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Maintaining Accuracy in Coding Is No Error; You Must Work at It

Make no mistake; accurate coding for services your medical practice offers is more important now than ever before. Further, accurate coding is rarely -- if ever -- the product of serendipity or "happy accident." Medical practices that code accurately do so because they have and use a good system for coding.

Accurate coding can benefit your practice in a number of ways. For example, most practices need to know what it costs to provide services, as part of their practice-wide cost-control efforts. The only way to ensure accuracy is to base the process on codes. Further, comparing managed care contracts is easier and more accurate if the process is code driven.

Fraud

But the main reason to make sure your coding effort is absolutely accurate is legal. The U.S. Department of Justice and the U.S. Department of Health and Human Services (HHS) have made it a priority to crack down on medical crimes, particularly Medicare fraud and abuse and similar offenses, some of which are punishable by fine and/or imprisonment.

If your coding is not pristine, you could be in deep legal trouble, even if you have *no intentions to defraud*. Justice and HHS still call it fraud, even if you didn't mean to. Every time you submit a bill to a third-party payor, accurate, justifiable coding can keep you out of trouble, and lack of it can get you into trouble.

The Centers for Medicare and Medicaid (CMS), which runs the Medicare program, always monitors coding. Particularly, CMS routinely compares CPT codes with ICD codes to determine whether the treatment the physician applies matches the diagnosis he or she makes.

Thus, even if some procedure codes seem unfair to you and tempt you, for example, to "unbundle" service packages to make sure you are fairly paid for *all* services you provide, resist temptation. Lobby for change, but until change happens at the payor level, take no such unbundling action.

As far as CMS is concerned, unbundling is fraud. Taking CMS's lead, other payors are also waiting to file suit against unbundlers. The courts have been extremely unsympathetic toward physicians who are charged with committing fraud; judges and juries rarely agree with the physician's point of view.

Matching Codes

Make sure that you use the codes you need. Three coding systems are essential to most practices:

- Physician's Current Procedural Terminology, Fourth Edition (CPT-4) for procedures;
- International Classification of Diseases, Ninth revision, Clinical Modification (ICD-9-CM) for diagnoses; and
- CMS's (Health Care Financing Administration, which runs the federal government's Medicare and Medicaid programs) Common Procedure Coding System (HCPCS), for materials, including, for example, injectables.

Naturally, if you are a diagnostician, you will have little use for procedure codes in most of the work you do. However, if your practice performs procedures, you must be certain that your diagnosis, procedure, and materials codes all match in every case.

Points to Consider

Understand that:

- Even if you do not use diagnostic codes in your procedure-oriented practice, CMS's OIG will convert your written diagnoses into ICD codes and then match CPT with ICD code, case by case. Obviously, it is better for *you* to use diagnostic codes from the start.
- In every case, the reason established by the diagnostic code must support the action indicated by the procedure code.
- A payor can deny a claim for lack of medical necessity if the diagnostic and procedure codes are mismatched. Further, a payor that detects one mismatch is likely to review closely many of your submissions, looking for other mismatches. A payor that detects a pattern of mismatched codes may take legal action against you.
- Medicare is denying claims if the ICD-9 code (which may have 3, 4, or 5 digits) has not been carried out to its full specificity. Thus, if it takes five digits to describe a diagnosis, be sure to use all five.
- Medicare even considers down-coding to be fraudulent. Thus, even if you accept less payment than you are entitled to receive, you could be sued.

A Matter of Responsibility

If you are in solo practice, code properly. If you are in a group practice, make sure that every one of your colleagues also codes properly. Go to the mat, if necessary. Every doctor in the practice must be committed to accurate coding and become resolutely involved in the coding process. Fraudulent coding -- even accidentally fraudulent coding or down-coding, as opposed to up-coding -- can lead to criminal prosecution of the practice's physicians. It is they, not the practice's non-physicians, who risk discovering all about prison life.

If you are unbundling, stop now. Instead, adjust your operating protocols, if you can. When you are reviewing contracts, review the payor's list of un-bundled surgical procedures. Lobby for changes.

Strive for documentation uniformity if you are in a group practice. No two physicians can be expected to code the same way; they often disagree on such vital starting points as degree of patient illness or injury. Still, each physician can resolve to code consistently and make sure to maintain the documentation necessary to support all coding, all the time.

Strongly consider establishing up a coding form that lists all services your practice provides, by code, as a quick coding reference. If you attach the form to the patient's chart, you can address the chart and the form simultaneously.

It is always the physician's responsibility to *determine* the correct code(s) in each case. Asking a staff member to do so begs for trouble and shirks your responsibility. Establish each code yourself, and leave no doubt about it, so your staff can perform its job without error.

If you are in a group practice, appoint one physician to be in charge of coding education for your group. He or she should attend coding seminars and conferences. Find out whether your specialty and or subspecialty societies offer the specific coding education your practice needs. Attend their meetings, obtain the necessary information, and update the people in your practice -- all physicians and those non-physicians who work with codes, particularly your coding specialists -- as necessary. Be available to answer questions about unusual cases.

Coding Specialist

Have a coding expert on your staff. Physicians are ultimately responsible for coding, but patient care comes first. A non-physician specialist -- perhaps your practice administrator, chief billing clerk, or staff member with no other responsibilities -- will:

- work with your physicians to determine proper coding;
- research the CPT-4, ICD-9, HCPCS, and St. Anthony's procedure texts, the local Blue Cross/Blue Shield books, Medicare and Medicaid publications, your state's procedure code manual (which should include the necessary HCPCS information), and your specialty-specific publications and books;
- obtain and use the commercially available manuals that match CPT and ICD codes and specify which matches are acceptable; alternatively, prepare such a manual in house;
- if your billing system is electronic, make sure that it includes an "edits" function that flags mismatched codes automatically, before they are sent out;
- contract the appropriate specialty societies, insurance carriers, and other expert resources, as appropriate;
- receive, read, use, and keep on file all coding bulletins and announcements;
- attend coding conferences and seminars, as necessary,
- update your practice coding books, computer software, and "superbill" (which includes your most frequently used CPT and ICD codes) annually and ad hoc, as necessary;
- consider joining a reputable coding organization and attend its meetings, sessions, and conferences (the American Academy of Procedure Coders has an informative newsletter and a coding hotline);
- question the physician every time a potential problem is spotted, to select the best possible code and determine if there is an appropriate modifier;
- confer with the physician on each "unusual" case, find out what factors made it unusual, and determine the best way to deal with the situation, in coding;
- randomly pull medical records to perform a self-audit using Medicare's "E/M Documentation Auditor's Instructions" and forms (available in the March, 1996, issue of *Medicare Report*);
- Consider using a billing service, which may decrease inadvertent coding problems and also may show (if necessary to do so in court) that you are doing your best to code properly.

Self-Audit

Periodically perform a practice self-audit of your entire coding system. Your coding specialist is the most appropriate person to audit the system. Consider hiring a business consultant to set up the audit and run it the first time, so you can see the finer points.

To perform your self audit:

- Make sure all practice coding personnel are working together.
- Be certain that all in-house coding materials and forms are up to date and accurate.
- At random, pull a number of charge tickets and compare ICD codes against CPT codes, then compare those findings against the information of the patients charts.
- Use the sample thus generated to compare documentation with billing and make in-house adjustments.

- If yours is a group practice, graph all available coding and cost information for a specific period and use this information to: evaluate physician performance, detect any trends, and make the necessary adjustments.

If you need more information about coding, accuracy in coding, billing and collections, putting together a superbill, or establishing a coding audit, contact us by phone at 800-473-0032 or e-mail at services@healthcaregroup.com.

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