Establish and Maintain Reliable Coding and Billing—With an EMR or Without

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One of the luxuries I allow myself is daily home delivery of the *New York Times*. My evening read is usually a 45–minute respite from the hectic world of medical billing. But the article I read from Saturday, September 22, 2012, drew me back into my work arena with the headline "Medicare Bills Rise as Records Turn Electronic."

The premise of this article is that usage of electronic medical record (EMRs) within hospitals and medical practices appear to be "... contributing to billions of dollars in higher costs for Medicare, private insurers and patients...," rather than reducing health care costs as expected.

New York Times journalists contacted representatives from a few hospitals, who claimed that the EMR allowed for more accurate coding, combined with an increase in number of patients needing care. At one Illinois hospital, though, a former ER physician claimed that the EMR automatically recorded thorough exams, thus inaccurately "upcoding" the level of service billed, even when a thorough exam was not performed. One "sophisticated patient witnessed the overbilling firsthand."

Our government, however, encourages the use of EMRs, stating that electronic records allow doctors and hospitals to avoid duplicate treatments, track and monitor patient care, and ultimately improve quality at lower cost.

As someone who consistently works to help practices increase revenue while maintaining compliance, I found the article particularly intriguing, given that so many practices in the Pittsburgh area are in the midst of implementing EMRs. And perhaps a comparable number of practices are still resisting usage of EMRs.

For our clients who are using EMR, I wonder: Does the use of EMR really increase reimbursement? And is the increase legitimate? For our clients who have not yet made the commitment to EMR I ask: Are those practices that choose to remain with paper documentation sacrificing revenue?

The article authors state that, "The Office of the Inspector General (OIG) is studying the link between electronic records and billing." (Find the entire article at http://global.nytimes.com/ and search using the story title). But, until results of the OIG study are published, it's worth considering what each medical provider can do to ensure accurate coding—and thus appropriate and maximum reimbursement—whether using electronic or paper records. Theo-

retically, if a physician is coding correctly and submitting correctly formatted and timely claims, there should be no difference in revenue, regardless of their medical records platform.

In my experience, inaccurate and/or incomplete coding and documentation is the single most compelling part of the revenue cycle that requires attention and correction. And it is the part of the revenue cycle that is often delegated by the physician to a staff member who may or may not be knowledgeable.

All other processes being equal, the physician who is involved in coding his/her services and monitoring coding trends via good management reporting is the physician who reaps the highest possible reimbursement. Period. The physician who ensures that documentation is complete for every service performed is the one who does not have to panic when the Medicare audit letter comes in the mail. Coding and documentation tasks can be designed into a physician's daily and monthly workflow, whether the medical record platform is electronic or manual.

It is a rare physician who performs his or her own coding and/or takes an interest in ensuring that:

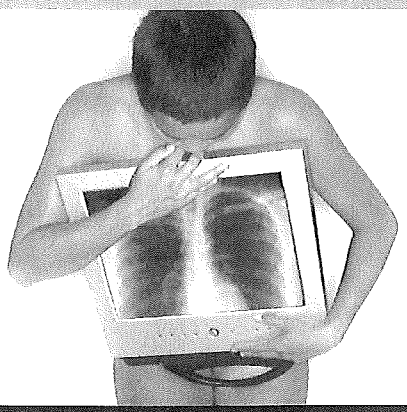
- all services performed are assigned accurate codes in the billing database;
- all codes are updated annually before the expiration deadlines for International Classification of Diseases (ICD) [September]; Current Procedural Terminology (CPT), and Healthcare Common Procedure Coding System (HCPCS) [December] codes;
- all codes represented on claims are fully supported by medical records documentation.

Regardless of whether you use a ballpoint pen, a Dictaphone, an electronic tablet, or point-and-click to record your notes, below are the keys to ensuring that coding, and thereby reimbursement, is accurate and appropriate:

Read the latest CPT, HCPCS and ICD manuals. Many offices don't purchase updates every year. Annually, relevant manuals must be obtained, reviewed and shared with both physicians and billing staff to ensure thorough and complete understanding and implementation of any additions, deletions or changes within the coding sections that are used by the physician. The physician must be engaged in this process; no one but the doctor knows exactly what services are being performed in the exam or operating room.

continued on page 479

Secrets of Medical Billing: Revealed



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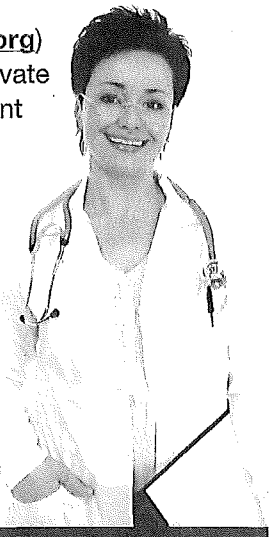

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Understand the nuances among CPT codes in your specialty area. For example, primary care providers must be fluent in the differences among levels of evaluation and management codes. Improperly coded visit levels can lower reimbursement if pre-payment notes are requested and the notes don't support the code on the claim. If audited, improper coding can cost a practice tens of thousands of dollars if a pattern of upcoding is identified. Surgical specialties must be aware of bundling situations or how to measure excisions. These are the details that impact reimbursement—and the differences can be dramatic.

Pay attention to Site of Service differentials. It is astounding to see the number of physicians who are unaware of the difference it makes whether the treatment is provided in an office or clinic, versus a facility setting such as a hospital or ambulatory center. This is particularly important in the Place of Service (POS)/Site of Service (SOS) section on claims. Make sure that your practice has a way to easily identify those services to which the SOS differential applies. Determine if the practice can arrange its schedule, offices and/or equipment to ensure that services are being performed at the location that affords the highest reimbursement.

If EMR is implemented, be involved. If using paper records, be involved.

Too often, physicians delegate the EMR implementation to the vendor or to their office staff. Although input from vendors and staff at many levels is necessary and important, don't minimize the significance of physician leadership and involvement. At a minimum, a physician must rigorously scrutinize and test the templates and databases that serve as the infrastructure for documentation and billing—before going live with an EMR. If using paper records, the scrutiny is with the fee schedule, the encounter form and with the claim formats to the payers.

Demand and review reports. Physicians who work with their administrative staff members and vendors to ensure full and accurate regular reporting, and who study these reports, tend to be more astute in finding potential inaccuracies. When conducting this review, it's important to pay attention to:

- units of production and/or relative value unit (RVU) by code and by payer,
- charges, payments and adjustments by code, by payer, by service location, and
- denials by code, by payer.

Physicians have a responsibility to maintain the integrity of their coding and billing systems and will often view the data and numbers very differently than their staff. These combined efforts and the feedback loop that is created serve to strengthen the coding and billing infrastructure.

Give your practice simple semi-annual medical billing check-ups. One easy way to ensure that coding and billing stays accurate is to randomly select one day of office visits, one day of surgeries, etc., and compare your schedule and documentation for each patient against the claims that were submitted. Are the codes correct? What about units of service? place of service? fees? Then review the Explanation of Benefits (EOBs) for each service to determine if reimbursement was correct, timely, and whether anything was denied or written off.

This exercise, performed maybe once or twice a year, informs a physician with excellent detail of how the revenue cycle is working within the practice, and reinforces what is working (or not) in the coding of services.

Coding is a dynamic and ongoing task that, when executed with thought and full information, is the foundation for ongoing robust revenue to any practice. Regardless of the platform selected for documenting and billing the service a physician provides, the platform should neither dictate accurate coding nor impact appropriate reimbursement. Whether EMR or paper, it is correct coding that ensures correct payments.

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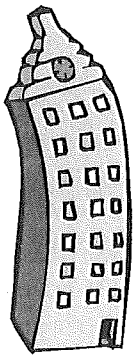

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