

## Eli's Rehab Report

### Rank Your CPT Code Use against National Averages

CMS doesn't have a crystal ball that reveals where your practice stands against other PM&R providers, but it does have a secret weapon. The U.S. Health and Human Services Department Office of Inspector General (OIG) compares your code use statistics to national averages to find red flags, such as physicians who consistently bill high-level E/M visits.

Benchmarking comparing your practice's code use to national averages can help you determine if you might be upcoding and help your practice find lost revenue if any of your physicians routinely undercode to stay on the conservative side.

#### Why E/M Benchmarking Works

Before you benchmark, you should understand that your practice's code use won't always mirror the national benchmarking averages. First, note that CMS's most recent utilization data is from 2000, which means it may be slightly outdated.

In addition, "Benchmarking may not be an exact science because it cannot take into account all the idiosyncrasies in the population base," says **Frank Cohen**, senior analyst at Medical Information Technology Systems, a national healthcare consulting firm, and author of *The E/M Bell Curve*. For instance, if you try to benchmark your practice's use of a specific code, such as 99263 (level-three follow-up inpatient consultation), the actual numbers depend on your practice's population base. If you are a hospital-based psychiatrist, you will likely bill significantly more inpatient consultations than an office-based physician would.

Consequently, most consultants recommend that practices perform an E/M comparison study because all psychiatrists perform at least some type of E/M service. CMS lists the raw data on its Web site, from which you can filter out the information for PM&R and calculate average percentages. (For utilization data regarding the most commonly billed E/M codes, as well as joint injection codes, see the chart on page 13.)

#### Use the Data Carefully

You should use this data in several ways, says **Eric Sandham, CPC**, compliance manager for Central California Faculty Medical Group, a group practice and training facility associated with the University of California at San Francisco in Fresno.

1. Review Data across Categories. For instance, determine the relationship between outpatient consultations (99241-99245) and new patient office visits ([CPT 99201 - 99205](#)), and then compare that to the national averages using the CMS database, Sandham suggests. If you are billing more new office visits than consultations, your practice may be confusing your consultations with referrals.

The point here isn't suddenly to start billing all of your new patient visits using consultation codes, but to prompt you to ensure that you're coding the charts correctly and that you aren't missing out on reimbursement (or collecting too much of it).

2. Review Data within Categories. For instance, compare your range of established patient office visit codes to Medicare's. Although your practice may bill mainly 99215s, the CMS data show that the average PM&R practice bills more 99213s. This should inspire you to determine whether you routinely upcode claims.

"You want to determine whether you are billing way above or below the average, and whether you use any particular code disproportionately for instance, you bill all 99214s," Sandham says.

## Don't Take CMS Averages as Gospel

Practices should not change their coding practices just to stay within the averages, Sandham warns. "If you have a higher utilization profile, you may simply be treating sicker patients."

For example, the chart shows that the average physiatrist bills 41 percent of his or her subsequent hospital care encounters as 99231s and only 4.5 percent as the higher-level 99233. But suppose you specialize in treating stroke patients, requiring more-complex hospital care evaluations. As long as your records demonstrate medical necessity, the averages should not cause you suddenly to stop billing for the more-comprehensive visits your patients require.

In addition, Medicare draws the statistics from unaudited data, Cohen says. Consequently, some of the statistical codes were probably assigned incorrectly. "Also, the CMS data is all Medicare, and your practice probably is not." (To learn how to normalize your practice's utilization against the CMS data, which is 100 percent Medicare, see "Make the Correct Code Comparison" in article 6.)

## Benchmark in the Community with Caution

Some practices choose to benchmark against similar practices in their geographic area, but Cohen does not recommend it.

For instance, the Smithtown PM&R Association decides to compare E/M code utilization averages among its member practices, he notes. "First of all, one practice may treat mainly patients rehabilitating from hip replacements, while another deals with stroke patients, so they won't be performing the same procedures, and therefore, comparing the frequency of a certain procedure code will not be accurate."

In addition, this type of comparison assumes that both practices are coding properly. "If you only bill 200 99215s a month and another local physiatrist bills 500, that doesn't mean you should start upcoding claims," Cohen advises. "If that practice is coding incorrectly, the entire model is skewed and can actually cause the OIG to look even more closely at your practice because it may say, 'Everyone in Smithtown is overbilling, let's look more closely at them.'"

## Compare Your Practice to Itself

The best benchmarking advice is to compare your practice's code use for one time period against your data for another period, Cohen says. For instance, compare your 99215 usage from January through June to your 99215 statistics from July through December. If the comparison shows a big change in the way your practice billed, look further to determine why. You may be coding more accurately now, or vice-versa. Keep an eye on compliance when comparing annual utilization statistics so you aren't tempted to say, "We billed more high-level codes last year, so let's report more of them this year."

You should also compare physicians' utilization individually, Sandham recommends. "Compare each physician in the practice to the group as a whole, then to CMS. Even though you may be on track with CMS's data, you may find that one physician in your practice is billing too high and that another is billing too low this would put you on average in the middle, but it doesn't mean that the physicians are coding correctly."

If your physiatrist is part of a multispecialty practice, do not compare his or her E/M code use against the other specialists' because the statistics can differ widely between specialties. For instance, physiatrists billed more than twice the number of 99203s than neurologists did in 2000, according to CMS. Neurologists, however, reported 99245 almost 14 times more than physiatrists did during the same year.