Beware the Pitfalls of Downcoding E/M Services

Downcoding evaluation and management (E/M) services, that is, selecting a code that reflects a less complex or lower-level service than the one actually provided, may appear to be a reasonable way to avoid unwanted scrutiny by the Department of Health and Human Services’ (HHS’s) Office of Inspector General (OIG). However, reimbursement experts call the practice self-defeating. For honest providers, and most providers are, it simply means that they will see their cash flow diminish.

The truth of the matter is that, technically, downcoding may be interpreted as fraudulent because it essentially involves a request for reimbursement for services that have not been provided, despite the fact that more complex services have been provided. Although it is unlikely that the government would prosecute someone under these circumstances, especially since the effort has not generated a true Medicare overpayment, it is not inconceivable that an overzealous investigator might order the suspension of provider reimbursements in the face of such activity.

Two recent studies, one by the Medicare Payment Advisory Commission (MedPAC) and the other by two independent medical researchers in Ohio, have attempted to shed some light on the trends in physician billing for E/M services.

MedPAC Findings
MedPAC indicated in its March report that some statistical evidence seems to show that physicians are undercoding for services that have not been provided, despite the fact that more complex services have been provided. Although it is unlikely that the government would prosecute someone under these circumstances, especially since the effort has not generated a true Medicare overpayment, it is not inconceivable that an overzealous investigator might order the suspension of provider reimbursements in the face of such activity.

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E/M services. Although data are inconclusive, MedPAC said the drop might signal that physicians are under-coding their services out of fear of government fraud-and-abuse control efforts. The commission’s examination of physician coding for E/M services shows that a shift toward higher-level E/M services occurred between 1993 and 1997. The trend then reversed itself in 1998, when physician coding of all levels of E/M services declined. The annual change in coding intensity documented by MedPAC was as follows:

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<tr>
<th>Type of Service</th>
<th>1993–97</th>
<th>1997–98</th>
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<tr>
<td>Office, new patient</td>
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<td>-1.8%</td>
</tr>
<tr>
<td>Office, established patient</td>
<td>1.0%</td>
<td>-1.6%</td>
</tr>
<tr>
<td>Hospital inpatient, initial care</td>
<td>0.6%</td>
<td>-0.6%</td>
</tr>
<tr>
<td>Hospital inpatient, subsequent care</td>
<td>1.5%</td>
<td>-0.7%</td>
</tr>
<tr>
<td>Emergency department</td>
<td>1.6%</td>
<td>-2.8%</td>
</tr>
</tbody>
</table>

“We want to see [the] right coding,” said Gail Wilensky, PhD, chairperson of MedPAC. “It is not appropriate to have people underbill for the services that they are providing, and it’s not fair.” Wilensky explained that MedPAC wasn’t able to isolate exactly why the coding drop occurred. The decrease could have been because physicians began undercoding, or it could reflect a return to more appropriate coding. Some physicians have stated that they undercode because they don’t understand the complex E/M documentation requirements. MedPAC plans to continue watching this trend, Wilensky said.

Family Practices Under a Magnifying Glass

What two medical researchers in Ohio have seen in family practices may shed even more light on the issue. George Kikano, MD, FAAFP, and Kurt Stange, MD, PhD, in the Department of Family Medicine at Case Western Reserve University in Cleveland, asserted that little is actually known about the accuracy of family physicians’ use of CPT coding for office visits, despite increased administrative oversight of Medicare billing practices. That is why Kikano and Stange compared the concordance of E/M services reported for 3,791 visits to 139 family physicians in northeast Ohio.

Kikano explains that “no studies have compared directly observed office visits with physician-assigned E/M billing codes. Most studies are done for financial reasons and are conducted after the fact. This study compared actual E/M billing codes assigned by family physicians with codes assigned by a trained nurse directly observing the same patient encounters.”

The length of visit, reason for the visit (categorized as acute illness, chronic illness, or well care), presence of a medical student, presence of another family member, and discussion of another family member’s problem were documented. The research nurse also recorded whether a drug was prescribed, a referral was made, whether the patient requested preventive services, or help with a behavioral change or emotional issues.

Findings showed that family physicians’ medical record documentation corresponded with their billing practices for outpatient services in more than half (55 percent) of the visits reviewed. Compared with billing codes assigned by standardized medical record reviews, undercoding and overcoding occurred with similar frequency, and differences were usually limited to one level of complexity differing from the expected CPT code.

Undercoding was more common than overcoding for visits by established patients, who constitute most outpatient visits to family physicians. For visits by new patients, both undercoding and overcoding were more common than for established patients, but overcoding occurred more often than undercoding. Despite higher fees for new patient visits, results of the study suggest that physicians overcode for the additional administrative burden of caring for new patients, which is not fully reflected in the medical record for the visit.

The most accurate billing was for acute-care visits when drugs were prescribed. The least accurate billing was for visits that included time providing preventive services and visits in which the...
Joseph Heyman, MD, a Massachusetts Ob/Gyn and PPAC member, was concerned that the vignettes would be expensive to develop and that carriers would use them to their advantage. “I’m opposed to doing the vignettes as an official HCFA-written guideline,” Dr. Heyman said at the meeting. “I’m worried that if they’re used as an official thing, they will eventually become a carrier’s way of [determining] whether or not someone has met the guidelines.”

Concerns were also raised that the vignettes could prompt specialists to compare services in an attempt to determine whether a particular service should be coded as a high-level E/M service. As such, the PPAC recommended that language should be added to the documentation guidelines that makes it clear the vignettes are for educational purposes and not for cross-specialty comparisons.

An independent contractor will work with specialty societies and the American Medical Association to develop the vignettes. HCFA expected that initial studies would be completed by the spring of 2001, with an evaluation of the draft June 2000 documentation guidelines by July 2001. However, at the PPAC meeting, Paul Rudolf, MD, executive director of the PPAC and senior technical advisor for HCFA’s Center for Health Plans and Providers, stated that the agency was running behind on developing the vignettes, but planned to have a contractor chosen by September 30. HCFA expects the process of developing specialty-specific vignettes to take three months.

Reducing the Number of E/M Service Levels

HCFA also plans to study whether it should revise the E/M codes to reflect three levels of services, rather than the current five levels, and to provide information it gathers to the AMA’s CPT Editorial Panel. One question that physicians raised on this issue is whether a reduction in the number of levels of E/M coding would result in payment cuts. According to Robert Berenson, MD, director of HCFA’s Center for Health Plans and Providers, precedent exists for maintaining budget neutrality in such circumstances, meaning that overall physician payments would not be reduced. However, he cautioned physicians at the meeting that no definitive plans have been made to reduce the number of E/M levels.

Physician Immunity

HCFA plans to test the draft 2000 documentation guidelines in a nationwide pilot project, which it hopes to launch late this year. Another pilot project will concentrate more on how physicians make medical decisions and less on history and physical examinations. The agency also plans to incorporate peer review of records into the pilot study, possibly by having physicians examine claims that a nonphysician reviewer has denied or assigned a lower level of service. Physicians at the PPAC meeting were concerned about whether HCFA will offer immunity to physicians who participate in this pilot study.

AMA Executive Vice President E. Ratcliffe, Jr, MD, asked that HCFA’s proposed pilot-test program be made as “user-friendly” as possible so that physicians and regulators can work out any problems “in as constructive a manner as possible.”

HCFA officials explained that Medicare statutes and regulations prevent them from offering immunity to physicians, but said they thought physicians wouldn’t be subject to a full-scale audit if reviewers found a miscoded service in the medical records examined for the postpayment study. Of course, the physicians would still have to reimburse the government for any overpayments.

Source: PPAC
Urinary incontinence is a big health issue, which is estimated to cost $10 billion each year for the care of individuals with this disorder. And the cost is exceedingly higher in the loss of quality of life for those patients whose activities become restricted due to incontinence. Estimates from the U.S. Department of Health and Human Services (HHS) put the number of individuals that suffer with this condition at 15 million, with 85 percent of them being women. Embarrassment often prevents patients from discussing it, even with their physicians, and many people remain undiagnosed and untreated as a result.

Since there are many different types of urinary incontinence, with a large variety of causes and treatments, classifying the diagnosis poses a problem for physicians and coders alike. Not all treatments cure the condition, but it is often possible to diminish the symptoms. Not only is it important for physician practice staff to select the code most appropriate for the type of urinary incontinence the patient has, it is also important to know and assign the proper code for the patient’s underlying condition, if known.

Bladder Composition 101
It is important to first understand the normal functioning of the urinary system, which is made up of the bladder, urethra, and kidneys, to understand incontinence. The kidneys remove waste materials from the blood and produce urine. The ureters are muscular tubes that carry the urine from the kidneys to the bladder, which serves as a urine reservoir.

As the bladder continues to fill with urine, it stretches, leading to the sensation of the need to urinate, which is usually when the bladder contains half of its capacity, or 250 ml of fluid. The brain and spinal cord also play a vital role in the process by allowing the bladder to contract and the sphincter muscles to relax as urination takes place. When micturation takes place, the urine is eliminated via the urethra, another tubelike structure, which is about 5 cm long in women and 20 cm long in men. The urethral sphincter, a circular muscle that surrounds the urethra, controls the flow of urine.

Transient Incontinence
Incontinence may be classified as “transient” or “established.” Although transient types of incontinence may be of long duration, it is important to recognize that this type is due to problems other than the urinary system, and is relieved by treatment of the underlying condition. Urinary tract infections (UTIs), alcohol, fecal impactions, atrophic urethritis, and vaginitis may cause this disorder. In addition, drugs such as diuretics, sedatives, narcotic analgesics, and antidepressants (to name a few) also may be the underlying reason for transient incontinence. Furthermore, impairment of mobility may result in functional incontinence, especially in the elderly or disabled who may find it difficult to get to the bathroom in time.

When incontinence is a symptom of an underlying condition, such as a UTI, it should not be coded separately. However, if transient incontinence is evaluated and is listed as a diagnosis in the patient’s chart, you would assign code 788.39.

Bladder Composition 101

Types of Established Urinary Incontinence
Urge incontinence is often referred to as “overactive bladder.” It is defined as unintentional urine loss associated with a strong sense of urgency, and is classified to code 788.31. In most cases, it is due to sudden involuntary contractions of the bladder (detrusor instability or DI), which is classified to code 596.59. However, when DI occurs due to nerve damage along the pathway from the bladder to the brain as a result of neurological disorders, such as a stroke or multiple sclerosis, the condition is referred to as detrusor hyperreflexia (DH), and is classified to ICD-9-CM code 596.54. Code 344.61, also listed as a subterm in the ICD-9-CM alphabetic index, would not be selected unless the physician specifically states that cauda equina syndrome is present.

Other urinary incontinence
Stress incontinence is evidenced by involuntary urine loss that occurs with coughing, sneezing, laughing, and other physical activities. This treatable type of incontinence may be due to physical changes brought about as the result of pregnancy, childbirth, and menopause. For this reason, it is more commonly found in women.

An intrinsic urethral sphincter deficiency, or ISD, also may result in stress incontinence. This condition may be congenital, such as among patients with myelomeningocele or epispadias, or it may be acquired due to trauma, radiation therapy, a lesion of the spinal cord, or a prostatectomy. When incontinence occurs as the result of ISD, the patient may experience constant leakage, even at rest.

This type of situation often requires the assignment of multiple codes. For instance, let’s say a patient who is status post prostatectomy is suffering from stress incontinence due to ISD. In this scenario, you would first assign a code to indicate the urinary complication of the prostate surgery. Since ISD is a known complication of the surgery, report code 997.5. Next, assign code 599.82 for the ISD, followed by the code for the stress incontinence, 788.32, as additional diagnoses.

Mixed incontinence combines symptoms of both urge and stress incontinence, with one symptom predominating over the other. This type is common in older women.

Overflow incontinence occurs as the result of overdistention of the bladder. Symptoms may be similar to those of urge or stress incontinence, or involve frequency of urination, and/or frequent or constant dribbling.

This type of incontinence occurs as the result of drugs, diabetes, spinal-cord injuries, fecal impaction, or a disturbance of the detrusor muscle motor nerve.

In women, obstruction can occur as the result of severe genital prolapse or surgical overcorrection of urethral detachment.

Men may experience it as the result of hyperplasia or carcinoma of the prostate, or due to urethral stricture. This type is classified to code 788.39.

Source: St. Anthony’s Illustrated ICD-9-CM Code Book, 1999

A source at AdminiStar Federal, Inc. says that the Health Care Financing Administration has ordered a delay in implementing parts of Version 6.2 of the National Correct Coding Initiative (NCCI) edits.

"Based on an instruction from HCFA released the week of September 10, new additions to Version 6.2 will be implemented with the effective date of September 5 and not August 14, as was the original delay from July 1," the source says.

AdminiStar Federal’s coding specialist, Linda Dietz, RHIA, CCS, CCS-P, states that “there is some confusion among carriers and their standard system maintainers about HCFA’s instruction on changing effective dates, so I cannot be sure that everyone is on board with this change yet.”

### Medicare Fee Schedule Database

Changes Boost Pay for Common Procedures

Changes contained in the final update to the year 2000 Medicare physician fee schedule database (MPFS-DB), for the most part, mean higher payment for some commonly performed procedures. Although the final update was implemented October 5, 2000, retroactive to January 1, 2000, don’t expect Medicare carriers to go back and adjust claims that have been paid already. However, carriers have been instructed to adjust claims brought to their attention. The final update impacts the transitional practice expense relative value units (PE RVUs) for the following:

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<th>Nonfacility PE RVU</th>
<th>Facility PE RVU</th>
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* -TC = technical component

Source: HCFA program memorandum B-00-40
Designate a Compliance Officer
Under the OIG’s Compliance Guidance Plan

As one of the seven core elements listed by the Department of Health and Human Services’ (HHS’s) Office of Inspector General (OIG) to be included in a compliance plan, designating a compliance officer in your practice may seem like an easy task. However, it is one that should be taken very seriously.

Naming a compliance officer is one area where the OIG has tailored the compliance plan elements. A practice should designate a compliance officer to oversee the compliance program, but this person may have other duties as well. The compliance officer could be the office manager or primary biller. Alternatively, a practice could outsource all or part of the functions of a compliance officer to a third party.

A practice also could designate more than one employee to carry out compliance monitoring. In lieu of having a designated compliance officer, a practice could designate “compliance contacts.” For example, one employee could be responsible for preparing written policies and procedures, while another could conduct periodic audits and answer billing questions.

The OIG says the key to holding the position of compliance officer is that the person should be sufficiently independent in his or her position so as to protect against any conflicts of interest that may arise from performing various duties. However, critics of the plan find this statement unreasonable. By virtue of being the primary biller or office manager, this person would be directly involved in areas of risk already identified by the OIG. Therefore, the expectation that this person could avoid any conflict of interest is unreasonable.

In addition, critics also point out problems with defining the duty of the compliance officer to ensure that practice employees and physicians “know, and comply with, pertinent federal and state statutes, regulations, and standards.” Given the tremendous amount of information this involves, some medical office professionals feel that practices will be lucky if the compliance officer/contact can know all of the applicable regulations and standards, let alone make sure that everyone else in the practice knows and complies with them.

Source: Federal Register, June 12, 2000

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VA and OH please add sales tax
Shipping and handling $9.95
Total amount enclosed

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Charge my:  MasterCard  VISA  Discover
AMEX
Card #: ____________________________
Exp. Date: ____/____/____
Signature: __________________________
Check enclosed. (Make payable to St. Anthony Publishing.)
Check#: ____________________________ P.O.# ____________
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For fastest service, please call (800) 632-0123, and mention source code 2291.
patient raised emotional issues or requested help with a change in behavior.

Underbilling was more common for visits by children, longer visits, visits involving greater amounts of time spent in negotiation, and visits resulting in a referral.

On the other hand, overbilling was more often observed for visits in which more time was spent planning treatment, visits in which the patient requested preventive services, and visits during which a medical student was present.

Stange states that “the E/M documentation guidelines poorly fit the common family practice visit where several problems may be presented. The majority of care provided by family physicians is for established patient visits. In fact, we found that family physicians are presented with an average of 2.7 problems during the course of a visit. For instance, a family practice physician may spend two minutes dealing with a patient’s hypertension, three minutes on prevention, and two minutes on acute-care concerns.”

“More attention needs to be paid to the medical decision-making component [and] the cognitive value of treating the patient during a primary care visit,” says Kikano. “Determining how the pieces fit together is the most vital part of patient care in the primary care environment.”


Questions and Answers

Nose Laceration

Q What code should I use to report a laceration of the bridge of the nose?

A You can find the correct ICD-9-CM code for this condition by looking in the ICD-9-CM alphabetic index under the main terms “Wound, open” and the subterm “nose,” which references code 873.20. Notice that other subterms indicating complicated wounds, multiple sites, and wounds that include the septum and sinuses are all indented under this subterm, so make sure that you verify your selection in the tabular list.

873.20 Other open wound of head, nose, unspecified site

Code for Drug-Seeking Behavior

Q How should I code a situation in which a patient presents to the office with vague complaints only for the purpose of obtaining drugs from the physician?

A This is a common scenario, particularly in emergency departments, because some drug abusers go from physician to physician to obtain drugs. You would assign code 305.90 first to report the drug abuse, followed by code V65.2 to report the fabricated illness.

305.90 Other, mixed, or unspecified drug abuse
V65.2 Person feigning illness