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THE PHYSICIAN'S COMPLIANCE ALERT™

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The Buzz About Coding Changes: What to *Really* Expect and When

There's been talk for years that the evaluation and management (E&M) billing codes will be revised or even eliminated. Changes would likely be welcome because the current system of choosing the proper code is complicated and confusing, especially when it comes to determining a particular level of service. But will the long-awaited codes be better?

The American Medical Association (AMA) copyrights and publishes the 8,000 Current Procedural Terminology (CPT) codes, which include the E&M codes. Certainly, no plans exist to abandon the majority of CPT codes, according to an AMA spokesperson. The codes, which have been used since 1963 and are updated annually by the AMA, are absolutely necessary for processing the five billion health care claims received by insurers each year, he added.

However, a new set of E&M codes are under development by the AMA, which is working on the revisions along with 11 specialty medical societies. The codes have already been revised, and the clinical examples are now being validity-tested to ensure that they meet the needs of all types of specialists. If the examples are shown to possess broad applicability, they will be submitted along with the new codes for approval by the Centers for Medicare and Medicaid Services (CMS). If the examples do not apply to all specialties, the codes themselves will have to be adjusted.

There is still a lot of work to be done, the AMA claims, and there is no set deadline for completing the clinical examples or the new codes. As for what the new E&M codes look like, the AMA is not yet commenting.

"I've heard rumors that the new codes are more in line with the process required by the 1995 set of E&M documentation guidelines than the 1997 set and that a pilot was done using the revised system, but physicians didn't like it," says Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Peak Performance Physicians, LLC, which is based in New Orleans, La. "It's been said that they may start all over. I don't know what that means because I haven't seen the codes." Regardless of what E&M codes are developed by the AMA, the CMS will ultimately determine which codes are to be used when filing for reimbursement.

Does the future hold diagnosis-related coding?

Nonetheless, many would like to see the E&M codes replaced with another system altogether. "All the literature supports the fact that at some point the E&M codes will disappear," says Randy J. Gershwin, MD, MMM, CPE, FACPE, medical director of Community Practice, Lutheran Hospital, in Brooklyn, New York. "They are not a fair assessment of what was done for the patient or of how the physician should be reimbursed," he says. "The current system is a confusing hodgepodge. For a 99212, for example, you have to check two items from column A and one item from column B and then assign the level of risk. And then there's the physical examination part," he adds. "Many physicians carry a cheat sheet in their pockets just to help figure it out."

How could today's setup be improved? "There's always been a lot of discussion about using a diagnosis-based system of compensation based

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EDITORIAL

Calculating the Cost of Change

As you will note in this month's cover article, it isn't difficult to get knowledgeable people to suggest improvements for the current coding systems. One major alteration is expected to occur in the near future: the ICD-9-CM code sets, volumes one and two, will be replaced by ICD-10-CM; volume three of the ICD-9-CM, used by hospitals to code for inpatient procedures, will be supplanted by ICD-10-PCS. Organizations involved in the implementation of the new codes are optimistic about their usefulness.

A new report from the RAND Corporation cites a number of potential benefits to be gained by the switch. *The Costs and Benefits of Moving to the ICD-10 Code Sets*, released in March 2004, points out that "if nothing else, they represent the state of knowledge of the 1990s rather than of the 1970s." In addition, the new sets are "more logically organized" and far more detailed—"by a factor of two in diagnoses (and 20 for injuries) and by a factor of 50 in procedures." The enhanced detail could promote more accurate payment for new procedures; fewer erroneous, rejected, and false claims; and improved understanding of the value of new procedures. More meticulous billing records might also allow payers and providers to better "identify patients in need of disease management and more effectively tailor disease management programs."

None of this will be accomplished without racking up some serious expenses. Overall, the researchers estimate that one-time training and system-change costs of conversion could fall between $425 million and $1 billion-plus, and productivity losses, parceled out over a 10-year period, could reach between $5 million and $40 million per year. Specifically, one-time training costs for physicians were estimated at $25 million to $100 million; cumulative productivity costs for physicians over a decade-long span were gauged at $50 million to $250 million. A copy of the report is available at: www.rand.org/publications/TR/TR132/.

We also examine the annual report, *Improper Medicare Fee-for-Service Payments*. This year, the Centers for Medicare and Medicaid Services did the study for the first time. In addition, some of your specific coding questions are addressed. As always, if you have coding questions, send them to us via e-mail—perhaps we can help.

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New Method, Similar Message: The Latest Improper Payment Study

With an ambitious new project under way, the Centers for Medicare and Medicaid Services (CMS) intends to trim the dollars Medicare pays in error to 4% of total dollars Medicare spends by 2008. The national paid claims error rate has been computed since fiscal year (FY) 1996, when 13.8% of payments ($23.2 billion) were based on poorly documented, medically unnecessary, incorrectly coded, or otherwise problematic claims.

Great improvements have been made in recent years. In FYs 2000, 2001, and 2002, the error rates were 6.8%, 6.3%, and 6.3%, respectively, but even these lower percentages represent billions of dollars that were improperly paid. A major change in research method occurred in FY 2003, when the CMS assumed responsibility for conducting the improper Medicare fee-for-service (FFS) payments study from the Office of the Inspector General (OIG) for the US Department of Health and Human Services. The transition provides the CMS with an opportunity to do a much larger study, according to a CMS official.

While the OIG used a sample size of 6,000 claims, the CMS sought 120,000 claims for the FY 2003 study. The CMS will request 150,000 claims in FY 2004 and subsequent years. "By increasing the sample size, we can come up with more detailed information, which will help us to better manage the program," the official adds. In addition to the paid claims error rate, the CMS can now calculate a services processed error rate (the percentage of errors among all claims processed, paid and unpaid) and a provider compliance error rate, which is the percentage of billed dollars that were incorrect before entering the Medicare contractor's assessment process. The agency can also determine the percentages of errors made by contractor, service type or provider type.

For example, if a contractor's paid claims error rate is significantly lower than the provider compliance error rate, the difference indicates "they're doing a good job of stopping the bad payments before they go out," the CMS officer explains.

Or the CMS can determine which codes are associated with an unusually high number of errors. "That helps us know where more education or review must occur," she says.

The latest findings

The FY 2003 study results, released in November 2003, estimated the national paid claims error rate to be 5.8%, which means the US government disbursed about $11.6 billion in erroneous payments (a copy of the report is available at www.cms.hhs.gov/providers/psc/cert.asp). Insufficient documentation accounted for 45% of errors, compared to 20.1% in FY 2002 and 30.5% in FY 2001. Also common were claims for medically unnecessary services, which made up 21.7% of total errors (vs 57.1% and 43.2% in FY 2002 and FY 2001, respectively). Incorrect coding accounted for 12.1% of dollars paid in error; "other" mistakes, 2.7%.

"Insufficient documentation is a constant problem," says Charles E. Colitre, president of Med-Management Group Inc., headquartered in Akron, Ohio. "It shouldn't necessarily be fixed by more documentation, just better documentation. You need to use the right words and phrases to cover the requirements of the CPT codes you've selected for the services or treatment you've provided." In fact, some of the errors labeled as medically unnecessary services may instead be the result of poor documentation. Colitre says that too often, physicians believe that the choice of diagnosis is enough to support a particular CPT code. "The physician hasn't adequately documented why treatment is necessary and as a result, doesn't get paid properly," he remarks. "If you don't write it down, nobody is going to make any assumptions."

The CMS also considers nonresponses to its requests for records to be errors, and in the latest report, nonresponses represented 18.5% of errors. Generally, the CMS had a lower response rate than had been experienced in the years the study was carried out by the OIG. The response rate, though 95%, was low enough to throw off the results: the initial paid claims error rate for FY 2003 was 9.8%, with 54.7% of these errors caused by nonresponse. Consequently, the CMS adjusted the results "to provide a more

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meaningful estimate" of where mistakes were truly occurring.

Among the factors blamed for the less vigorous response was providers' confusion about whether submission of medical records defies rules associated with the Health Insurance Portability and Accountability Act (HIPAA) and their lack of familiarity with the Comprehensive Error Rate Testing (CERT) contractor charged with assembling the information. Colitre, formerly an agent with the Federal Bureau of Investigation, emphasizes that sharing of patients' medical records with the CERT contractor "absolutely doesn't violate HIPAA. I've seen this argument, and it's ridiculous. This is a contractor hired by the US government to do a quality control study."

Looking ahead

A number of strategies are being put in place to both improve the annual study response rate and reduce mistakes on claims. For example, revised request letters better explain the role of the CERT contractor and stress that compliance with the request does not violate HIPAA. To help make compliance more convenient, a fax line has been created for submission of medical records. Providers who fail to comply also risk a call from the OIG. "Each non-responding provider is contacted seven times by the CERT contractor—with four letters and three phone calls," the CMS official says. "In the past, nothing happened after that fourth letter other than that the provider would get a denial and the contractor would take back the money for the claim."

As of April 30, 2004, the contractors will have access to the names of those providers who have yet to comply. Ultimately, the contractor will try one last time to convince the provider to forward the records. "If the claim in question is worth $40 or more, the contractor makes a referral to the OIG," she states. "At this point, the OIG may contact those providers by phone in an attempt to understand why they have not responded." If officials suspect fraud for any reason, they can then ensure the provider's billing habits are further scrutinized.

The CMS's to-do list for educational initiatives includes enhanced one-on-one contacts with providers billing in error. A centralized database of articles on billing, coding, and coverage is currently under development. Error rates will be produced more quickly so that Medicare contractors can better track the progress of their initiatives. Contractors will also be urged to address providers' questions more consistently.

Information provided by the FY 2003 study has underscored specific areas requiring CMS attention. Chiropractors had the highest percentage of provider compliance errors (see table on this page). To address this finding, the CMS is making its chiropractic coverage and billing rules more explicit and working on procedure code modifiers that help practitioners to better determine what is and is not covered.

As for physicians, it is once again apparent that their documentation skills could use some refinement. And certainly, if you receive a request from the CERT contractor for medical records, do reply. "If I was going to counsel a client along this line, I'd say mail them; don't fax them," Colitre suggests. "I'd feel more confident if they were copied and mailed. It's not an urgent treatment situation. Besides, you could be talking about a voluminous amount of paper. But don't ignore the request."

Reported and written by Cynthia Starr, editor. For more information on billing and coding compliance, go to our Web site (see page 8).

Some Error Rates by Provider Type

Provider Type	Paid Claims Error Rate		Provider Compliance Error Rate		Services Processed Error Rate	
	Including NRCs (%)	Excluding NRCs (%)	Including NRCs (%)	Excluding NRCs (%)	Including NRCs (%)	Excluding NRCs (%)
Physical therapy	23.7	18.2	29.4	24.7	21.4	16.4
Internal medicine	23.1	13.5	26.3	17.5	21.8	15.3
Chiropractic	16.3	11.3	30.6	27.3	14.2	10.6
Family practice	16.5	10.0	19.8	13.9	17.5	13.1
Cardiology	15.0	8.8	19.2	13.6	20.1	13.2
General practice	17.7	7.8	21.6	12.7	21.0	13.0
Hematology/Oncology	9.9	5.4	21.1	17.7	15.5	10.0
Urology	8.9	5.3	20.9	18.2	13.2	10.6
Podiatry	9.2	4.0	18.7	14.5	11.7	8.5
Ophthalmology	5.6	3.0	14.3	12.3	8.8	6.2
Diagnostic radiology	10.8	1.9	18.2	10.7	13.6	5.8

Key: *NRCs, non-response claims.* ***Note:*** *Some provider types are not included because they were not adequately represented in the claim sample volume.*
Source: *Centers for Medicare and Medicaid Services.*
Fiscal Year 2003 Improper Medicare Fee-for-Service Payments.
Available at: http://www.cms.hhs.gov/providers/psc/medicare-error-rate-short-report.pdf

Questions About "Incident-to" Billing Continue to Perplex

Q: *Must the ordering oncologist be on-site when a nurse practitioner (NP) provides chemotherapy services in order to bill for those services on an incident-to basis? Many oncologists insist that they don't need to be in the office to bill as if they had performed the service themselves. In our multispecialty practice, other partners cover the chemotherapy nurse in the event of an adverse outcome, but none wants to be responsible for ordering chemotherapy or documenting treatment.*

A: It is true that incident-to billing requires direct physician supervision for a service provided by a nonphysician practitioner to be charged under the physician's name and identification number, explains Rhonda Lynn Picou, RN, MSN, CPC, vice president of physician compliance for Peak Performance Physicians, LLC, headquartered in New Orleans, La. Of course, the benefit of billing the NP's work as incident to the oncologist's care is that the practice should be reimbursed at 100% of the physician's fee rate rather than at the lower rates reserved for NPs and other auxiliary health care professionals.

In the case you describe, the absent oncologist can bill for administration of chemotherapy if the drugs are given in the office because his or her partners, though not oncologists, can provide the required direct supervision, Picou points out. When the Centers for Medicare and Medicaid Services (CMS) revised the Medicare Carriers Manual sections on incident-to billing with Transmittal 1764 (Change Request 2222), which was issued on August 28, 2002, it set out four essential criteria for coverage of incident-to services, and these are generally the same whether you are billing for a solo practice, a physician-directed clinic, or a group association. An eligible service must be:

- Integral but incidental to the doctor's professional service
- Usually provided at no charge or included in the physician's bill
- Normally rendered in a physician's office or clinic
- Delivered by the physician or by auxiliary personnel under the physician's direct supervision.

In discussing "highly organized clinics, particularly those that are departmentalized," the document notes that direct physician supervision may be shared among several doctors. "The physician ordering a particular service need not be the physician who is supervising the service," according to the CMS. "Therefore, services performed by auxiliary personnel are covered even though they are performed in another department of the clinic."

The physicians in your practice do not have to see the patient during the visit, but they do have to be physically present in the office and immediately available to help the NP if needed. If chemotherapy is administered in the patient's home, however, the oncologist must accompany the chemotherapy nurse to qualify for incident-to billing. When chemotherapy is delivered in a hospital, the hospital is reimbursed for the service.

Q: *What CPT-4 code would you use to bill for wound care?*

A: Removal of devitalized tissue from a wound is billed with codes 97601 and 97602 on a per-session basis, Picou says. The first denotes selective debridement without anesthesia. Methods used include high-pressure waterjet and sharp selective debridement with scissors, scalpel, and tweezers. In contrast, the code 97602 covers nonselective debridement without anesthesia. Relevant techniques include wet-to-moist dressings, enzymatic debridement, and abrasion. Payment for each service encompasses topical applications, wound assessment, and instructions for ongoing care.

When patients require simple dressing changes for wounds that do not require debridement, you should generally bill an E&M service with the diagnosis code V58.3, which is defined in the 2004 ICD-9-CM codes as attention to surgical dressings and sutures (change of dressings; removal of sutures). In one example offered by the American Medical Association (AMA) in its *CPT 2004 Professional Edition*, the code 99211 is used to bill for an office visit in which an established patient has a new dressing applied to a skin biopsy site. The AMA applies the same code to charge for partial removal of antibiotic gauze from an infected wound on an established patient. Pondering both models, Picou observes that auxiliary health care personnel could perform either task. "If the requirements of incident-to billing are met, the practice could then be reimbursed at the physician's rate."

Editor's note: Readers of The Physician's Compliance Alert *are invited to visit our Web site (see page 8) and submit their questions. Members of our Advisory Board will offer their expert opinions on a variety of situations.*

on the primary diagnosis and ICD-9-CM codes," recalls John W. McDaniel, president and CEO of Peak Performance Physicians, LLC (see box on page 7 for an update on proposed changes to the ICD-9-CM codes). "Doctors see 30 patients a day, and whether they meet a level three or level four is not on their minds. And it really shouldn't be."

"I believe a system based on diagnosis-related group (DRG) or time spent per patient would be better," recommends Picou. "Physicians have to code for diagnosis anyway, and the system would be easier for physicians to use and easier to computerize." On the other hand, the ICD-9-CM as it now exists couldn't capture E&M codes, she notes.

"A system like that would probably help doctors and be a timesaver for them as well, but I don't think physician billing will ever use a DRG-type of system," says Charles E. Colitre, president of Med-Management Group Inc., headquartered in Akron, Ohio. "It would be easier, though, because the physician would not have to include all the specifics beyond the diagnosis, except to show medical necessity," he adds.

A fundamental dilemma

Another way of simplifying the codes would be to limit the levels of service for established patients. "The vast majority of E&M codes use five levels of service, but using only three levels may simplify the coding process considerably," suggests Colitre. On the other hand, a three-level system may lead to overcompensation for mid-level visits or undercompensation for other types of visits, McDaniel says.

With the current situation, physicians are often afraid to bill beyond level three, observes Picou. "For example, they may be doing enough work to warrant compensation for a level four office visit, but they're worried that they don't have all the documentation they need, so they submit the lower code and forgo the higher fee." Then again, the E&M documentation guidelines, as they stand now, could inadvertently support higher than appropriate coding.

For example, in selecting a level of E&M code for an office visit by a new patient, you must meet or exceed the requirements for history, examination, and medical decision making; for an established patient, you need only meet or exceed the requirements for two of these three key components, Picou explains. If you took a level three history, performed a level four examination, and were required to make a high-complexity medical decision for a new patient, you would only be allowed to submit a level three E&M code because that's the level common to all three key components. In contrast, if you were to take a level five history and provide a level five examination for an established patient whose care necessitated only a straightforward medical decision, you could, in theory, bill a level five E&M code if your documentation supported it.

"Obviously, you wouldn't give every established patient who walks in the door a level five history and physical examination, whether they need it or not," says Picou. "This may be appropriate on occasion, but if you bill everyone with a level five code, even with the proper documentation you could prompt an audit," she adds. "You still have to be guided by medical necessity regardless of how much documentation you have." Picou advises physicians to bill according to the medical decision-making component in these cases. "Technically, it isn't what the guidelines require, but if every patient is getting the same code, medical necessity is becoming very blurred."

Another consequence of allowing the amount of documentation to trump the extent of care given when selecting a code would be that the bell-shaped curves used by CMS as audit standards may not represent what physicians are doing; rather, the curve would reflect what they are coding, Picou comments. This is a crucial point, since the curves are based on bills that are submitted, and they are used by CMS to identify outliers who merit closer scrutiny. They are also used by practices to assess their own coding habits.

Whatever the solution, these issues need to be resolved to give physicians the direction they need, urges Picou. "The bottom line is that we require a system that focuses on patient care and also truly represents the level of service provided. This has to be addressed, especially since coding of E&M services is scheduled for further investigation on the Fiscal Year 2004 Work Plan generated by the Office of the Inspector General of the US Department of Health and Human Services," she adds. As it is, today's system forces doctors to meet paperwork needs, rather than the needs of the patient.

Know the current rules

Until the new system arrives, whatever it will look like, there is little option but to accurately use the system now in place. Some physicians may feel that learning current codes is a waste of time since the E&M codes are being revised, but that's a dangerous attitude to have. "Until the new codes are here, you'd better know the current rules or you're putting yourself at real risk," warns Colitre.

ICD Changes in the Works

Revisions for evaluation and management codes aren't the only changes on the horizon. The National Committee on Vital and Health Statistics has recommended that the US Department of Health and Human Services adopt International Classification of Disease-10, Clinical Modification (ICD-10-CM) as the Health Insurance Portability and Accountability Act (HIPAA) standards for national implementation as a replacement for ICD-9-CM, volumes 1 and 2. The new ICD-10-CM will replace ICD-9-CM, which is used to code and classify morbidity data from inpatient and outpatient records, physician offices, and most National Center for Health Statistics (NCHS) surveys. It will not replace the ICD-10, which is used for reporting mortality data from death certificates.

These adoption efforts are well under way. According to the NCHS, the new system is now being processed for implementation and should be in use by October 2008. Publication is expected in 2005, followed by a comment period, then publication of the final rules, which is slated for 2006. The new classifications will go into effect two years after the final rules are published. The NCHS reports, though, that these dates could slip.

The new classification system contains a significant increase in the number of codes compared with ICD-9-CM, and some sections have been revised. Nonetheless, the two systems are very parallel and will not require more work from physicians and others who use them, the NCHS comments. Except in rare instances, no modifications have been made to the three-digit categories and the four-digit codes physicians are currently familiar with, an NCHS spokesperson indicates.

The American Health Information Management Association (AHIMA), along with the American Hospital Association, conducted a field test of ICD-10-CM early this year and found that the new system can be implemented without excessive training costs or changes in documentation. Physician billing services will have to be updated to include the ICD-10-CM codes, however. The AHIMA has called adoption of ICD-10-CM a milestone and a major step toward moving the quality of health care and patient care into the 21st century. A draft version of ICD-10-CM can be viewed on the NCHS Web site, at www.cdc.gov/nchs/about/otheract/icd9/icd10cm.htm.

There are some helpful methods of working within the current system. "I think that the trend toward dictation and electronic medical records will help physicians considerably," says McDaniel. He notes that over the next five years, the number of physicians using electronic records systems is very likely to skyrocket from about 20% to 80%.

Good products are available, but software can have disadvantages, too, says Colitre. "I'm just a bit skeptical of software products for coding. In some cases they can steer the doctor toward an incorrect conclusion," he says. Practices should always run tests to ensure that the CPT codes being billed by the software meet the requirements, he says.

"These systems don't know what is medically necessary and could prompt a doctor to simply document everything," adds Picou.

It would be helpful if CMS were to endorse the software programs themselves, advises Gershwin. "Then we could use our laptop or a handheld device to simply check off what we did, and the system would decide what level of service we provided. It would be a shame to lose the narrative in patient records, but at least it would be accurate," he says.

Even with electronic records, however, physicians will always require judgment when coding. "Doctors need to balance what is necessary to document with what they feel is needed clinically," says Picou.

After all is said and done, it still boils down to physicians having to document their services, and there is no substitute for coding education for doctors, says Gershwin. Deaconess Medical Group in Evansville, Ind., where he served as medical director until early this year, allots a tremendous amount of resources to educate physicians, with both in-house and consultant programs. Every month, they graph each physician's coding patterns to compare them to the bell-shaped curve for their area, he says. If they see a spike at any coding level, the charts are audited to determine whether or not codes are accurate.

"We seem to be in a permanent holding pattern. But until divine wisdom intervenes, this is the system we must use—right, wrong, or indifferent," says McDaniel. Learning to correctly use the codes is thus the only current option for staying compliant.

Reported and written by Deborah Epstein in West Milford, NJ. More information on coding is available on our Web site *(see page 8)*.

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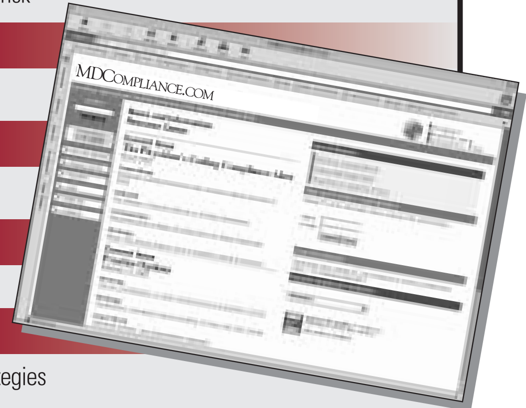

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