THE OFFICE

E & M Coding Blunders

Welcome to the first edition of The Office. Each column will feature an expert's advice for managing the business and politics of running an office. Appropriately, this first installment features coding expert Emily Hill's recommendations for avoiding costly coding blunders.

BY EMILY HILL

Dollars are at stake when evaluation and management service category definitions are not well understood. So, taking the time to read the Evaluation & Management Services Guidelines—and specifically the section that reviews patient definitions—is wise. Different categories of service have different relative value units, even for the same level of service. Each additional relative value unit (RVU) means additional reimbursement. For Medicare, each RVU is worth $37.90; for other payers, it's usually more. The additional reimbursement could add up fast. Following are details about some problematic areas:

► **New versus established patients.** How many times a day do you see a patient who comes into the office for the first time in 4 years? It's a common scenario for most family physicians. The problem is that 4 years is a tricky duration. Many physicians might clearly remember the individual and therefore make the mistake of classifying him or her as an established patient. But in this case, the physician can rightfully code the service as a new patient visit, which is billed at a higher RVU, because more than 3 years have elapsed. Most patients won't be affected financially, because the copayment will be the same regardless of E & M category.

► **Call it a consult.** Family physicians frequently miss the opportunity to code a visit as a consultation. A typical example is the physician who is called upon to clear a patient for a surgical procedure. The default may be to code such a visit as a new or established patient service. But doing so means being paid less. A level 3 new patient and a level 3 consultation require the same extent of history and medical decision making, but the consultation pays about $130 versus $97. The caveat: Consultation coding requires meeting the CPT definition for a consultation and some additional documentation requirements, but it's well worth it.

► **Code PM.** Not choosing a preventive medicine code when it is appropriate to do so might actually have a negative financial impact on the patient. Many physicians don't bill visits as preventive medicine because either they assume that patients won't have coverage for those services or they believe that they will be paid better for a problem visit. But often, the assumption or belief is inaccurate. The patient with coverage from a health savings account might have a very high deductible; however, most plans carve out preventive medicine or screening services from being applied to the deductible. If such services are coded as something other than preventive medicine, the patient bears full responsibility as opposed to having no out-of-pocket costs.

► **Code for time.** Family physicians frequently spend a lot of time speaking with patients, and when an encounter is predominately counseling, one can select services based on time. Often, this coding option pays better. As is frequently the case, however, a physician will do little history and feel that they should code at a lower level, such as 99212, because they haven't done what they think of as a problem visit. Yet in fact, they've been with the patient for 15 minutes and that would be a 99213. If the visit has been 25 minutes or longer, that's a 99214. When counseling or coordination of care dominates more than 50% of the visit, time can be the factor for determining level of E & M service, as long as the discussion is well documented.

► **Limit use of the Goldilocks code.** Overuse of 99213 can be a red flag for an auditor. Busy physicians will often use this code because they think that more extensive documentation will be needed for anything higher. At the same time, they believe 99213 is safe. It's not too high and not too low, and so the assumption is that the coding will go unnoticed. The problem is that physicians lose reimbursement when they get stuck on 99213. Alternatively, others make 99214 their default, and that's a problem too, because it's a flag for overcoding. One's risk for an audit is always higher when there is not a reasonable distribution of codes within a practice. If a single code is predominant, the assumption is that the physician isn't really coding for individual encounters. Figuring out coding patterns can easily be done by gathering data off the billing system, which will also allow a comparison with the national Medicare norms. Gather several years of data at first to see if there are any outliers or problems. ■

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POINT/COUNTERPOINT

Are opioids an appropriate treatment for chronic nonmalignant pain?

Manage opioid users closely and be realistic.

Despite almost universal acceptance in acute and cancer pain treatment, opioids have been avoided for treating chronic nonmalignant pain. However, that tide began to turn in the 1990s, and with good reason.

The risks from opioids are relatively low. Organ toxicity from opioids, even with chronic use, is essentially nil. Data from methadone maintenance patients show that they have minimal functional impairment. And many patients have improved cognition with opioids. Over the last decade or so, there has been a real sea change among professional pain societies and even state regulators moving toward acceptance of the use of opioids for chronic pain treatment.

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But despite evidence of efficacy and low toxicity, many pain physicians have stopped prescribing opioids for chronic nonmalignant pain. Part of the reason is the disappointment that the use of opioids hasn't resulted in the end of pain. Pain and function often improve minimally, and many—perhaps most—patients discontinue them after several months. There have been problems of selective efficacy. Opioids don't help everyone and we don't have good response predictors. And we, as physicians, also have had unrealistic expectations of these medications.

Some physicians have condemned opioids, saying that many patients do better when weaned off the drugs entirely. It's true that some patients experience relief when taken off opioids, but it's not a surprise that people improve when taken off a drug that wasn't working.

Most prescription opioid abuse involves people for whom the drug was not prescribed, and thus is not an indictment of the drug. It is an alert that patients must be counseled and held accountable for securing these drugs from others.

Opioid prescribers have been unrealistic, expecting drugs alone to restore those with chronic pain to normal lives. Many failed to treat the whole patient or to select patients wisely. It's essential that we use opioids to restore quality of life and that we exploit the analgesia obtained to restore socialization and other activities. This balanced approach will result in better outcomes for patients and more responsible management of these drugs. ■

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Widespread opioid use is questionable.

Opioids can be the best and most appropriate therapy for some patients. However, opioids also pose significant risks in terms of drug diversion and have a lack of demonstrated long-term safety and efficacy.

Opioids pose a significant risk to society in terms of potential abuse. For example, opioid sales figures are inconsistent with the expected indication.

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Between 1997 and 2007, oxycodone sales jumped 383% and methadone sales increased 392%. In 2002, the deaths from prescription opioids (4,451) far outnumbered those from heroin (1,061) and cocaine (2,569).

Clearly, current mechanisms of control are largely ineffective in preventing diversion.

Making opioids more widely available without unequivocal data to justify this practice is irresponsible. Questions also remain about both the long-term safety and efficacy.

In terms of safety, while there is an absence of organ toxicity with opioids, there also is hyperalgesia, respiratory depression, immune suppression, endocrine dysfunction, and a 10%-16% incidence of addiction with chronic use.

Regarding efficacy, we have failed to require the same rigor for the practice of opioid prescription as for other medical therapies.

There are no prospective studies over a period of years that demonstrate long-term functional improvement or analgesia.

We must recognize that long-term use of opioids is not without risk and there is little scientific evidence to support our current prescriptive practices. Increased opioid availability is associated with significant mortality for our patients and also poses a significant and increasing public health risk.

Whereas no one is advocating the elimination of opioids as a tool for treating chronic nonmalignant pain, we should demand at least the same rigor that we demand for other treatments. ■

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