Internal Medicine Coding Alert

Monitor E/M Coding to Protect Reimbursement and Ensure Compliance

No set of codes is more important in internal medicine that those for evaluation and management (E/M) services (99201-99295, new patient and 99211-99215, established patient). Since many internists dont perform the complicated (and expensive) procedures that many specialists do, therefore the bulk of their reimbursement comes from their ability to accurately report all of the history, physical examination and medical decision-making they perform for each patient visit.

In addition, increased scrutiny of medical billing practices by both federal regulators and third-party payers makes it imperative that internists know how to code E/M services correctly, and that they maintain documentation sufficient to justify the levels they bill in the event that auditors come calling.

How can you be sure your practice is receiving the reimbursement it deserves, while at the same time complying with the complicated CPT E/M documentation guidelines and other coding and billing requirements?

The answer, many practices have found, is to audit your own charts before someone else decides to.

We started doing it [auditing] when the E/M codes first came into existence in 1996, says **Beth Jordan,** office manager for New Bern Internal Medicine and Cardiology, a practice in New Bern, NC, that employs nine physicians, a physician assistant (PA) and a nurse practitioner (NP).
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Jordans staff randomly selects 10 charts from each physician (as well as those of the PA and NP) each month and, using the E/M documentation guidelines, checks the documentation against the codes reported for that visit, she explains. In the beginning, the doctors audited each others charts, she continues. I gave Doctor As charts to Doctor C. Now, however, we have a coding specialist and she audits the charts.

Internal Audits Reinforce Coding Diligence, Highlight Problem

When the practice first started internal chart audits, Jordan noticed that many of the physicians were undercodinga common problem in internal medicine.

To solve this problem, we all meet once a month and go over any documentations and/or coding problems that we find. Also, we pick two codes a month to review our coding, she reports. Our coding specialist educates the physicians about what diagnosis warrants the codes selected, and what procedures warrant which codes.

For the seasoned MDs, we pull the 10 per month. For a new physician, she audits each chart until the doctor becomes comfortable with the documentation requirements, Jordan explains.

The physicians at New Bern are responsible for assigning the visit level themselves, Jordan says. The coder sometimes performs audits for specific codes, or if a problem or irregularity is noticed when the data is entered.

Sometimes, if we get a new patient and the visit is reported at a level 5, then we would look back at the physician documentation to make sure it warrants that level of E/M service, she says. We also do other random checks throughout the month on particular codes, such as consult levels and other similar items.

I still, at this point, have one or two physicians that tend to undercode, she reports. But the random audits help. They are important to the practice because they prevent lost reimbursement and ensure that they are complying with all regulations, she stresses. This keeps everybody on their toes in terms of the requirements.

Audited Charts Ease HMO Reviews

Another benefit of internal audits is that charts already looked over by the physicians staff are definitely ready in the event of a chart review by a third-party payer, says **Diane Baxter,** office manager for Internal Medicine Associates, a two-physician practice in Chestertown, MD.

If you have a chart review by an HMO, your charts are ready, she explains. It works out really well and saves time in the long run. A lot of times the HMO asks for some of the same charts you have already audited internally and you know everything is going to be fine.

Baxters practice contracts with HMOs who often review charts to ensure they meet their own HEDIS regulations, she explains. They ask for specific charts, especially if they are doing a case study, where they are looking for diabetic patients or HIV patients. We do audit the charts randomly, but it is so much easier if you have charts among them that have already been audited.

Baxter also notes that her practice is able to easily audit the physician charts because they both use dictation and the chart information is given to the staff in typed form.
All of the doctors dictate their charts and the dictation is typewritten so they are very easy to read, she says.

This also helps ensure compliance because there is no question about what is documented in the chart, she adds. There is no question about their handwriting or whether something was done. It makes it easy when patients are transferred as well, if another office has to read them.

Determine if You Are at Risk for an Audit

Another way to get a rough idea of how well your practice is coding E/M services is to compare how often you report particular codes to national averages, states Brett Baker, third-party relations specialist with the American College of Physicians-American Society of Internal Medicine (ACP-ASIM) in Washington, DC.

The Health Care Financing Administration recently published a database of the frequency that each CPT code is reported by different specialties. The database is available on the administrations website at: http://www.hcfa.gov. (See related story on how to download and interpret the database in the next column.)

Internists shouldnt try to conform to that average, it will just give them an idea of what other physicians are doing, he explains. But internal practices should be aware that third-party payers (including Medicare) maintain information on how often each code is reported in their area, says Baker. It is widely understood that carriers decidewhen they do their post-payment auditingwho to audit based on local billing profiles. If you are at the high end of utilization, if you are reporting more high level codes than other physicians in your specialty, in your region you are more likely to be audited, Baker continues.

This does not mean that physicians who report a lot of high-level codes are coding incorrectly, he emphasizes. If you are a internist who sees a lot of patients with complex medical problems, you are more likely to report higher codes. You just need to be aware of that and make sure that your documentation supports the services you report, Baker cautions.

The specialist also notes that the HCFA information is a national average, and carriers will be more interested in local billing patterns, but this is the only information of its kind that is available.

We have been pushing HCFA to tell its carriers to distribute out this kind of information that they have collected on specialties, just for educational purposes, but they have been reluctant to release that information and I dont know of a region that is doing it, he says.

Carriers do perform random prepayment reviews of E/M codes to obtain data on whether the providers documentation is up to speed. But, they havent put anything out to the providers that would help them improve if there is a problem.

ACP-ASIM is working with its state chapters to collect localized information that would be distributed to its member physicians, Baker says.

Another concern is that physicians, hoping to avoid any possibility of a Medicare audit or investigation, are coding too conservatively and under-reporting their services, Baker says.

He hopes that by comparing their E/M billing patterns with national average, some internists may go back and reevaluate their coding methods to ensure they are getting proper reimbursement.

Again, you shouldnt take this information and say, Heres where my specialty stands and I should conform to that, but it will give you an idea of where you stand, he clarifies.