THE PHYSICIAN'S
CODING COMPLIANCE ALERT™

April 2002

ENSURING APPROPRIATE REIMBURSEMENT WITH MINIMIZED AUDIT RISK

Aiming for Average: The First Step Toward Coding Compliance

A coding compliance program encompasses three basic components, according to John McDaniel, President and CEO of Physician Management Group, Inc., practice management advisers based in New Orleans. Utilization analysis, the first step, is discussed here in great detail. Chart audits and physician education, steps two and three, will be presented in upcoming issues.

"We teach people how to do a coding compliance program by themselves," McDaniel says, adding that his firm also provides this service. "A lot of big practices don't have time, so they like having an outside party do it. We don't care either way, as long as it gets done. Let's face it, the government doesn't send people to prison for not having attended educational sessions or for not having all their patient education materials in one spot. They can, though, if you have a severe coding problem and do nothing about it."

A side-by-side assessment

Begin the process by going to your computer and running a CPT-4 frequency report for a specific time period. For example, you can determine how many times you used each code during 2001. Once you have the full report, extract the numbers for the major evaluation and management (E&M) codes and figure out what percentage of services has been billed with each code. In other words, divide the number of times you have used the lowest new patient visit code—99201—by the total number of times you have coded for all new patient visits (99201 through 99205). After finishing all of the new patient visit codes, move on to the codes for established patient visits, hospital admissions, hospital visits, and office or other outpatient consultations.

That is essentially how national usage distributions are compiled by the Centers for Medicare and Medicaid Services (CMS), albeit on a much larger scale. The agency develops averages for the use of each code by practitioners in each area of medicine, and these are used as audit standards. If new patient codes (99201 through 99205) were submitted a total of 92,461 times by internists, and 5,031 of these were given the code 99201, then the CMS would determine that of all new patient visits to internists, approximately 5% warrant the lowest code. "This is basically the radar screen that the government uses," McDaniel says. While the CMS posts only raw totals on its Web site, McDaniel's company has already calculated the average percentages for each area, some of which appear in the table on page 6.

With both sets of percentages at hand, profile your use of codes against the national averages and see how close you come. "Quite honestly, I'd say that anything within 5% should be okay in most cases," McDaniel estimates. "For example, the national figures indicate the 99214 code is used by internists 22% of the time. If you are at 25%, you're a little above, but that's fine." A significant variation demands close attention. Potential under-coding means you may have a chance to improve your reimbursements. Or, if you appear to be over-coding, you may be headed for an audit. Whatever the numbers, only the subsequent chart audit can determine whether your documentation justifies your use of codes.

Of course, some natural variation

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EDITORIAL

The Numbers Are In for 2001

An "overwhelming majority of health care providers follow Medicare reimbursement rules and bill correctly." That's the encouraging word from the Centers for Medicare and Medicaid Services (CMS) in its new report, Improper Fiscal Year 2001 Medicare Fee-for-Service Payments. At the same time, the study, released in mid-February 2002, also notes that of the $191.8 billion in processed fee-for-service Medicare payments made during fiscal year (FY) 2001, some 6.3%, or $12.1 billion, were improper. (See the full report at www.oig.hhs.gov/oas/reports/cms/a0102002.htm.)

The rate, while less than one half the 13.8% found in FY 1996 when the government first calculated the percentage of inappropriate payments and the lowest yet, hasn't really changed significantly over the last four years. Medically unnecessary services account for 43.2% of errors, while documentation mistakes—insufficient or nonexistent information on services rendered—are a close second at 42.9%. The dollar amount of documentation errors rose by nearly 20% when compared with that of FY 2000. That is, this category represents an estimated $5.1 billion in improper payments versus $4.3 billion made during the previous year. Coding errors were estimated at 17%; noncovered services or other mistakes, 3.1%.

As you can readily see, coding compliance is destined to remain a front-burner issue, and we will help you continue to do it right, spotlighting areas that offer the greatest potential for improvements in coding and revenue. We begin this issue with pointers on comparing your use of evaluation and management codes with the CMS's national audit standards. This is the first of three core steps in an effective coding compliance program. The next two—chart audits and physician education—will be examined in upcoming issues.

Coordination of your coding efforts is important. Perhaps you should consider having a certified professional coder on your staff. We present information that suggests it's a great idea. You should also read about David Bright, a practicing physician who developed a computer network that strengthens his compliance efforts, boosts practice efficiency, and improves his quality of life.

We were overwhelmed by your positive response to the inaugural issue of *The Physician's Coding Compliance Alert*. Thank you very much, and please continue to share your thoughts and ideas so that we can address your specific areas of interest in future issues.

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Does Your Office Need a Certified Coder? The Experts Say "Yes"

Has your billing staff been coding for a few years? Have you invested in a good encounter form with codes you can check off? If so, do you really need a trained, certified coding professional? Since coding certification first became available in 1988, the level of complexity of medical coding has grown—and with it the risk of lost revenue and increased liability.

"When I was a consultant, I heard lots of stories about practices that hired an employee who really understood coding and their revenues went up exponentially—sometimes as much as $25,000 to $50,000 a year," says Rita Scichilone, director of Coding Products and Services for the American Health Information Management Association (AHIMA), one of the two organizations that offers a certification credential for coding professionals. "The practice would have left a lot of items unaccounted for that were legitimately billable. A skilled coder could make certain that all the correct codes were on the claim form in order to capture deserved payments."

Disallowed claims are another expensive waste of time. "A certified coder's billing is less likely to be thrown back by payers for incorrect coding," observes Clare Bailey, marketing manager for the American Academy of Professional Coders (AAPC), the other major certifying body. "If you get the claim back, you have to go through the chart again, resubmit the materials to prove it should be paid, and you're basically paying double for bounced claims. Sometimes practices don't bother to resubmit, and that's lost revenue."

Liability may be an even stronger incentive. "A certified coding professional can warn the physician about possible compliance difficulties and save the doctor from prosecution and fines for fraudulent and/or abusive billing practices," says Scichilone. "Coding professionals are also very knowledgeable about documentation requirements, so they can assist the physician in keeping all those bases covered. That's how you stay in compliance and out of trouble."

> **"If you're losing $40,000 a year through coding errors or denied claims, then by all means invest a few thousand to get your person certified and then support that individual in CE."**
>
> ***—John W. McDaniel***

The continuing education (CE) requirement for maintaining certification can be an important boon, relieving physicians of having to stay current on changes and developments in regulations. "Coding professionals keep track of all those volumes of regulatory requirements and reimbursement rules," Scichilone says.

One recent modification makes the liability issue even more pressing. "The rules constantly change," concurs Karn Weirman, JD, and Director of the Medical Coding Certificate Program at the University of New Orleans (UNO). "Recently they've changed the definition of fraud in medical billing. Because the rules are public knowledge, it's now much harder to plead an innocent mistake."

Types of credentials

AAPC offers two types of coding certifications: the CPC (certified professional coder), who is trained to code for professional services where payment comes to the physician; and the CPC-H (certified professional coder—hospital), who has additional training in coding for outpatient hospital care, where payment goes to the facility.

Applicants must have at least two years of coding experience and pass the exam, which is offered quarterly by local chapters for a fee of $285. To accommodate entry-level coders who have passed the exam but do not have the necessary experience, AAPC is launching new credentials—the CPC apprentice and the CPC-H apprentice. Apprentices must meet the same CE requirements—18 units—as fully certified coders, while gaining practical experience. A coder who has both a CPC and a CPC-H certification needs 24 units of CE each year.

AHIMA has been offering the CCS (certified coding specialist) for coders in institutional settings and

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the CCS-P (certified coding specialist—physician) for coders in physician practices. These are intended for individuals with demonstrated experience and skills. Applicants, who must be high school graduates or have equivalent education, take a six-hour exam, which in 2001 was given twice a year. The fee is $275 for members, $320 for nonmembers. While professional experience is not required when sitting for the exam, it is strongly recommended. In Fall 2002, AHIMA will offer an entry-level examination for the designation CCA (Certified Coding Associate), designed for those who have obtained basic training, but may lack the experience to successfully pass the specialist exams. AHIMA's CE requirements include 10 units within a two-year cycle if a coder has one certification and 20 for those who have both.

Training programs

AAPC offers an independent study program, and AHIMA has developed an online Coding Basics course, but both also approve or otherwise accredit programs taught by colleges, universities, hospitals, and other organizations. "Some people really need the structure of the classroom to learn," says Weirman. "They need someone talking to them and responding to their questions."

AHIMA's Coding Basics course includes 12 modules at a cost of $2,000. Topics as diverse as health care delivery systems, health data, medical terminology, microcomputers, pathophysiology, and medical office procedures are covered, as well as basic and intermediate ICD-9 and CPT coding, billing, and reimbursement. A fundamental course in anatomy and physiology is a prerequisite for the Coding Basics program.

AAPC's independent study program is available in six modules for $975 (members) or $1,075 (nonmembers); the CPC-H study program is $150 more. That course focuses more exclusively on coding issues, but covers the full range of specialty coding. "Our exam covers all the specialties," says Bailey, "so if coders take our exam and pass it, then they know a lot about coding for all the specialties, not just the one in which they may work." But while the course is "pure coding," students need a working knowledge of medical terminology, anatomy, and physiology.

The UNO and a handful of other colleges have an even more extensive curriculum, designed primarily for students without experience. In addition to two courses each in ICD-9 and CPT coding, medical terminology, and anatomy and physiology, the program offers some extras that veteran coders might benefit from, but don't absolutely need.

"We get many students who have never been in health care," says Weirman, "so we have an Introduction to the Health Care Industry course. We also added subjects specific to medical office management and medical records.

Legal aspects are also covered so that students understand the regulations and repercussions for flouting them. "Anybody involved in fraud and abuse can end up in jail," Weirman says. "I want students to understand the risks involved."

RHIT (Registered Health Information Technician) or RHIA (Registered Health Information Administrator) certification is also helpful. The training encompasses all aspects of records and data management, coding, reimbursement, and compliance. Both credentials are available through AHIMA and may be obtained after graduation from an accredited degree program. With pending regulatory requirements soon to be mandated and increasing conversion from paper charts to electronic records, the broader credentials may be the best investment.

Cost of a certified coder

A certified coder may command a higher salary, but the difference may not be as much as you'd think. According to the AAPC's annual salary survey for 2001, the average salary for a certified coder in 2001 was $40,676, while noncertified coders averaged $30,790 a year. Obviously, one way to measure the return on investment for certification is to ask yourself whether you're losing more than $10,000 a year on coding errors.

But it may be an even better move to pay for training someone who's already in your office. That's the kind of benefit sure to improve staff morale and help reduce turnover because it demonstrates your commitment to providing employees with growth opportunities.

"A great number of medical practices appreciate the return on investment in equipment far more than they do the same investment in personnel," comments John W. McDaniel, President and CEO of Physician Management Group, Inc.

"You can absolutely quantify the benefits of a trained coder. If you're losing $40,000 a year through coding errors or denied claims, then by all means invest a few thousand to get your person certified and then support that individual in CE," he concludes. "The coding requirements are changing all the time. In the end, liability always comes back to the physician. Having a well-trained coder guarantees that what comes out of your practice won't get you in trouble."

Reported and written by Lauren M. Walker, in Cambridge, Mass. More information on coding certification is available on our Web site (at www.Coding-Compliance.com).

Florida FP Devises Ingenious Approach to Accurate Coding

Like many physicians, family practitioner David E. Bright does not like paperwork. Perhaps that's an understatement. In a quest to clear paper from his practice, Medical Partners of Martin County in Stuart, Fla., he has constructed a computer network that captures the essentials of an office visit while it is still in progress.

"The system enables us to quickly and effectively manage patient visits and produce legible, organized reports as well as computer-generated prescriptions and laboratory requisition slips," Bright explains. "Our goal is to have the report, prescriptions, and patient education material laser-printed by the time the patient finishes up, and we accomplish that goal about 99% of the time."

Simultaneously, all documentation required for proper coding and billing is completed. For example, this family practitioner says, "instead of having to hand-write separate laboratory slips, we order tests and justify them easily within the context of the program by assigning each to a particular diagnosis, which is the way Medicare and the insurance companies want you to do it." When coding questions arise, Bright turns to a member of his office staff who is trained as a certified procedural coder. "We can resolve issues right away," he reveals. "It's more advantageous to have everything done at the time of service rather than having to do it later." (See "Does Your Office Need a Certified Coder," page 3.)

An electronic medical records package and voice recognition software form the core of the system. While Bright examines the patient and discusses his findings, he also addresses a nearby computer, which, in turn, translates speech into text, creating a permanent record of what has transpired. Additional knowledge banks on the desktop keep essentials such as patient education materials, pharmacology information, or general office resources at hand. High-speed Internet access and bookmarks allow the staff to click into helpful Web sites whenever they want. "We've also created a firewall system because we were worried about possible security breeches," Bright says.

So far, this physician has merged more than six readily available software applications into what he refers to as a 'medical digital nervous system.' These have been further customized with templates for oft-used forms, shortcuts, and macros—a word or portion of a word that expands into a larger sentence or paragraph—to meet office needs. "For example, if I say the word 'alert,' the word 'alert' comes up big and red and in a different font so that I will immediately see it," Bright explains. The entire work in progress has evolved over the past three to four years, expanding from a single computer on his desk to about 14 that are strategically placed throughout the office, including one in each exam room and in the laboratory, one on the physician assistant's desk, and several at the front desk.

The endeavor has been well worth it, saving time and making money. For example, when patients request prescription refills, the staff rarely has to pull a chart, as most necessary information is visible on the computer. Bright no longer needs a transcription service, and the care he has given his patients is detailed far more accurately than if he was working with pencil, paper, and dictating machine. As a result, his claims reflect exactly what was done, and he is paid accordingly. In fact, the physician estimates that the system has helped boost his net income by some 20%.

Along with computer expert Bill Phipps, Bright has formed Doctor's Desktop, Inc., and together they consult with physicians interested in building a similar network. However, unless you're in the neighborhood, you will likely need a local computer person to help set everything up initially. "With permission, we can get into your system and teach you how to do it via remote," Bright says. "Because we're small and I have a practice to run, we can't fly all over the country, but we can teach physicians what works and what to avoid." The duo maintains a test network so they can determine whether new additions will damage existing applications or crash the system before ever going near the live network.

While Bright still uses traditional charts in the office, the plan is to be rid of them by year's end. "If you stay with paper, it's an almost impossible task," he says. "If I had to go back to all paper, I don't think I'd want to practice."

For more information on Doctor's Desktop, go to www.doctorsdesktop.com. Or, call Dr. Bright at (561) 286-5551. Reported and written by Cynthia Starr, editor. More information on helpful software is available on our Web site (at www.Coding-Compliance.com).

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exists among specialties. Note that critical care specialists use the highest level of hospital visits 40% of the time, compared with 14% for allergists or 16% for general practitioners. Similarly, internists code for the highest level of new patient visits 23% of the time compared with 7% for family practitioners. Comparing your distributions to that of another type of practitioner would border on the proverbial apples and oranges.

A financial perspective

"Many physicians purposely under-code because they are afraid of being audited," McDaniel says. While this strategy may limit liability, it also reduces your income. The practice not only affects your Medicare reimbursement, but payments you receive from all other payers. "Anybody who under-codes Medicare claims is doing the same with claims sent to private insurers," he points out.

What about apparent over-coding? "Let's say you are an internist using the 99215 code, the highest established office visit code, 10% of the time when the national standard is 5%," McDaniel suggests. "The government's system may kick you out as being over, but that doesn't necessarily mean that you are over-coding. If you have the documentation to support that level of service, you are in good shape. Submit what you are

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Centers for Medicare and Medicaid Services' Actual National Usage Distributions

CPT Code[1]	Allergy-Immunology Distribution (%)	Cardiology Distribution (%)	Critical Care Distribution (%)	Family Practice Distribution (%)	General Practice Distribution (%)	Internal Medicine Distribution (%)	Rheumatology Distribution (%)
99201	2	2	3	6	5	2	1
99202	8	5	17	28	25	12	4
99203	29	22	19	39	38	30	23
99204	41	40	33	20	22	33	44
99205	20	31	28	7	10	23	28
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**
99211	4	9	5	4	3	4	6
99212	13	8	11	18	18	11	5
99213	57	49	50	60	59	58	49
99214	23	31	30	16	17	22	37
99215	3	3	4	2	3	5	3
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**
99221	11	5	4	9	11	5	5
99222	35	30	30	47	43	35	36
99223	54	65	66	44	46	60	59
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**
99231	36	25	15	36	37	29	38
99232	50	54	45	51	47	53	48
99233	14	21	40	13	16	18	14
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**
99241	2	1	2	5	8	3	1
99242	7	5	7	19	18	9	4
99243	32	24	20	39	29	27	18
99244	45	47	46	27	30	38	49
99245	14	23	25	10	15	23	28
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

1. Codes 99201-99205, new patient visits; codes 99211-99215, established patient visits; codes 99221-99223, hospital admissions; 99231-99233, hospital visits; 99241-99245, office or other outpatient consultations. Source: Physician Management Group, Inc.

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entitled to, and let the chips fall where they may."

The situation is much like filing an income tax return. "If your W-2 form says you earned $100,000, and you filed $40,000 worth of deductions, you have likely exceeded what the Internal Revenue Service views as a reasonable deduction amount for that income level," McDaniel says. "Nonetheless, if circumstances provoked an unusual amount of deductions and you know you can prove they are just, would you not take them because you might get audited? Absolutely, you take the deductions. Code the same way!"

McDaniel likes to translate use of codes into monetary terms, allowing physicians to see approximately how much is at stake. He frequently uses the examples of two physicians, one of whom is using code 99214, a higher level of established office visit, at more than twice the average rate. As shown in the table on this page, Physician B rarely uses that code, relying more heavily on the lower levels, 99212 and 99213. In fact, those two codes account for nearly 88% of his established visits. Assuming that 26% of these claims go to Medicare and Medicaid with a 75% collection rate, and 74% to other payers with an 89% collection rate, McDaniel's team calculates that Physician A, whose charts don't support his claims, is over-coding by about $17,154 per year. Physician B, despite good documentation, is under-coding by about $8,669 per year. Benchmark frequencies provide a goal that is more in line with the national audit standards.

All tied to documentation

Again, your own coding distributions mean little unless detailed records bolster them. "We see it all the time," McDaniel emphasizes. "Sometimes doctors appear to be under-coding, but their documentation does not even support the lower-level codes they are using, which then means they are actually over-coding. Conversely, those who may appear to be over-coding may not be at all. Documentation drives this process."

In recent years, the government has performed a special audit to track use of the codes 99214 and 99233, both of which "accounted for a significant portion" of the coding errors noted in fiscal years 1998 and 1999, according to the CMS's new report, Improper Fiscal Year 2001 Medicare Fee-for-Service Payments. Instead, "documentation for many of these services more appropriately supported CPT codes 99212 and 99231." The latest analysis suggests problems with these particular service levels have yet to be resolved. As a result of these audits, McDaniel says, 58.2% of these codes have been reduced to a lower level of service and another 15.3% were denied.

"It's not necessarily that the codes are over-used, but they are clearly under-documented," he continues. "The government has recouped a lot of money. Overall, for every dollar CMS spends on investigating physicians, it's getting back $13 more—and that's serious money."

Both the utilization analysis and chart audit offer a great educational opportunity. Take all the results, scrutinize them, and look for ways to make improvements—and document what was discussed during the session. "You wrap all that up, store it with your compliance plan, and depending on the severity of the situation, you may do this once, twice, or four times a year," McDaniel says. "If you're over-coding or under-coding by $6,000 in a 12-month period, check your methods once a year. If it's $50,000, you may want to look at what you're doing every few months and track your progress. It's what we call a velvet hammer. We don't want to beat you up, but rather gently remind you that this is very important.

For more information on the CMS's gross coding totals or its report on improper Medicare payments, go to www.hcfa.gov/stats/resource.htm and oig.hhs.gov/oas/reports/cms/a0102002.htm. Reported and written by Cynthia Starr, editor. You can also learn more about national usage distributions by going to our Web site (at www.Coding-Compliance.com).

Utilization Patterns for Two Physicians

CPT Code	Charge ($)	Actual Frequency Physician A	Actual Frequency Physician B	Percentage Distribution Physician A	Percentage Distribution Physician B	CMS Standard (%)	Benchmark Frequency Physician A	Benchmark Frequency Physician B
99211	22	16	105	0.5	7.6	4	126	55
99212	38	319	312	10.2	22.7	19	596	261
99213	56	1,748	891	55.7	64.9	58	1,820	796
99214	84	968	64	30.8	4.7	15	471	206
99215	122	87	1	2.8	0.1	4	126	55

Source: Physician Management Group, Inc.

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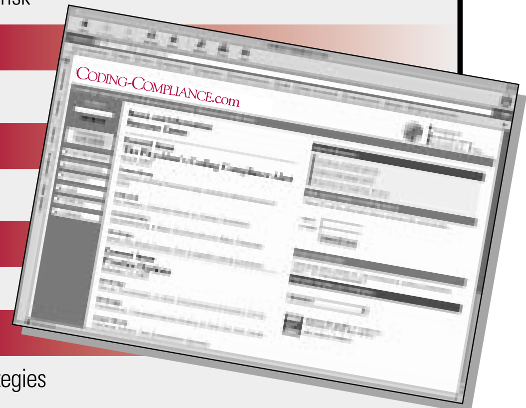

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