Coding spotlight: tips and best practices for compliance

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Need for coding compliance
Coding compliance refers to the process of ensuring that the coding of diagnosis, procedures and data complies with all coding rules, laws and guidelines.

All provider offices and health care facilities should have a compliance plan. Internal controls in the reimbursement, coding, and payment areas of claims and billing operations are often the source of fraud and abuse, and have been the focus of government regulations.

Compliance plan benefits:

- More accurate payment of claims
- Fewer billing mistakes
- Improved documentation and more accurate coding
- Less chance of violating state and federal requirements including self-referral and anti-kickback statutes.

Compliance programs can show the provider practice is making an effort to submit claims appropriately and send a signal to employees that compliance is a priority.

Medical records documentation
All medical records entries should be complete and legible, and should include the legible identity of the provider and date of service.

Each encounter in the medical record must include the patient's full name and date of birth. Documentation integrity is at risk when there is wrong information on the wrong patient health record because it can affect clinical decision-making and patient safety.

Providers' signatures and credentials are of the utmost importance in all documentation efforts. The signature is an attestation from the treating and documenting provider that certifies the written document as reflecting the provider's intentions regarding the services performed during the encounter, and the reason(s).

Specific information is required to describe the patient encounter each time he or she presents for medical services.

Each encounter generally will need to contain the following:

- The chief complaint
- The history of present illness
- The physical examination
- Assessment and care plan.

Common coding and billing risk areas
The following billing risks are commonly subject to Office of Inspector General (OIG) investigations and audits:

- Billing for items or services not rendered or not provided as claimed
- Double billing, resulting in duplicate payment
- Submitting claims for equipment, medical supplies, and services that are not reasonable and necessary
- Billing for non-covered services
- Knowingly misusing provider identification numbers, which results in improper billing
- Unbundling
- Failure to properly use modifiers
- Upcoding the level of service.

Evaluation and Management (E&M) claims are typically denied for two reasons:

- Incorrect coding, such as the code not matching the documentation, and insufficient documentation, which can include a lack of a provider signature or no record of the extent and amount of time spent in counseling.
- Coordination of care when it is used to qualify for a particular level of E&M service.

There are several strategies on how to prevent E&M claims being denied:

- In addition to the individual requirements for billing a selected E&M code, providers should also consider whether the service is reasonable and necessary (for example, a level 5 office visit for a patient with a common cold and no comorbidities will not be reasonable and necessary).
- Remember the following when selecting codes for E&M services:
    - Patient type (new or established)
    - Setting/place of service
    - The level of service provided based on the extent of the history, the extent of the examination, and the complexity of the medical decision making (for example, the number and type of the key components performed).

Best practices to avoid common documentation mistakes

Providers need to formulate a complete and accurate description of the patient's condition with a detailed plan of care for each encounter. Listing problems without a corresponding plan of care does not confirm physician management of that problem and could cause a downgrade of complexity. Listing problems with a brief, generalized comment (for example, diabetes management (DM), chronic kidney disease (CKD), congestive heart failure (CHF): Continue current treatment plan) equally diminishes the complexity and effort put forth by the physician.

The care plan needs to be documented clearly. The care plan represents problems the physician personally manages, along with those that must also be considered when he or she formulates the management options, even if another provider is primarily managing the problem. For example, one provider can monitor the patient's diabetic management while the nephrologist oversees the chronic kidney disease (CKD).

Pathology service, laboratory testing, radiology and medicine-based diagnostic testing contributes to diagnosing or managing patient problems.

Documentation tips:

- Specify tests ordered and document rationale in the medical record
- Document test review by including a description in the note (for example, elevated glucose levels)
- Indicate when images, tracings, or specimens are personally reviewed; be sure to include a comment on the findings

- Summarize any discussions of unexpected or contradictory test results with the provider performing the procedure or diagnostic study.

Patient risk in E&M is categorized as minimal, low, moderate or high based on the presenting problem, diagnostic procedures ordered and management options selected. Chronic conditions with exacerbations and invasive procedures offer more patient risk than acute, uncomplicated illnesses or noninvasive procedures. Stable or improving problems are considered less risky than progressing problems; conditions that pose a threat to life/bodily function outweigh undiagnosed problems where it is difficult to determine the patient's prognosis.

To determine the right complexity of the patient's problems, providers should:

- Document the status for all problems in the plan of care and identify them as stable, worsening, or progressing (mild or severe), when applicable; do not assume that the auditor or coder can infer this from the documentation details.
- Document all diagnostic or therapeutic procedures considered.
- Identify surgical risk factors involving co-morbid conditions that place the patient at greater risk than the average patient, when appropriate.

Frequent auditing is key to medical coding compliance

To ensure your organization's E&M services are coded appropriately, it is important to periodically review your charts to check for insufficient documentation, miscoding, upcoding and downcoding. Conducting audits of your medical coding process and procedures can help give you an understanding of recurring risk areas and key improvement opportunities. Using these insights, you can then incorporate best practices and address any bad habits, lessening the chances of negative consequences.

Resources

1. *CPT® Professional Edition, 2020*. AMA
2. *Compliance Guidance*. Office of Inspector General. **https://oig.hhs.gov/compliance/compliance-guidance/index.asp**
3. *Risk Adjustment Documentation & Coding, 2nd edition*. American Medical Association

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