

# Getting Paid for the Work You Do

The art of accuracy in coding.

BY MICHELLE REESE, CPC

Reimbursement for patient face-to-face professional services (evaluation and management) has traditionally been driven by volume and level of service. With the current shift to value-based reimbursement, providers must now understand how they are being measured and how the specificity and detail of their coding will be used in that measurement. Claim submission is all about the data, using numbers (CPT codes, ICD-9/ICD-10 codes) to “paint a picture” of the patient’s current disease state, describe the services performed, and request payment for that work. The accuracy of how you paint that picture may affect your revenue in the shift from volume to value. With that in mind, what is your painting style: Jackson Pollock or Leonardo da Vinci?

As part of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) established the value-based payment modifier, which provides a positive or negative differential payment to physicians and physician groups, identified by their taxpayer identification number, based on quality and cost. This is a huge departure from more traditional payment models based on volume across cardiovascular services. As reimbursement has decreased in recent years, providers have responded by trimming costs and increasing volumes. In the ambulatory world, schedules have been optimized to fit two to three more patients into every day. Also, advanced practice providers (often known as “APPs”) have been added to increase efficiencies, focus resources, and see more patients. At the same time, there has been a goal of adhering to complicated coding and documentation guidelines. The ultimate goal is to bill the correct level of service based on medical necessity rules, reduce compliance risk with accurate documentation, and not undervalue services.

By using claims data, payers (government and private payers alike) are tracking specific metrics by system, practice, and provider, and they are comparing providers to their peers. It is critical for providers to know how they are doing. Evaluating and understanding each provider’s CPT metrics is a key indicator and necessary first step

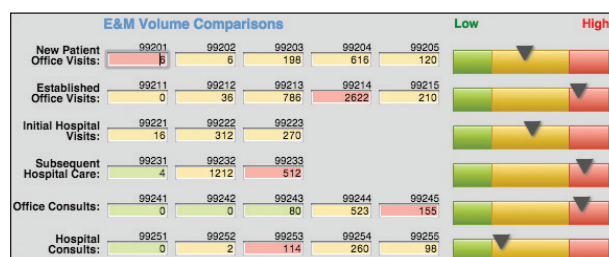


Figure 1. Comparing evaluation and management code levels (MedAxiom’s risk vs opportunity calculator).

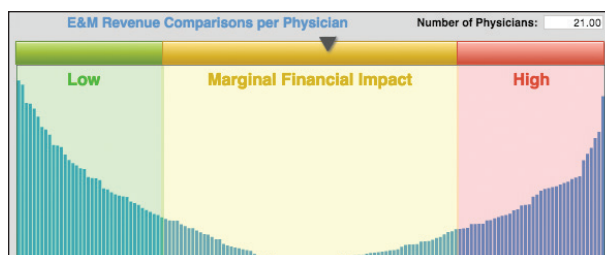


Figure 2. Potential risk in billing patterns (MedAxiom’s risk vs opportunity calculator).

in determining the revenue cycle performance across an enterprise. It is important to understand if there is utilization variability between individual physicians within your practice or system and if differences exist in the severity of patient populations. Dashboards analyzing risk versus opportunity may provide a good initial assessment in understanding your cardiology evaluation and management code levels, and perhaps most critical, organizations must have a method to compare these rates to their peers (Figure 1). Often, evaluation and management utilization varies widely among providers in the same group, which may be an indicator of an unclear understanding of coding rules. Reviewing volume data by provider can illustrate this pattern of behavior and identify potential risk, as well as opportunity. Risk may be associated with a pattern of coding too many high-level codes, and opportunity is associated with a pattern of coding too many low-level codes. Using a dashboard

to compare individual utilization by provider, as well as at the group level against Medicare's national bell curve data by specialty, can be eye-opening (Figure 2).

## DIAGNOSIS REPORTING

Billing the accurate level of service remains important and can have a significant impact on reimbursement; accurate evaluation and management diagnosis reporting is equally important. A reflection of the patient's disease severity and acuity is documented via the ICD-9-CM (future ICD-10-CM) codes submitted for claims payment and must be supported by the documentation. Your ability to accomplish this accurately and with the level of granularity required will be used to risk stratify the severity of your patients' disease. Because providers' cost and quality are scored comparatively, diagnosis reporting now holds a significant meaning, as it can affect your value modifier score and, ultimately, directly affect your reimbursement.

In this new and growing world of value-based medicine, providers will be challenged to improve their accuracy of reporting patient diagnoses. ICD-10 requires a greater level of specificity. However, specificity of diagnosis reporting has historically not held the same crucial importance in provider billing; particularly in the ambulatory setting, providers have relied on old standbys, the unspecified codes (eg, congestive heart failure, unspecified; atrial fibrillation; coronary artery disease; myocardial infarction, etc). This is not because greater specificity was unknown, but because it is simpler documentation and in a provider evaluation and management world, it really did not matter. Reimbursement was the same for an encounter reported with congestive heart failure, unspecified (ICD-9 code 428.0) or acute on chronic systolic heart failure (ICD-9 code 428.23).

In addition to more specific diagnosis documentation, capturing and reporting all other related conditions and comorbidities is necessary to accurately reflect the severity and acuity of the patient's clinical status. For example, a patient being evaluated for new-onset chest pain who also has "known coronary artery disease, status post percutaneous coronary intervention of the left anterior descending artery, with chronic obstructive pulmonary disease and end-stage renal disease," is a very different picture than simply "chest pain, unspecified." That entire collective becomes important in painting that patient's story, a story told with numbers. This is a key point, as providers are now being measured on cost and quality.

## ELECTRONIC HEALTH RECORD CHALLENGE

The challenge to improve documentation (and subsequent billing) is, in many ways, hampered due to the one tool that was supposed to make life easier: the

electronic health record (EHR). Many EHR systems have become enablers in a world where there are just too many "clicks" involved to get through the day. Anything that will save a click or two becomes the default; "copy and paste" has become prevalent. Those defaults and copy-pasting actions can lead to incorrect documentation and inaccurate billing. A 2013 report published by Daniel R. Levinson, Inspector General for the Office of Inspector General, states, "Experts in health information technology caution that EHR technology can make it easier to commit fraud. Certain EHR documentation features, if poorly designed or used inappropriately, can result in poor data quality or fraud."<sup>1</sup> The report goes on to describe copy-pasting and overdocumentation as examples of EHR practices that could be considered fraud or abuse.<sup>2</sup>

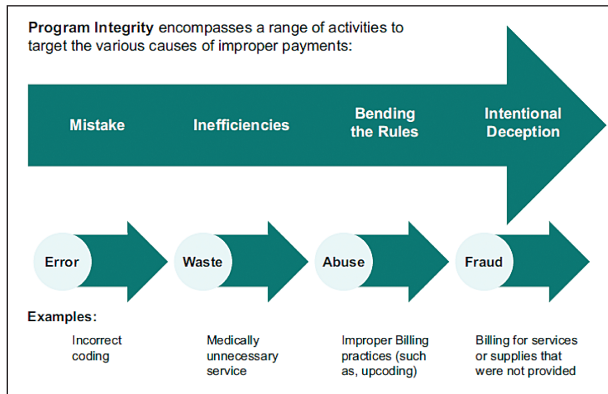
Occasionally, incorrect diagnosis reporting is an EHR workflow issue. Understanding how a particular electronic system assigns the primary diagnosis is critical. Many systems will reorder the diagnoses on claims in either alphabetic or numeric order if the primary diagnosis is not properly designated. This can lead to a stable comorbid condition, such as hyperlipidemia, being reported as the primary condition, even when an acutely ill patient was seen.

It is commonly believed that the transition to ICD-10 will somehow fix inaccurate diagnosis reporting and will force improved documentation. But will it? It's not enough to select a very specific diagnosis for billing purposes. Documentation rules mandate that the diagnoses billed must be substantiated in the record for that date of service. The process of billing a claim to an insurance company (Medicare and Medicaid included) is an "on-your-honor" system, much like filing your taxes. You file, and if you are due a refund, you get paid. In the health care world, you file an insurance claim and, provided there are no edits or rejections, you get paid. This happens regardless of whether the documentation in the record actually matches what was billed. CMS has stated that, "Abuse describes practices that, either directly or indirectly, result in unnecessary costs to the Medicare Program. Abuse includes any practice that is not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and priced fairly."

Examples of Medicare abuse from CMS include:

- Billing for services that were not medically necessary;
- Charging excessively for services or supplies; and
- Misusing codes on a claim, such as up-coding or unbundling codes.

According to CMS, "Medicare abuse can also expose providers to criminal and civil liability."<sup>3</sup>



**Figure 3. Improper payments.** Reprinted with permission from the Centers for Medicare & Medicaid.

Figure 3 shows examples of improper payments along the spectrum of causes. The risk for incorrect coding and improper billing is in postpayment or retrospective audits, such as those performed by the CERT (Comprehensive Error Rate Testing), RAC (Recovery Audit Contractor), and ZPIC (Zone Program Integrity Contractor) programs. In a postpayment review in which supporting documentation is requested, providers may be subject to repayment and/or possible penalties if the documentation does not support the codes billed. If a pattern of behavior is identified, providers can expect additional scrutiny, which could lead to prepayment reviews, additional fines and penalties, or worse.

In the past, these reviews have been primarily focused on documentation being supportive of the level of service and much less so on the evaluation and management diagnosis. However, this is very likely to change now that an increasing percentage of reimbursement is linked to diagnosis reporting. It is important to note that diagnostic and therapeutic procedures have been subject to coverage determination policies and diagnosis reviews for some time.

## COST VERSUS QUALITY

With its phase-in approach, the value modifier incentives and penalties are set to affect all providers in 2017, based on performance year 2015, meaning that what is being done today is being measured and is already having an impact on providers. Think about a patient under the new value modifier system who is attributed to you or your practice. As an example, you may have a high-risk patient with expensive hospital procedures, interventions, and critical care services, and yet your claims have been inaccurately reporting low complexity or unspecified diagnosis codes. This misrepresents the

true level of severity and acuity for that patient. Costs associated with that patient's care will be high and, based on your diagnosis reporting, unexplained. This disparity will likely have a negative outcome on your value modifier score. More important than ever, billing and documentation must accurately reflect the high-risk and/or complicated patients and show that the severity of their conditions warrants such expensive interventions.

## PAINT BY NUMBERS

How are providers using numbers to accurately paint the picture for each patient?

- Education on current coding and documentation rules regarding levels of service;
- Bill correctly for the medically necessary level of service provided to the patient;
- Do not leave any money on the table; and
- Do not create unnecessary risk by coding higher than the documentation supports.

Additionally, providers must place a renewed focus on diagnosis coding and documentation. Some helpful tips are:

- Develop a CDI (clinical documentation improvement) program at the ambulatory level. Diagnosis rules differ based on site of service (ie, inpatient versus outpatient).
- Combine diagnosis billing and education efforts with planned ICD-10 education. Specific and thorough documentation will support the added granularity of the new codes.
- Use the value modifier as an opportunity. Document well and bill accurately to paint a clear and well-defined picture, not a sloppy, confusing, or contradicting one. If costs are high, documentation will support this, and providers will not be an outlier to their peers.

The key is accurate coding, accurate documentation, and accurate reimbursement. Achieve a positive value modifier score and reap the benefits by "painting" like Leonardo da Vinci. ■

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