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Part B Insider (Multispecialty) Coding Alert

PART B MYTHBUSTER: Avoid Basing Code Selection on SuperbillChoice -- Or Risk Denials

No matter which specialty you code, bill based on documentation -- not the codes circled on the superbill.

Myth: If your physician circles his E/M code on the superbill after seeing a patient, then he's already done your job for you.

Reality: Submitting a claim to your carrier based solely on the physician's writing on the superbill could put you at risk.

A practice wrote in to the Insider with the following question: "Our office manager is trying to 'streamline' the E/M coding process and has asked that we code from the charge ticket (superbill) only -- without access to the patient record. We're not totally comfortable with that type of process. Can you advise?"

We asked our experts to help this practice -- check out their advice below and determine whether you're in the clear.

Separate Superbill From Record

"The fee slip is a communication tool between the physician and the front desk/coder/receptionist/support staff," says **Suzan Berman-Hvizdash, CPC, CEMC, CEDC,** coding and compliance manager for UPMC-Surgery/Anesthesia. "It actually should not become part of the medical record. It should be kept in a separate financial record if that is accessible."

Therefore, she advises, "The coding on the fee slip is just that, a communication to the person entering the charge that the physician believes that is the level of service performed. If the documentation doesn't match, it's the documentation that drives the code -- not the fee slip."

Rule Applies to All Services

You should avoid coding directly from the superbill in all aspects of your practice -- not just E/M.

"Coding directly and only from the superbill is what I call a 'two-edged sword,'" says **Leslie Johnson, CPC,** coding supervisor for Duke University Health System and owner of the billing and coding Web site AskLeslie.net.

"While there is absolutely no doubt that this kind of coding is faster in terms of productivity time for claims processing, this process is also laden with possibilities for errors and missed revenue," Johnson says. "First of all, if the superbill is incomplete or out-of-date, this can have serious consequences. Secondly, if the person entering the data can't confirm procedures done, incorrect claims can result." This applies to all specialties across the board, Johnson points out.

In fact, the American Society of Anesthesiologists (www.asahq.org) notes, "Billing slips or superbills do not replace the anesthesia record. Documentation of the clinical services provided must appear in the patient's medical record, not in an extraneous document. The practice of using billing slips or superbills alone to bill for anesthesia services is not recommended. Although convenient, the check-offs & shortcuts that are the essential elements of the billing slip can lead to inaccurate coding. If billing personnel do not bill from the anesthesia record based upon the services actually documented, they're billing blindly."

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Your best bet: Always use the documentation to confirm that the physician selected the right code. If not, bill the code that best fits what the physician recorded in the patient's medical record, and not what he circled on the superbill.

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