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Internal Medicine Coding Alert

E/M Service: Double Check Documentation Before Shifting from 99204 to 99203

Do not attract unnecessary audits due to regular downcoding.

National insurer data from previous years shows that medical practices undercode E/M claims to the tune of over $1 billion annually. That's money that physicians could have collected based on their documentation, but forfeited because they reported a lower-level code than they should have. Your responsibility is to code based on your physician's documentation -- but don't fall into the trap of downcoding just to be "on the safe side."

Could You Be Triggering an Audit?

The top reason many practices undercode is because they don't want to "trigger an audit." However, coding all low-level E/M codes is sure to get a payer's attention, because the claims reviewers will be wondering why you never offer high level evaluations to your patients.

When claims reviewers study "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 once in a while. If an auditor reviews your records and determines that you're deliberately downcoding claims, they'll conclude that you've been coding improperly. This has been a focus of the Office of Inspector General (OIG) in the past.

Consider 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.

In addition, any such accusations would have to demonstrate that the practice downcoded purposely, whereas the reality is that a physician 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 four 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."

Determine How Much Revenue You're Losing

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 for the **CPT 99204** , you've just forfeited about $56.00, which is the difference in average reimbursement between the two codes. 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.