Is "Correct Coding" Even Possible?

By Holly Louie, RN, CHBME

THE NEVER ENDING SAGA OF coding changes, code inadequacy, idiosyncratic payor interpretations and political battles has created a system that makes "correct coding" more difficult than finding the cure for cancer. It is a system that rarely, if ever, results in any physician reimbursement improvements. Toss in the hot topic of "standard of care" as a basis for false claims, and we have an incendiary device. The following items do not scratch the surface of coding issues, but may help those in our industry who do not code to better understand the issues we all face.

Yesterday's technology tomorrow

CPT coding cannot keep pace with the scientific advancements that modify clinical care. Category III codes are just one small step to address the larger problem. Some surgical specialties, radiology, cardiology, and pathology are particularly at risk for lost revenue due to new procedures and technology. Some published specialty standards have no current CPT code. Unlisted CPT codes require submission of hard copy reports and reliance on the payor to appropriately value the service. Unfortunately, reimbursement is often lower than that allowed for CPT codes that define a lesser service. Even worse, the payor decides the service is "experimental," regardless of supporting authoritative documentation.

Which rule applies this time?

Modifier 25 is addressed in the 2004 work plan of the Office of the Inspector General (OIG). The assumption is that providers may be improperly reporting modifier 25 which results in overpayments. CMS and CPT have published instructions that modifier 25 is correctly used to report a "significant, separately identifiable" E&M service. The OIG stated that modifier 25 is correctly used to report an "unrelated" E&M service and the use of modifier 25 should be the exception, not the rule. Other published discrepancies pertinent to correct use of modifier 25 state that it is appropriate for new patients, appropriate for professional services in an emergency department, may not be appropriate for the facility in an emergency department, must have an E&M with an unrelated diagnosis, or does not require an unrelated diagnosis. Some commercial payors have circumvented the issue by ignoring all authoritative sources and disallowing payment for an E&M with any procedure. Conflicting coding guidance is so prevalent that the term "correct coding" must be applied to each individual claim.

Liar, liar, pants on fire

Virtually all payors state they follow CPT guidelines and/or Medicare's Correct Coding Initiative. That statement is disingenuous in most cases. The rest of the story is that payors apply their own interpretation of correct code utilization, ignore modifiers, add idiosyncratic bundling edits, modify guidelines, etc. While in some cases appeals will overturn initial denials, appeals are time-consuming and expensive. The payor counts on the fact that its policies will create coding and billing problems so complex and onerous that the billing company or provider will either not identify the problem or not pursue the issue when a claim by claim fight is involved. The typical patient has no coding and billing education and believes the insurance company correctly adjudicated the claim, especially when the provider participates and there is no balance due from the beneficiary!

Is that your final answer?

E&M services are the majority of services for many specialties. Assigning the "correct" E&M code is the most disputed area of coding for a variety of reasons. Do you select the code based on CMS documentation guidelines, CPT guidelines, E&M score sheets, 1995 guidelines, 1997 guidelines, AMA guidance, carrier interpretations, or WHAT? Typical of all coding conundrums, multiple interpretations are published. Some payors allow mixing and matching of body areas and organ systems for the physical examination and some do not. Some payors count "noncontributory" and some do not. Some payors state a detailed ROS requires a minimum of four organ systems and some require two. The crux of the problems is that the AMA does not think a bean-counting methodology to score E&M services is appropriate or necessary and CMS does think it necessary. Can physician cognitive services be reduced to "you need three of these and four of those?" What if the four of those is completely irrelevant to what the physician needs to know or do to provide the standard of care?

Food for Thought

Maybe procedure coding is a dinosaur. What if physician services were charged and reimbursed like the rest of the service industry? The consumer chooses whom they want to do business with and the provider of the service determines price and product. You can comparative shop, but once you've chosen who, the price is what you pay.

A solution to the above ambiguities is probably not even on the radar screen. But we can all keep our fingers crossed that perhaps someday, sanity may reign.

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