



Coding Secrets Unlocked

Coding is no fun, but you gotta get it right. Here's a how-to guide.

By Robert Lowes

Medical coding is an abomination. A Kafkaesque quagmire. A dismal science intended to prevent physicians from getting paid for what they do, and which induces obsessive-compulsive disorder.

Ever had such thoughts? Probably.

Unfortunately, coding isn't going away; even the most ambitious healthcare reform plans don't envision its demise. So, however much you may loathe coding, you still need to know how to do it well if you want to get paid what you're owed. And to be good at coding, you need to be on guard against the bad habits and rationalizations that develop as you seek shortcuts through a complex subject.

You should also know what the Medicare audit police are focusing on in any given year, and understand the new directions in healthcare policy and reimbursement that will change how you'll code in the future.

But we've got you covered. We interviewed a bevy of coding pros for advice that will burnish your skills and help you submit accurately coded claims. Improvement in this bothersome aspect of medicine will reduce denials, avert audits, and maybe even boost your revenue. And when you get good at something, it gets easier.

Sound like it might be worth your time?

Let's get started.

The roots of undercoding

Medical coding is rational, in theory. Do this, this, and this for a patient with this condition, and document it properly, and you're entitled to get paid for what you did. The code is really just shorthand. In practice, however, doctors frequently code by emotion.

Some kindhearted physicians, for example, undercode a 99213 office visit with an established patient — marking it as a 99212 — to reduce what a Medicare patient owes out-of-pocket, which is 20 percent of the Medicare allowable once the deductible is met, says coding consultant Bill Dacey in Stanley, N.C. The problem is that doctors who do this cost themselves more money than they save the patient — a lot more.

By picking a 99212 instead of a 99213, the doctor saves the patient \$4.83, but foregoes \$19.33 in revenue (see the table below). "This sensitivity to Medicare patients carries



over to commercially insured patients, with more undercoding as a result,” says Dacey.

How Much Does Undercoding Cost You?

EVALUATION AND MANAGEMENT CODE	MEDICARE ALLOWABLE	CO-INSURANCE OWED BY PATIENT (20 %)	MEDICARE'S PAYMENT TO DOCTOR (80 %)
99213	\$61.31	\$12.26	\$49.05
99212	\$37.15	\$7.43	\$29.72
The Difference	\$24.16	\$4.83	\$19.33

Besides surrendering revenue, these intentional undercoders risk being charged with Medicare noncompliance, even though the government comes out ahead financially. So what’s a compassionate doctor to do when his patients can’t afford his fees? “Code the visit right, and address the patient’s finances afterward as a hardship issue,” says Terri Fischer, a healthcare consultant with CPA firm LarsonAllen in St. Louis. “Medicare lets you waive a patient’s coinsurance if you have a hardship policy, and the patient satisfies its criteria. You must apply this policy to all your patients, though, not just Medicare recipients.”

Another emotion that leads to undercoding is fear. “Some physicians will code every office visit as a 99212 just to stay under the radar and avoid a Medicare audit,” says Ginny Martin of Healthcare Consulting Associates of NW Ohio in Waterville. “However, coding everything the same can initiate an audit as well.”

Other types of undercoding are unintentional, but just as detrimental to revenue. Dacey says some physicians become victims of their own clinical prowess. They see lots of patients with multiple chronic illnesses, many of whom qualify for a 99214 office visit. “These doctors become so good at treating complicated patients that they view them as commonplace, not so hard, and they mentally classify them as 99213, which is right in the middle,” says Dacey. The solution? Code scrupulously and give yourself credit for the work you do.

The roots of overcoding

While you must guard against undercoding, Medicare data suggests that, for evaluation and management services, overcoding is far more common. Medicare providers overcode with the ubiquitous 99213, for example, almost twice as often as they undercode with it, according to the latest claims error data from the agency.

One antidote to overcoding is rejecting the conventional wisdom that says the intensity of your service — and your documentation — earns you a particular E&M code. To be sure, you must always hit your marks for the history, the exam, and medical decision making, with each of these components having its particular level of intensity per code. You’d appear to qualify for a 99214, for example, if you recorded a detailed history and detailed exam (for this office-visit series, you only need to measure up on two of the three



components). “But an auditor might ask, ‘Did you need to do all this stuff? Was it medically necessary?’ ” says Bill Dacey. “You can’t manufacture a 99214 from a hangnail.”

Medical necessity, Dacey says, is a payer’s ace in the hole for claims disputes. The Medicare claims-processing manual says as much: “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.”

The AMA also underlines the importance of medical necessity in its CPT manual. The reference book defines five categories of presenting problems — minimal, self-limited or minor, low severity, moderate severity, and high severity — and specifies a category for each E&M code. For a 99214, the nature of the presenting problem, or NPP, is usually of a moderate to high severity, in contrast to a 99211, where the NPP is usually minimal.

Pinning down the NPP level is the key to accurate coding for Stephen Levinson, an otolaryngologist in Easton, Conn., and author of “Practical E/M: Documentation and Coding Solutions for Quality Patient Care.”

“Once you document the NPP, no one can dispute you on medical necessity,” says Levinson.

His book, which was published by the AMA, teaches physicians to arrive at a tentative NPP as part of their differential diagnosis once they take a comprehensive history. For new patients, this is achieved with the help of a patient questionnaire that explores the family and social history as well as the personal medical history (don’t shortchange yourself with a form that doesn’t ask enough questions). To get coding credit for the questionnaire, sign it or note in the chart that you’ve reviewed it. Doctors can score a comprehensive history for established patients by reviewing and updating the initial questionnaire.

The tentative NPP, Levinson says, determines the nature of the exam and the medical decision making that follows. At the end of the visit, make your final decision on the NPP level. Tip: Include a field for the NPP on your hard-copy encounter form or in your EMR.

Want a better idea of how different medical problems grade out on the NPP scale? An appendix of the AMA’s CPT manual titled “Clinical Examples” lists vignettes for each of the E&M codes. Under office visits for new patients, for example, a 22-year-old female with irregular menses falls under 99203. An initial visit for a 70-year-old female with polyarthralgia illustrates 99204. More detailed examples are found in another AMA book titled “CPT Reference of Clinical Examples: Official Scenarios for Correct Coding.”

Diagnostic codes



One common mistake physicians make with diagnostic codes is omitting a fourth or fifth digit that some codes require. The root code for asthma is 493, but submitting just those three digits will cause a claim to flunk. You need two additional digits to complete it. A 493.12, for example, tells an insurer that the patient has intrinsic asthma with acute exacerbation. Design your charge ticket or EHR templates to prompt you to code asthma correctly to the fifth digit.

When it comes to diabetes, some physicians go out to five digits by submitting 250.00, indicating that the diabetes is under control. That's fine, if it is controlled, but they use that code for every darn case, says Bill Dacey. "I'm stunned by how many doctors do that. A 250.00 means Type II diabetes that's under control. What if it's not under control? That's 250.02."

Although it sounds picky, diagnostic codes must be listed in the proper sequence to pass muster with payers. Take a patient with Type II uncontrolled diabetes with background diabetic retinopathy. The code for the eye problem, 362.01, must follow the code for the underlying diabetes. Reverse the order, and you're headed toward Denial City.

As America ages, doctors will treat more patients with multiple chronic conditions, which complicate diagnostic coding. A classic example is the patient with Type II diabetes and hypertension. If he comes into the office with a spike in blood pressure, you're going to factor in his diabetes as you treat him. You'd need to code both hypertension and diabetes in that order — a move that would help you qualify for medical decision making of moderate complexity, which in turn would help you qualify for a level-4 office visit. However, your chart note should explain the impact of the second diagnosis on the first. That may be obvious to you, and not worth documenting, but remember, says Dacey, the chart is not for your personal reading pleasure.

Don't go overboard, though, and automatically include every active diagnosis for a patient on a claim, whether or not it relates to the presenting problem. In other words, you ordinarily wouldn't list congestive heart failure for a patient being treated just for sunburn. Some doctors pile on diagnosis codes in hopes of earning a higher-paying code; others do it mindlessly, often with the help of practice-management software that's programmed to insert the entire problem list. "I turn that off everywhere I find it," says Fischer. "If you include every active diagnosis on claims, you're inviting an audit."

What the watchdogs watch

The US Department of Health and Human Services' Office of Inspector General publishes an annual "[work plan](#)" that details what kind of malfeasance it's going to investigate — such as incorrect and outright fraudulent coding. The document, available at the agency's Web site is required reading for doctors who want to avoid a visit from



the watchdogs.

The work plan for 2009 spotlights several coding foibles. One of them involves place-of-service errors that put more money in a physician's pocket than she deserves. For example, if you see someone in a hospital's outpatient department, your claim should list place-of-service code 22. "However, some doctors will list code 11, which indicates the setting was a physician office, and which bumps up the reimbursement," says Fischer. While a 99213 performed in your office pays \$61.31, for example, it pays only \$44.72 in a hospital outpatient department. Sometimes the source of the error, she says, is practice-management software that's programmed to default all claims to place-of-service code 11.

The OIG is also looking this year at whether doctors are collecting undeserved dollars within global surgery periods. The theory behind global surgery periods is that one fee covers not only the operation, but also any follow-up care, including E&M services, for a specified number of days afterward. The OIG worries that some doctors are sneaking in E&M claims during global periods and justifying them with modifier 24, which indicates the service is unrelated to the procedure. Sure, modifier 24 might sanction a billable office visit with someone who's just been on the table for hernia surgery, and now complains about a sinus infection. But if he comes in with post-operative bleeding? Fuggeddaboutit: Treating that is included in what the government has already paid for.

Coding for hockey pucks

Medicine is evolving, and every change alters the coding genome. Online consults, for example, have gone from a geeky novelty to a mainstream phenomenon that insurers are beginning to reimburse for, provided you code it right.

Coding For Virtual Visits

A few insurers, notably Cigna and Aetna, will pay you for treating a patient's minor problems on the Internet using E&M code 99444. To qualify for it, however, you must satisfy the following guidelines:

- You respond in a timely manner to a patient's online query about his condition. Most physicians practicing e-medicine promise to respond within 24 hours, which sounds reasonable (nobody's supposed to be e-mailing you about emergencies anyway). Getting back to someone two weeks later probably

won't pass the "timely" test.

- It's a stand-alone consult. If you e-mail the patient about an E&M service you've provided him within the previous seven days — he was in your office Monday with a skin rash, and you're giving him additional advice online Wednesday — this activity is considered bundled into the earlier service, and not billable.
- You bill the 99444 only once in a seven-day period for an episode of care. In other words, you can't bill for every back-and-forth e-mail over several days about how to treat someone's urinary tract infection. But if the infection gets worse a week later, and there's another e-mail exchange, you may submit another 99444.
- You must document the online encounter and store it in the record, whether it's hard copy or electronic.

Likewise, there's money to be earned by electronically transmitting prescriptions to the pharmacy. The coding for this is complicated, but you'll want to master it even if you love your prescription pad, because Medicare will impose a 1-percent penalty on doctors who aren't e-prescribing by 2012. The penalty increases to 1.5 percent in 2013 and 2 percent in 2014 and beyond.

Unfortunately, more complexity looms on the horizon. Do you think the Physician Quality Reporting Initiative — Medicare's pay-for-performance experiment — with all its coding hassles is just a trial that some other doctor got suckered into? Well, PQRI represents the future of how all physicians will earn Medicare raises, says coding consultant Betsy Nicoletti, owner of Medical Practice Consulting in Springfield, Vt. "And with Medicare planning to post online the names of doctors who've successfully participated, you risk losing patients if your name isn't on the list," Nicoletti says. Some observers predict PQRI will become a carrot-and-stick program like e-prescribing — shun the program, and you'll suffer a pay cut.

And talk about punitive — ICD-10 and its super-sized set of diagnostic and procedure codes will finally replace the current ICD-9 set in 2013. Start putting aside some serious money to make the switch. The Medical Group Management Association estimates that between training, software upgrades, jammed-up insurance claims, and increased



documentation costs, a three-doctor practice will take an \$84,000 hit due to ICD-10.

True, ICD-9 is outdated, and ICD-10 is the norm for the rest of the advanced world, but progress is still painful. ICD-10 has some 155,000 diagnostic and procedure codes, about 10 times the number for ICD-9. And while ICD-10 lets you code with more precision, how much precision is necessary? Right now, if a surgeon stitches up a kid who's cut in an ice hockey game, he would submit diagnostic code E917.0, which essentially covers any way you can get whacked in sports. Under ICD-10, he can select W21.210 for getting struck by a hockey stick, W21.220 for getting struck by a hockey puck, or W21.32 for getting struck by skate blades. Will doctors be punished for giving up and picking W21.9 — getting struck by “unspecified sports equipment”?

Must-have resources

Your coding skills are only as good as your reference materials. Essential hard-copy resources are anchored by a trio of annual guides from the American Medical Association, all available at its Web site. Buy these guides every year; don't skimp, because codes change, and if you use outdated ones, you're inviting denied claims.

- **CPT 2009 Professional Edition** (\$73.95 member, \$102.95 non-member)
- **AMA Physician ICD-9-CM 2009**, Volumes 1 and 2, softbound (\$72.95 member, \$89.95 non-member)
- **AMA HCPCS 2009 Level II** (\$74.95 member, \$94.95 non-member)

To go a little deeper, consider three more AMA references:

- **Practical E/M: Documentation and Coding Solutions for Quality Patient Care** (\$67.95 member, \$89.95 non-member)
- **CPT Reference of Clinical Examples: Official Scenarios for Correct Coding** (\$74.95 member, \$99.95 non-member)
- **CPT Assistant newsletter** (\$149.95 member, \$199.95 non-member)

Sometimes you want one little handbook that, like a cheat sheet, covers a broad range of topics and summarizes their key points. The science of coding has such a handbook;

- **“The Field Guide to Physician Coding,”** by Betsy Nicoletti, (Greenbranch Publishing, \$79.95).

Complement hard-copy resources with these found online:



- [Medicare Claims Processing Manual](#) from CMS, click on “100-04.”
- [Physician Fee Schedule Look-Up](#) from CMS.

The following Web resource for coding is not only free, but also innovative:

- [Codapedia](#) is a wiki, or collaborative Web site, that draws on the collective wisdom of medical coders nationwide, who will edit each others’ entries for accuracy.

One way to check your E&M coding for accuracy is to compare yourself to your specialty peers. The standard way is to extract your E&M codes from the claims data in your practice-management system and create bell curves for each series, such as office visits for established patients. Then you look at the bell curve for your peers to see if you’re selecting, say, more 99215s than typical.

Where do you find these national bell curves? Armed with spreadsheet software, you can create your own from Medicare data at the [CMS Web site](#). Search for “Medicare Utilization for Part B” and select “Evaluation and Management Codes by Specialty.” If you’re in a hurry, though, you can buy national E&M bell curves:

- “**2009 E/M Bell Curve Data Book**” (DecisionHealth, \$299.99).

Because CPT, ICD-9, and HCPCS codes get changed or deleted throughout the year, experts recommend having an online resource that regularly updates what you’ll find in the AMA’s annual manuals. Here are two:

- **CodeManager 2009** (\$464 member, \$564 non-member). This is a CD-ROM from the AMA that you can refresh with online downloads.
- **CodeCorrect Knowledge PRO** (\$426 per user, one to three users).

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This article originally appeared in the May 2009 issue of Physicians Practice.