoring (e.g., provider ranking tool). In most medical groups, there will be a mix of providers who need quarterly, biannual, or annual feedback. New providers should always meet with the coding educator during their orientation and then again after they have been seeing patients for a couple of months. The most important thing is to have a consistent process in place and not fall behind on the scheduled meetings.

**Group sessions versus individual sessions.** While it is usually easier to get a group of physicians together than to schedule individual meetings, the latter will generally get far better results in terms of true improvement to coding and documentation. The group setting works best for a "Coding 101" presentation to go over the basics.

**Don't try to cover everything at once.** A common mistake that coding educators make is to overwhelm providers with the minutiae of coding (e.g., "You need four of these, two of these unless it's an established patient, eight of these," etc.). It's no wonder some physicians get extremely frustrated with the process. Focus on one or two pertinent issues rather than trying to make all the physicians "master coders" in one session.

**Make sure the discussion is relevant.** It is always best to use the physicians' own documentation as examples, whenever possible. It's also useful to tailor the discussions to the individual physician's style and personality—if he or she is a precise, "cut to the chase" personality, this is not the time to

start talking about the history of CPT coding. Additionally, whatever you can do to make the information more "user-friendly," and perhaps communicated with a touch of humor, will be appreciated.

**Keep the communication going.** Make sure physicians know how to contact the appropriate coding staff when they have questions. Depending on the practice, it might be a matter of calling or e-mailing "their" coder, or perhaps as simple as making a big question mark on a charge ticket when they don't know how to code a new procedure. Be proactive in your communication with physicians—don't wait until hundreds of claims have been submitted to find out, for example, that the new family practitioner didn't know there were specific codes for preventive medicine.

### **Special cases for primary care providers**

**Preoperative consultations.** Although primary care providers normally use consultation codes only rarely compared to specialists, there is one scenario that warrants the use of consultation codes and should not be overlooked as a legitimate revenue opportunity. When a surgeon has requested preoperative clearance and there is medical necessity, the service may qualify as a consultation, even though the provider is seeing his or her own patient.

"Medical necessity" is demonstrated when the patient has a specific medical condition(s) and/or other factors that contribute to increased risk of undergoing surgery. If the patient is healthy and there are no specific chronic conditions, high-risk medications, or other factors, then the appropriate new or established patient visit code should be used rather than a consultation code.

The usual "3 Rs" of documentation apply as for all consultation services: **R**quest for advice/opinion (name of the requestor and the reason); **R**ender the opinion; **R**eport back to the requestor. (The report should be a written communication, except when there is a shared record, such as in the inpatient setting.)

A consultation request that outlines the medical necessity can easily be incorporated into the documentation of the chief complaint. For example: *"I was asked by Dr. Jones to perform preoperative clearance for Mr. Smith, who will be having a hernia repair May 15. Patient is a 46-year-old male who has had moderately severe COPD for several years. He also has atrial fibrillation, currently well controlled on Coumadin."*

**Preventive medicine.** The use of preventive medicine alone or with a problem-related E/M code is a hot topic for many practices. For example, in a perfect world, a patient presents with an acute problem, and it is coded as an E/M visit; or a patient presents for the annual visit with no complaints and no findings, and it is coded as a preventive medicine visit. In reality, it is common in the course of a visit to have both an acute problem addressed and to have a physical. In such cases, both services should be reported. Factors making this an issue include the patient's insurance coverage, financial circumstances, and/or the physician's perception of these concerns. Regardless, accurate reporting of both services following the CPT guidelines is necessary.

### **Compliance and coding**

Since the advent of CPT coding in the mid-1960s, clinics and facilities have spent many grueling hours developing coding compliance plans for their facilities. And many practices

even followed these ... for a while. Unfortunately, today many of those plans are sitting on a shelf collecting dust.

Compliance plans are built on seven fundamental elements: standards and procedures; oversight; education and training; designation of a compliance officer; auditing and monitoring; reporting, enforcement, and discipline; and response and prevention. To be effective, a compliance plan requires organizational dedication and commitment to keep the plan alive and follow through on all of those elements. In addition, many successful practices work hard to educate patients on the importance of compliant coding and remind physicians to triage patients' concerns over coverage to the appropriate business office staff.

To ensure that your compliance plan is current, review your plan annually and verify that you are performing all of the actions set forth in the compliance plan within the designated time frame. Make appropriate changes immediately and be sure to flag the issues that need follow-up.

At first glance, it may not seem that coding compliance should be a priority during tough economic times, but just the opposite is true. Diligent monitoring of coding and documentation is a valuable survival tool for your medical practice, allowing it to weather the storm with lower compliance risk and, at the same time, ensuring the highest revenue possible. ■

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