Part B Insider (Multispecialty) Coding Alert

E/M Coding: Answer the $56 Question--Are You Downcoding Your E/M Visits?

You're not only losing revenue--you're also coding improperly.

CMS 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. But remember that your responsibility as someone who submits claims to Medicare is to code based on the documentation-- anything else is incorrect coding.

If you're one of the practices that's downcoding claims, take note of the following reasons that you should code based on your documentation rather than undercoding.

Could You Be Triggering an Audit?

The number one reason that 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 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 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.

Consider Compliance Implications

If you're deliberately undercoding your 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 Medicare 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 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."

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.

For 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 Part B 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.