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Internal Medicine Coding Alert

E/M Coding: Stop Downcoding E/M Visits, and Add Minimum of $56 to Your Bottom Line

Trap: You might not only be losing revenue -- you're also drawing chance of audit.

National insurer data shows that physicians undercode E/M claims to the tune of more than $1 billion annually. That's money physicians could have collected based on their documentation but missed out on because they reported a lower-level E/M code than they should have. Read on for three reasons to always file claims based on the physician's documentation instead of "playing it safe" with lower-end codes.

1. Staying Low Doesn't Keep You Below Radar

If you shy away from upper level E/M codes because you don't want to trigger an audit, remember this: Reporting all low-level codes will also get a payer's attention, because reviewers will wonder why your physician never offers high-level examinations.

When claims reviewers review "bell curves" to determine whether a practice is coding outside the norm, they aren't just looking for upcoding -- they are looking at trends across the board. This means that a practice with all 99212s and 99213s will be vulnerable, because nearly every practice sees more complex patients requiring high level E/Ms at least occasionally. If an auditor reviews your records and determines that you're deliberately downcoding claims, they'll conclude that you've been coding improperly, which may prompt them to look at other aspects of your coding and billing. This has been a focus of the Office of Inspector General (OIG) in the past.

2. Undercoding Also Carries Compliance Implications

If you're deliberately undercoding Medicare or Medicaid claims to stay under the radar, you're technically violating the False Claims Act because you are knowingly submitting a false claim.

"It's a violation just as much as deliberate upcoding is a violation, but the government most likely isn't going to pursue it," because ultimately, it saves the program money, says **John B. Reiss, PhD, JD**, a health care attorney with Saul Ewing, LLP in Philadelphia.

Plus: Any such accusations would have to demonstrate that the practice downcoded purposely, whereas the reality is that physicians might report a 99213 rather than a 99214 because they aren't confident that they've met the criteria for the higher code.

"What I'm seeing isn't that physicians are reporting a level one code when they've documented a level five -- they're maybe downcoding one level to be conservative," says **Daniel C. Oliverio, JD,** who heads the False Claims Act Practice Group at Hodgson Russ, LLP, in Buffalo, N.Y. "In many cases, the doctors are playing it safe because they aren't sure they've met the criteria to report the higher code. They don't want an auditor saying, 'you missed a requirement for a higher code, so you've upcoded,' so if there are shades of gray, they're going to play it safe and code lower rather than higher."

3. Remember How Much It Changes Your Revenue

You may think that downcoding claims is only costing you a small amount of money per year, but "If a practice is undercoding just one level, they're probably leaving a massive amount of money on the table over the course of a year," Reiss says.

Example: If your physician's documentation justifies billing a level-four new patient office visit (99204) but she downcodes it to a 99203 because she isn't confident that she has adequate notes to bill the 99204, you've just forfeited about $56.00, which is the difference in average reimbursement between the two codes (based on the national unadjusted, non-facility Medicare rate). If just one physician at your practice does this twice a day over the course of a year, you've written off nearly $30,000 annually.

Best practice: Educate your physicians about how to document thoroughly and select the most accurate code based on that documentation.