Do You Know the Code for Success?

CODING ISSUES FOR EVERY BILLING COMPANY

By Holly Louie, RN, CHBME

Billing codes are the source of every payment for every service. Code it wrong and payment will be wrong. Whether a billing company codes or "only" bills, codes equal money.

The term "coding" actually includes changing codes, linking diagnosis and procedure codes, adding modifiers, adding digits to incomplete codes, and sequencing codes. Many billing companies that "do not code" actually perform some or all of these activities at times. Regardless of who is responsible for designating the code(s), billing company policies and procedures should address coding. It should be part of compliance training in every billing company.

Accurate coding is based solely on legible medical record documentation. If the billing company does not code, the mechanism by which the client verifies the accuracy of codes submitted for billing should be explicitly documented. Incorporation into the contract is the most desirable method.

THE BIG PICTURE

Coding is used by payors for more than simply issuing payment. All payors track codes submitted and/or paid. It is common for payors to share this data in the event questions concerning accuracy, frequency, validity, veracity, or medical necessity arise. Payors also compare coding patterns, known as profiles, to other practitioners or providers of the same specialty in the same geographic region. Geographic regions are compared to national patterns. The Centers for Medicare and Medicaid Services (CMS) *Progressive Corrective Action Plan (PCA)* uses data profiling to identify practitioners/providers who deviate from the norm. The intent is to focus resources and audits on investigating only when data indicates probable problems. Specific actions, based on the audit error rate, are defined. Patterns that deviate from the norm may not mean there is a problem, just as patterns that mirror the norm do not mean the codes submitted were correct.

CODING LIABILITY

The fact that a billing company does not code does not necessarily mean it has no accountability if a client codes improperly. The Office of the Inspector General (OIG) believes a professional billing company should be able to recognize potentially erroneous claims and refrain from submitting them. Every billing company should have the tools to compare the codes it submits on behalf of clients to the appropriate averages. This allows prompt identification of patterns that *may* indicate errors and merit investigation. Physicians are able to obtain their personal profile from the Medicare carrier that processes their claims. Billing companies should encourage and assist clients in obtaining the information. If the physician is willing to share this information, the billing company has a base line to begin profiling Medicare data. Non-Medicare data is available from many national and state specialty associations.

CODING AS VALUE ADDED

The development of reports to track and trend coding patterns is useful and need not be difficult. An excellent starting point is profiles by the types of errors listed in the OIG Compliance Guidance for Third Party Medical Billing Companies. Examples include upcoding, clustering, and improper use of modifiers. Coding risk areas that are itemized in the applicable compliance guidance for the type of services you bill (hospitals, physicians, laboratories, etc.) should be included in your profile reports.

In addition to the bell curve analysis of Evaluation and Management services, reports should be developed that look at total numbers of services by time. Carriers use the average time assigned to each Evaluation and Management service as a baseline. How many services did the physician perform in a twenty-four hour period? Add timed services, such as critical care, to the total. Add the time for the total number of procedures. CMS considers minor procedures to be approximately five minutes. CPT-starred procedures are a reasonable equivalent. One source for the average times assigned to major procedures is found in the CMS anesthesia calculations. Every service performed should be assigned its average time and the total should be divided by hours in the day (24) or by the number of hours the physician typically works per day. *(continued on page 10)*

(continued from page 9) If the result is consistently unreasonable, investigation is appropriate.

Payor denials provide another important compliance profiling opportunity. Persistent billings of invalid, not allowed, unbundled, not covered, or not-medically-necessary services could be defined as abuse and trigger a carrier review. High numbers of duplicate claims may also be abusive. Duplicate claims that consistently constitute more than one percent of total claims have been cited as an unacceptable average.

CMS consider the explanation of the reasons for benefits denial to be an educational tool. In other words, you knew or should have known what you were doing incorrectly! Billing companies should have procedures to post denial reasons by code, physician, and/or practice to allow timely and accurate analysis of unpaid claims. Communicating denial patterns to the coder and client should be a priority. Reports reflecting the type and number of denials should be prepared on a monthly basis. Use coding profiling to evaluate and address identified patterns with your client. Monitor and analyze trends and document changes.

Work plans and special alerts published by OIG often include coding targets. CMS and Medicare carriers notify physicians and providers that specific codes have very high error rates and are a focused review area. For example, 99214 has been a CMS focus for the past two years. Pneumonia and sepsis DRG coding is another focus. Billing companies should make sure the profile reports include all identified targets.

Profiling codes and coding outcomes is a powerful tool that allows billing companies to provide value-added service through their compliance processes as a normal course of business. Coding, including how you will monitor and address identified aberrant patterns, should be part of your billing contract. Your compliance plan should specifically address the steps in your internal processes through policies and procedures. Taking a proactive approach to promptly identify, evaluate, correct, and monitor coding errors reduces risk while enhancing appropriate revenue. Knowledge is power; use it. ◆

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