# Undercoding for Hepatitis C Is Common, Costly

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — Many physicians who manage patients with chronic hepatitis C could increase their incomes simply by paying closer attention to coding, Dr. Imtiaz Alam said at the annual meeting of the American Association for the Study of Liver Diseases.

"Physicians tend to play it safe" when billing for hepatitis care by choosing Evaluation and Management (E&M) codes appropriate for visits with little complexity in the medical decision making, said Dr. Alam, medical director of a private hepatitis center in Austin, Tex.

Instead, visits with patients being treated for hepatitis C almost always should be coded at levels of moderate or high complexity, he said.

The difference can add up. For visits with established patients, Medicare reimburses an average of $38 for E&M code 99212 (the least complex medical decision-making), $52 for code 99213 (low complexity), $82 for code 99214 (moderate complexity), and $119 for code 99215 (the most complex decision making), he noted.

If there is a $30 difference in payment between codes 99213 and 99214, and a physician undercodes seven visits per day as 99213 even though they qualify as 99214, that would lead to a substantial loss of income—$1,050 per week, Dr. Alam said.

A common mistake is to assume that physicians must spend more time with more complex patients to qualify for the level 4 or 5 codes, he suggested. "Coding levels have little to do with how quickly or easily you come up with a plan of care," but rather reflect the physician's effort and the level of risk to a patient in implementing a plan of care, he said.

An experienced hepatologist may spend only 10 minutes with a hepatitis C–infected patient and still determine the plan of care, Dr. Alam noted.

He described other conditions that typically qualify for codes 99212-99215. An office visit to provide reassurance to an established patient with an irritated skin tag would be code 99212. Code 99213 might be used for an office visit with an established patient with stable cirrhosis of the liver. "But how many of your hepatitis patients are stable? I suspect most of them are not," he said.

Code 99214 would be appropriate for an office visit by an established 45-year-old patient on immunosuppressive therapy for rheumatoid arthritis. "How is that different from your hepatitis C patients who are on therapy?" he asked. Code 99215 might be used for an office visit with an established 36-year-old patient who is 3 months post transplant and is developing peripheral edema, increasing blood pressure, and progressive fatigue. "I suspect that many of your hepatitis C patients on interferon therapy are probably having many issues," Dr. Alam said.

**There can be a $38 difference between coding for 99244 (moderate complexity of decision-making) and 99245 (the most complex cases).**

For office visits by new patients, there can be a $38 difference between coding for 99244 (moderate complexity of decision making) and 99245 (the most complex cases). Code 99245 would be appropriate for a first visit for initial evaluation and management of Cushing's disease. "How is that different from your initial evaluation of hepatitis C when you're going to consider them for therapy? I don't believe there's any difference," he said.

The key to feeling comfortable with appropriate coding is to document the steps needed to qualify for those codes, he added. New patient visits require a history, exam, and medical decision making.

Only two of those three are required for visits with established patients. An exam isn't necessarily essential if the patient fills out a Review of Systems form and the physician documents height, weight, and blood pressure and engages in the appropriate level of medical decision making. For higher-complexity coding, the physician also should ask about changes in family or social history (such as alcohol consumption). ■

# Hepatology Service Generates Substantial Hospital Charges

BY SHERRY BOSCHERT
San Francisco Bureau

SAN FRANCISCO — For every $1 billed by the hepatology section at one institution, the hospital generated an additional $27 in charges, a retrospective study showed.

The data are the first to document why medical centers should support their hepatology sections and their hepatologists in this more consultative and less procedurally oriented specialty, Dr. Donald M. Jensen said at the annual meeting of the American Association for the Study of Liver Diseases.

The study was prompted by Dr. Jensen's experience of having to justify budgets and salaries in his hepatology section to hospital administrators—who focused mainly on practice-generated revenue and not downstream revenue.

"Every year I'd have to go through this genuflecting about why we're not generating more revenue," said Dr. Jensen, who coauthored the study while at Rush University, Chicago, and now is the director of the center for liver diseases at the University of Chicago Hospitals. Dr. Stanley M. Cohen of Rush University was lead author of the study (Hepatology 2005;41:968-75).

The investigators analyzed data on new outpatient consultations and initial admissions over a 3-month period for 179 patients in the hepatology section and 179 patients in the gastroenterology section, who were followed for 12 months.

They calculated both direct charges (generated directly to the sections) and indirect charges (generated to the hospital system). The hepatology section had 3 full-time physicians, whereas the gastroenterology section had 7.5 full-time physicians.

In total, the hepatology section generated nearly $5.9 million in charges for the hospital, compared with $2.3 million generated by gastroenterology. Direct charges accounted for 4% of charges from hepatology and 16% of charges from gastroenterology. The mean charge per patient was $32,090 for hepatology patients and $12,700 for gastroenterology patients, he said.

Compared with the $27 generated for the hospital for every $1 charged to hepatology, in gastroenterology every $1 charged generated an additional $5 in charges for the hospital. Among the hepatology patients, 9 of the 179 underwent orthotopic liver transplant during the study period. These patients generated 64% of the hepatology revenues, 98% of which were hospital charges.

Every $1 charged to hepatology for the transplant patients generated an additional $51 for the hospital. Even without the transplant patients, every $1 in hepatology charges generated $14 in downstream charges, Dr. Jensen noted.

That compares favorably with previous data from studies of other specialties that do not rely heavily on procedures, he added. A study of primary care services found that every $1 in direct charges generated $7 in indirect charges for the hospital. "Hepatology was clearly above that range," Dr. Jensen said. One limitation of the study is that the gastroenterology section at Rush University Medical Center sees more than twice as many patients as does the hepatology section during a 3-month period, he added. ■

# *Insurance Law May Be Barrier To Alcohol Screening, Treatment*

BY MARY ELLEN SCHNEIDER
Senior Writer

Nearly 25% of trauma surgeons report that they have been denied payment by an insurer in the last 6 months because a patient was under the influence of alcohol or drugs when his or her traumatic injury occurred, according to Dr. Larry M. Gentilello of the University of Texas Southwestern Medical Center at Dallas and his colleagues.

The failure to pay on the part of insurance companies may be affecting alcohol screening and treatment practices in hospitals, the researchers said. They analyzed responses from 98 general trauma surgeons around the country and found that less than half reported routinely measuring blood alcohol concentration among their patients even though 91% of respondents said it was important to do so.

The barrier for many physicians is the Uniform Accident and Sickness Policy Provision Law (UPPL), a national model law that allows insurance carriers to deny coverage for injuries sustained while under the influence of alcohol or drugs. The model law was developed in 1947 by the National Association of Insurance Commissioners, and as of April 2004, it had been adopted by 38 states and the District of Columbia.

But in 2001, the commissioners amended the model law to prohibit insurers from applying the substance abuse exclusion to medical expenses. As of April 2004, six states adopted the new model law.

The survey results indicate that the general fear of insurance denials may be causing some physicians to circumvent the laws by not documenting the use of alcohol or drugs. Dr. Gentilello and his colleagues found that only 37% of surgeons report that half or more of their patients with alcohol problems receive counseling. And 82% of the respondents said that if there were no insurance barriers, they would be willing to help their trauma center establish a brief alcohol intervention program if provided with other clinical tools.

Either physicians are not screening and documenting intoxication or insurers are not applying the law in every case, the researchers wrote, because with 35%-50% of trauma patients estimated to be under the influence of alcohol or drugs, trauma centers could not absorb the resulting cost of uncompensated care.

Studies specifically looking at alcohol screening and intervention among injured patients show that brief interventions can reduce future alcohol use and hospital readmissions, Dr. Gentilello, professor of surgery and chairman of the division of burns, trauma, and critical care at the University of Texas Southwestern Medical School, said in an interview. After being treated for a serious injury resulting from substance abuse, most patients are in an ideal state of mind for this type of counseling.

"They've had a real teachable moment," Dr. Gentilello said. "Trauma presents a crisis we can capitalize on."

But the existence of the UPPL means that physicians who practice good medicine by screening and treating alcohol and drug abuse are denied payment, said Eric Goplerud, Ph.D., a George Washington University professor and director of Ensuring Solutions to Alcohol Problems. ■