6 steps to better coding

The typical doctor could boost revenue dramatically without doing any extra work. Here's how.

May 20, 2005

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Medical Economics

The doctors in the Louisiana multispecialty group were stunned when they examined their accountant's report. **Over the past year, each doctor had managed to bring in more than $25,000 in additional billings—without adding patients, services, or staff.**

The windfall was simply the result of proper coding, explains Susan Reese, a coding consultant at MedaPhase in San Antonio. Undercoding—especially on E&M codes—is all too common. **Doctors tend to "play it safe" by coding all visits 99212 or 99213, when, in reality, many office visits are level 4 or even level 5. Assuming a 99214 pays approximately $30 more than a 99213, and the typical doctor undercodes three visits a day, that's about $90 per day per doctor in lost earnings.**

Why do doctors undercode? Some may not know the rules. Others may be too rushed. But most doctors say they drop a level **to "stay in a safe coding zone" and avoid government scrutiny**. Practice management experts have long suspected that undercoding is a widespread problem, and now a recent study offers proof. The study ("How Many Problems Do Family Physicians Manage at Each Encounter? A WReN Study," Beasley JW, Hankey TH, Erickson R, et al., Annals of Family Medicine, 2004;2:405-410), which looked at 29 family physicians and 572 patient visits, found that while physicians managed an average of 3.05 problems per visit, they recorded only 2.82 in the chart and even fewer on the bill—just 1.97.

The study also reported that doctors frequently neglect to code for mental health and substance abuse problems, presumably out of concern for patients' privacy. Physicians documented 137 mental health and substance problems, including tobacco use, but only 58 related diagnoses appeared on the subsequent bills.

In short, doctors undercode, underbill, and cheat themselves out of revenue due them.

So how can you stop shortchanging yourself? We asked consultants for their advice. Here are six steps they say are critical.

1. Don't sell yourself short. "Doctors tend to rationalize, 'I didn't spend much time with that patient' or 'I deal with hypertension all the time, so it's easy for me,'" says Reese. "Doctors don't realize that coding levels have little to do with how quickly or easily they come up with a plan of care."

"You can spend only 10 minutes with a patient and still determine the plan of care," explains Carol Pohlig, senior coding specialist for the office of clinical documentation at the University of Pennsylvania Medical Center in Philadelphia. "What weighs in is the effort and risk involved in executing and implementing that plan of care."

"Doctors are sometimes already up to a level 3 visit before they even touch the patient who has chronic diseases in addition to a chief complaint," says C. Nancy Noonan, a consultant from Yellow Springs, OH. For example, say a hypertensive, insulin-dependent diabetic presents with a troublesome cough. You see that the vitals and glucose reading are within normal limits, so treatment for HTN and diabetes requires no adjustment. You examine the patient and note in the chart a diagnosis of an upper respiratory infection. You don't think to document that you've made a considered decision not to change his regimen.

In fact, nontreatment is part of medical decision making, says Noonan. That visit could legitimately have been coded 99214, but instead, it will get a 99213.

2. Establish the purpose of the visit up front. Your hand is on the doorknob, you've already noted the complexity of the office visit, but now your patient says to you, "Oh, by the way, would you mind looking at . . . ." You've just been ambushed into a lengthy exam or counseling session. Afterward, you're even further behind your schedule—there's certainly no time to redo your documentation or figure out the level of this visit. So you take the easiest route and code midway between a minimal visit and a complex one.

One way out of this dilemma is to train your staff to begin your documentation for you, advises Noonan. Have a nurse or assistant ask the patient, "Why are you here today?" and document the chief complaint so that you have an inkling of the visit's complexity before you enter the room. Even better—also have your scheduler establish the chief complaint over the phone so she can allot sufficient time.

If, despite your best efforts, the patient hits you with a last-minute question that's not a medical emergency, try saying something like this: "I'm afraid I don't have time right now to give your headaches the attention they need. Let's see about making you another appointment."

3. Have staff cue you when you're running over. A doctor could spend an additional 20 minutes with that "Oh-by-the-way" pa-tient and lose track of how much total time he's spent in the room, says Jo Ann Steigerwald at Medical Business Con-sultants in Baraboo, WI. Not only is your schedule now out of whack, you may have lost the possibility of billing for

counseling time, which is based, in part, on the percentage of the visit spent in counseling (assuming the visit lasts at least 40 minutes).

Steigerwald's advice: Have a nurse or medical assistant cue you anytime a visit runs longer than expected. Although the doctor may be oblivious to how long a visit is lasting, "it's the staff on the other side of the door that can tell you to a red minute how long the doctor has been in the room," she says. "They're the ones who want to keep the doctor on schedule and the patients happy." That warning will let you document accurately, particularly when counseling is involved.

4. Use templates and cheat sheets. Because so many things that doctors do never wind up in the patient's record, Jean Acevedo of Acevedo Consulting in Delray Beach, FL, suggests that doctors replace their encounter forms with templates.

For example, in Acevedo's state of Florida, doctors often have to obtain and review old records for their retired patients, which adds to the complexity of data, yet she rarely sees a note of that on the record. With a template, where doctors simply need to check a box, that information would be documented.

Also, points out Steigerwald, "doctors aren't good at noting negative or normal findings even though they increase code levels. With a template, they're less likely to fail to document them." Then, away from the pressures of the exam room, either the doctor or a competent staff member can choose a code. The American College of Physicians offers templates at its Web site that you may be able to adapt for your practice. See www.acponline.org/pmc/pcforms

5. Switch to an electronic health record. By auto-mating your documentation, an EHR can vastly improve the speed and accuracy of your coding. And that greater accuracy will mean less undercoding and more revenue. True, EHRs aren't cheap. Some estimates put their cost at $30,000 per physician (including implementation and training). But if undercoding has been a serious problem in your practice, an EHR may pay for itself in just a few years. (For more on how your colleagues are using EHRs, see "Exclusive survey: Doctors and EHRs ," Jan. 21, 2005)

6. Have a certified coder on staff. Either hire one, or train someone already on staff. "The money a good coder will save you by coding accurately will more than compensate for her salary," says Acevedo. Two of the organizations that certify coders are the American Academy of Professional Coders (www.aapc.com) and the American Health Information Management Association (www.ahima.org). (See "Coding credentials for your staff: Why and how," Feb. 6, 2004.)

"Once you have a qualified coder on staff, have this person perform internal chart reviews and pay special attention to your documentation," adds Bruce Rappoport, an internist and consultant at RCH Healthcare Advisors in Fort Lauderdale, FL. "If the coder discovers undercoding, have her show the doctors what they should have coded."

Even CMS agrees

Last year, CMS reviewed about 160,000 claims from 2003 and uncovered $1 billion in underpayment, mostly by Part B carriers. According to the agency, 83.1 percent of all underpayment dollars were for E&M codes, and downcoding by one level was common. Nearly one-third of underpayment dollars resulted from these codes: 99241, 99212, 99211, and 99201. For more on CMS' "Improper Medicare Fee-for-Service Payment Report," see coverage.cms.fu.com/certpublic.