Many physicians would be happy to delegate all coding issues to the staff, but doctors play an integral role in the coding process.

Chapter in Brief:

▲ Doctors are ideally positioned to accurately capture information from office and hospital visits, not only for documentation purposes, but also for billing.
▲ Although documentation is the basis for coding, doctors do not always include enough detail to support accurate codes.
▲ Modifiers 25 and 59 are used to signal payers that multiple services or procedures were provided to a patient on the same day and that these meet criteria for separate payment. Without these modifiers, the charges may be denied.
▲ After taking a basic course on coding, doctors and their staff should continually attend seminars to refresh themselves on the rules and regulations, which are subject to change.

Most doctors view coding as a necessary evil,” says Patricia Hubbard, CPC, CPC-OBGYN, a medical practice manager in New York State. “Most would rather take care of their patients and work on what they were trained to do.” Instead, they may also be responsible for choosing procedure and diagnostic codes, which may involve lengthy or complicated criteria.

Doctors are the ones who actually go through the medical decision-making process; thus they are ideally positioned to more accurately capture information from office and hospital
I have type 2 diabetes. This is my 24/7 glucose control.

Indications and usage
Levemir® is indicated for once- or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long-acting) insulin for the control of hyperglycemia.

Important safety information
Levemir® is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

Hypoglycemia is the most common adverse effect of all insulin therapies, including Levemir®. As with other insulins, the timing of hypoglycemic events may differ among various insulin preparations. Glucose monitoring is recommended for all patients with diabetes. Levemir® is not to be used in insulin infusion pumps. Any change of insulin dose should be made cautiously and only under medical supervision. Concomitant oral antidiabetes treatment may require adjustment.

Inadequate dosing or discontinuation of treatment may lead to hyperglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. Levemir® should not be diluted or mixed with any other insulin preparations. Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy. Dose and timing of administration may need to be adjusted to reduce the risk of hypoglycemia in patients being switched to Levemir® from other intermediate or long-acting insulin preparations. The dose of Levemir® may need to be adjusted in patients with renal or hepatic impairment.

Other adverse events commonly associated with insulin therapy may include injection site reactions (on average, 3% to 4% of patients in clinical trials) such as lipodystrophy, redness, pain, itching, hives, swelling, and inflammation.

Whether these observed differences represent true differences in the effects of Levemir®, NPH insulin, and insulin glargine is not known, since these trials were not blinded and the protocols (eg, diet and exercise instructions and monitoring) were not specifically directed at exploring hypotheses related to weight effects of the treatments compared. The clinical significance of the observed differences in weight has not been established.

For your patients with type 2 diabetes, start once-daily Levemir®
Levemir® helps patients with diabetes achieve their A1C goal.:
- 24-hour action at a once-daily dose
- Provides consistent insulin absorption and action, day after day
- Less weight gain

To access complimentary e-learning programs, visit novomedsite.com/Levemir

References:
1. Data on file, Novo Nordisk Inc, Princeton, NJ.
2. Meaney DF, Rosenberg KS, Krener C, Melchion M, Liddell H. Insulin detemir improves glycemic control with less hypoglycemia and no weight gain in patients with type 2 diabetes who were insulin naive or treated with NPH or insulin glargine. Clinical practice experience from a German subgroup of the PREDICT study. Diabetes Obes Metab. 2007;9(4):419-425.

Please see brief summary of Prescribing Information on adjacent page.

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Novo Nordisk
Levemir®
insulin detemir (rDNA origin) injection

Rx ONLY
BRIEF SUMMARY. Please see package insert for prescribing information.

INDICATIONS AND USAGE
LEVEMIR is indicated for once- or twice-daily subcutaneous administration for the treatment of adult and pediatric patients with type 1 diabetes mellitus or adult patients with type 2 diabetes mellitus who require basal (long-acting) insulin for the control of hypoglycemia.

CONTRAINDICATIONS
LEVEMIR is contraindicated in patients hypersensitive to insulin detemir or one of its excipients.

WARNINGS
Hypoglycemia is the most common adverse effect of insulin therapy, including LEVEMIR. As with all insulins, the timing of hypoglycemia may differ among various insulin formulations. Glucose monitoring is recommended for all patients with diabetes.

LEVEMIR is not to be used in insulin infusion pumps.

Any change of insulin dose should be made cautiously, and only under medical supervision. Changes in insulin strength, timing of dosing, manufacturer, type (e.g., regular, NPH, or insulin analogs), species (animal, human), or method of manufacture (rDNA versus animal-source insulin) may result in the need for a change in dosage. Concomitant oral antidiabetic treatment may need to be adjusted.

PRECAUTIONS
General
Inadequate dosing or discontinuation of treatment may lead to hypoglycemia and, in patients with type 1 diabetes, diabetic ketoacidosis. The first symptoms of hyperglycemia usually occur gradually, over a period of hours or days. They include nausea, vomiting, drowsiness, flushed dry skin, dry mouth, increased urination, thirst and loss of appetite as well as acetone breath. Untreated hyperglycemic events are potentially fatal.

LEVEMIR is not intended for intravenous or intramuscular administration. The prolonged duration of activity of insulin detemir is dependent on injection into subcutaneous tissue. Intravenous administration of the usual subcutaneous dose could result in severe hypoglycemia. Absorption after intramuscular administration is both faster and more extensive than absorption after subcutaneous administration.

LEVEMIR should not be diluted or mixed with any other insulin preparations (see PRECAUTIONS, Mixing of Insulins).

Insulin may cause sodium retention and edema, particularly if previously poor metabolic control is improved by intensified insulin therapy.

Lipodystrophy and hypersensitivity are among potential clinical adverse effects associated with the use of all insulins. As with all insulin preparations, the time course of LEVEMIR action may vary in different individuals or at different times in the same individual and is dependent on site of injection, blood supply, temperature, and physical activity.

Adjustment of dosage of any insulin may be necessary if patients change their physical activity or their usual meal plan.

Hypoglycemia
As with all insulin preparations, hypoglycemic reactions may be associated with the administration of LEVEMIR. Hypoglycemia is the most common adverse effect of insulins. Early warning symptoms of hypoglycemia may be different or less pronounced under certain conditions, such as long duration of diabetes, diabetic nerve disease, use of medications such as beta-blockers, or intensified diabetes control (see PRECAUTIONS, Drug Interactions).

Such situations may result in severe hypoglycemia (and, possibly, loss of consciousness) prior to patients’ awareness of hypoglycemia.

The time of occurrence of hypoglycemia depends on the action profile of the insulins used and may, therefore, change when the treatment regimen or timing of dosing is changed. In patients being switched from other intermediate- or long-acting insulin preparations to once- or twice-daily LEVEMIR, dosages can be prescribed on a weight-based basis; however, as with all insulin preparations, dosing and timing of administration may need to be adjusted to reduce the risk of hypoglycemia.

Renal impairment
As with other insulins, the requirements for LEVEMIR may need to be adjusted in patients with renal impairment.

Hepatic impairment
As with other insulins, the requirements for LEVEMIR may need to be adjusted in patients with hepatic impairment.

Injection Site and Allergic Reactions
As with any insulin therapy, lipodystrophy may occur at the injection site and delay insulin absorption. Other injection site reactions with insulin therapy may include redness, pain, itching, hives, swelling, and inflammation. Continuous rotation of the injection site within a given area may help to reduce or prevent these reactions. Reactions usually resolve in a few days to a few weeks. On rare occasions, injection site reactions may require discontinuation of LEVEMIR.

In some instances, these reactions may be related to factors other than insulin, such as irritants in a skin cleansing agent or poor injection technique.

Systemic allergy. Generalized allergy to insulin, which is less common but potentially more serious, may cause rash (including pruritus) over the whole body, shortness of breath, wheezing, reduction in blood pressure, rapid pulse, or sweating. Severe cases of generalized allergy, including anaphylactic reaction, may be life-threatening.

Intercurrent Conditions
Insulin requirements may be altered during intercurrent conditions such as illness, emotional disturbances, or other stresses.

Information for Patients
LEVEMIR must only be used if the solution appears clear and colorless with no visible particles. Patients should be informed about potential risks and advantages of LEVEMIR therapy, including the possible side effects. Patients should be offered continued education and advice on insulin therapies, injection technique, life-style management, regular glucose monitoring, periodic glycosylated hemoglobin testing, recognition and management of hypo- and hyperglycemia, adherence to meal planning, complications of insulin therapy, timing of dosage, instruction for use of injection devices and proper storage of insulin. Patients should be informed that frequent, patient-performed blood glucose measurements are needed to achieve effective glycemic control to avoid both hyperglycemia and hypoglycemia. Patients must be instructed on handling of special situations such as intercurrent conditions (illness, stress, or emotional disturbances), an inadequate or skipped insulin dose, inadvertent administration of an increased insulin dose, inadequate food intake, or skipped meals. Refer patients to the “LEVEMIR Patient Information” circular for additional information.

As with all patients who have diabetes, the ability to concentrate and/or react may be impaired as a result of hypoglycemia or hyperglycemia.

Patients with diabetes should be advised to monitor their health care professional if they are pregnant or are contemplating pregnancy (see PRECAUTIONS, Pregnancy).

Laboratory Tests
As with any insulin therapy, the therapeutic response to LEVEMIR should be monitored by periodic blood glucose tests. Periodic measurement of HbA1c is recommended for the monitoring of long-term glycemic control.

Drug Interactions
A number of substances affect glucose metabolism and may require insulin dose adjustment and particularly close monitoring.

The following are examples of substances that may reduce
the blood-glucose-lowering effect of insulin: corticosteroids, danazol, diuretics, sympathomimetic agents (e.g., epinephrine, albuterol), terbutaline, isoniazid, phenothiazine derivatives, somatropin, thyroid hormones, estrogen, progestogens (e.g., in oral contraceptives).

The following are examples of substances that may increase the blood-glucose-lowering effect of insulin and susceptibility to hypoglycemia: oral antidiabetic drugs, ACE inhibitors, disopyramide, furosemide, quinolones, MAO inhibitors, propranol, salicylates, somatostatin analog (e.g., octreotide), and sulfonamide antibiotics.

Beta-blockers, clonidine, lithium salts, and alcohol may either potentiate or weaken the blood-glucose-lowering effect of insulin. Pentamidine may cause hypoglycemia, which may sometimes be followed by hyperglycemia. In addition, under the influence of sympatholytic medicinal products such as beta-blockers, clonidine, guanethidine, and reserpine, the signs of hypoglycemia may be reduced or absent.

The results of in-vitro and in-vivo protein binding studies demonstrate that there is no clinically relevant interaction between insulin detemir and fatty acids or other protein-bound drugs.

Mixing of Insulins

If LEVEMIR is mixed with other insulin preparations, the profile of action of one or both individual components may change. Mixing LEVEMIR with insulin aspart, a rapid-acting insulin analog, resulted in a about 40% reduction in AUC,

LEVEMIR® should not be mixed or diluted with any other insulin preparations.

Carcinogenicity, Mutagenicity, Impairment of Fertility

Standard 2-year carcinogenicity studies in animals have not been performed. Insulin detemir tested negative for genotoxic potential in the in-vitro reverse mutation study in bacteria, human peripheral blood lymphocyte chromosomal aberration test, and the in-vivo mouse micronucleus test.

Pregnancy: Teratogenic Effects: Pregnancy Category C

In a fertility and embryonic development study, insulin detemir was administered to female rats before mating, during mating, and throughout pregnancy at doses up to 300 mmol/kg/day (3 times the recommended human dose, based on plasma Area Under the Curve (AUC) ratio). Doses of 150 and 300 mmol/kg/day produced numbers of litters with visceral anomalies. Doses up to 900 mmol/kg/ day (approximately 135 times the recommended human dose based on AUC ratio) were given to rabbits during organogenesis. Drug-dose related increases in the incidence of fetuses with gall bladder abnormalities such as small, bilobed, bifurcated and missing gall bladders were observed at a dose of 900 mmol/kg/day. The rat and rabbit embryofetal development studies that included concurrent human insulin control groups indicated that insulin detemir and human insulin had similar effects regarding embryotoxicity and teratogenicity.

Nursing Mothers

It is unknown whether LEVEMIR is excreted in significant amounts in human milk. For this reason, caution should be exercised when LEVEMIR is administered to a nursing mother. Patients with diabetes who are lactating may require adjustments in insulin dose, meal plan, or both.

Pediatric use

In a controlled clinical study, HbA1c, concentrations and rates of hypoglycemia were similar among patients treated with LEVEMIR and patients treated with NPH human insulin.

Geriatric use

Of the total number of subjects in intermediate and long-term clinical studies of LEVEMIR, 85 (type 1 studies) and 363 (type 2 studies) were 65 years and older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out. In elderly patients with diabetes, the initial dosing, dose increments, and maintenance dosage should be conservative to avoid hypoglycemic reactions. Hypoglycemia may be difficult to recognize in the elderly.

ADVERSE REACTIONS

Adverse events commonly associated with human insulin therapy include the following:

Body as a Whole: allergic reactions (see PRECAUTIONS, Allergy).

Skin and Appendages: lipodystrophy, pruritus, rash.

Mild injection site reactions occurred more frequently with LEVEMIR than with NPH human insulin and usually resolved in a few days to a few weeks (see PRECAUTIONS, Allergy).

Other:

Hypoglycemia: (see WARNINGS and PRECAUTIONS).

In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, the incidence of severe hypoglycemia with LEVEMIR was comparable to the incidence with NPH, and, as expected, greater overall in patients with type 1 diabetes (Table 4).

Weight gain:

In trials of up to 6 months duration in patients with type 1 and type 2 diabetes, LEVEMIR was associated with somewhat less weight gain than NPH (Table 4). Whether these observed differences represent true differences in the effects of LEVEMIR and NPH insulin is not known, since these trials were not blinded and the protocols (e.g., diet and exercise instructions and monitoring) were not specifically directed at exploring hypotheses related to weight effects of the treatments compared. The clinical significance of the observed differences has not been established.

Table 4: Safety Information on Clinical Studies

<table>
<thead>
<tr>
<th>Weight (kg)</th>
<th>Hypoglycemia (severe or moderate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment</td>
<td># of subjects</td>
</tr>
<tr>
<td>Type 1</td>
<td></td>
</tr>
<tr>
<td>Study A</td>
<td>LEVEMIR</td>
</tr>
<tr>
<td>NPH</td>
<td>N=133</td>
</tr>
<tr>
<td>Study C</td>
<td>LEVEMIR</td>
</tr>
<tr>
<td>NPH</td>
<td>N=257</td>
</tr>
<tr>
<td>Study D</td>
<td>LEVEMIR</td>
</tr>
<tr>
<td>Pediatric NPH</td>
<td>N=115</td>
</tr>
<tr>
<td>Type 2</td>
<td></td>
</tr>
<tr>
<td>Study E</td>
<td>LEVEMIR</td>
</tr>
<tr>
<td>NPH</td>
<td>N=239</td>
</tr>
<tr>
<td>Study F</td>
<td>LEVEMIR</td>
</tr>
<tr>
<td>NPH</td>
<td>N=200</td>
</tr>
</tbody>
</table>

* Major = requires assistance of another individual because of neurologic impairment
** Minor = plasma glucose <56 mg/dl, subject able to deal with the episode him/herself

OVERDOSAGE

Hypoglycemia may occur as a result of an excess of insulin relative to food intake, energy expenditure, or both. Mild episodes of hypoglycemia usually can be treated with oral glucose. Adjustments in drug dosage, meal patterns, or exercise may be needed. More severe episodes with coma, seizure, or neurologic impairment may be treated with intramuscular/subcutaneous glucagon or concentrated intravenous glucose. After apparent clinical recovery from hypoglycemia, continued observation and additional carbohydrate intake may be necessary to avoid reoccurrence of hypoglycemia.

More detailed information is available on request.

Rx only

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Manufactured for Novo Nordisk Inc., Princeton, NJ 08540
 Manufactured by Novo Nordisk A/S, 2880 Bagsvaerd, Denmark
www.novonordisk-us.com

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novo nordisk®
visits, not only for documentation purposes, but also for billing.

“Their only ones who truly know what’s going on in their minds when it comes to picking management options and differential diagnoses,” says Marie Felger, CPC, CCS-P, an Indiana-based coding instructor and medical office auditor. “A staffer can look at the exam and count the necessary elements, but the physician has a true handle on the medical component. Therefore the physician should select the evaluation and management code.”

Even when doctors don’t do procedural coding, it is important for them to be familiar with the CPT descriptions and guidelines for the procedure codes pertaining to their specialty. “If [doctors are] familiar with what the code describes, they can make sure their operative note is specific enough,” says Nancy Enos, FACMPE, CPC, CPC-I, CPC-E/M, a consultant and coding instructor in Warwick, R.I.

“Historically, doctors haven’t paid a whole lot of attention to

Hire Credentialed Coders

Even when physicians take an active role in coding, it doesn’t eliminate the need for credentialed coders. Certified coders are trained to understand the complex criteria for proper code selection, the appropriate use of modifiers, CCI edits, and bundling issues. According to Deborah Grider, CPC, president of the National Advisory Board of AAPC (American Academy of Professional Coders), a certified coder “can be their partner and can correct coding before it goes to the insurance company. It can keep them from losing revenue.”

“Physicians do not need or desire to be coders,” says Garry L. Huff, MD, CCS, associate director of DRG Review, Inc. “They need to have confidence and rely on the coding and documentation professionals. But for these professionals to be able to do their jobs, they need to have open lines of communications with their physicians.”

Coders also play an importance role in compliance. They make sure that charges without proper documentation don’t get sent, says Rita Bowen, MA, RHIA, CHPS, SSGB, enterprise director, HIM Services for Erlanger Health System in Chattanooga, Tenn. “They are our eyes and ears for compliance before the claim goes out the door,” says Ms. Bowen. They’re trained to ask questions if they see a charge for something that has not been documented.
codes,” admits Gerald J. Russo, MD, FAAP, chief medical officer of Bloodhound Technologies, a claims editing company based in North Carolina. Doctors didn’t spend much time on diagnosis codes because the procedure (CPT) codes drove the revenue. Because of this, “they wouldn’t differentiate between an allergic asthmatic and an intrinsic asthmatic; they would just use the general code for asthma.” But that was before coding was used to track quality of care.

Dr. Russo, who practiced pediatrics for 10 years before becoming Bloodhound’s chief medical officer, says that at the minimum, doctors should do their own code assignment for the evaluation and management service. “Looking from the outside, it’s easy to misjudge the complexity of the service,” he says. “In the best functioning office, the doctor assigns the code on a routing slip. And the doctor has the coding and billing specialist look at it to see if there are any questions about over-assigning or under-assigning and [has the specialist] get back to him or her to address any concerns.”

Superior Superbills

To make it easier for doctors to do their own coding, the office should print commonly used codes for that specialty on the superbill. The doctor can then check off items on the charge sheet so that it’s ready for billing. While this procedure seems obvious, not all office practices follow it. The American Academy of Professional Coders (AAPC) estimates that only 50 percent of physicians use superbills.

Debbie Sword, CCBS, who established her own medical billing service in Illinois after working in medical offices, says that one of the first things she creates for a new client is the superbill, if the office doesn’t already have one. “We design the superbill so all you have to do is circle, circle, circle,” she says. With this system, she usually gets the information she needs to file accurate claims.

But physicians can’t rely on the superbill alone to ensure proper coding. Ms. Felger says doctors need to be certain that staff members are capturing all ancillary charges, like injections. And physicians themselves need to be familiar with documentation guidelines in order to select the correct level of evaluation
“They can’t just turn it all over to someone else,” she says. What coding rules should physicians know? “They need to understand that coders can’t specify a diagnosis to a higher level than the doctor has [documented in his notes],” says Garry L. Huff, MD, CCS, associate director of DRG Review, Inc., a national consulting firm that works with hospitals to link the clinical and coding processes. For example, Dr. Huff says that only the doctor can provide the specification as to the patient’s type of anemia.

“In the office you must link every procedure you do with a covered diagnosis,” Dr. Huff says. “If you do an EKG and you put down something like abdominal pain, very likely you won’t get paid, because they recognize that you do not do an EKG for abdominal pain. You must link a diagnosis with a CPT code.”

Dr. Huff sometimes gives a lecture titled “Coding and Physician Self-defense,” which highlights why physicians need to pay close attention to the coding of their records and ways to better communicate with those responsible for coding.

**Documentation**

“Good documentation is what produces good coding,” says Ms. Hubbard. “It’s important for physicians to be thorough in the documentation of the patient’s history, the physical examination, and the medical decision making.”

Documentation serves many purposes; the most obvious is a historical record of the patient’s condition and treatment plan. Documentation is the basis for coding. But doctors do not always include enough documentation to support their codes, especially with E/M codes. “They don’t document enough for that level of service. They miss things in the history that they
performed but didn’t document,” says Deborah Grider, CPC, CPC-H, CPC-P, CCS-P, CCP, a consultant and president of the National Advisory Board of the American Academy of Professional Coders (AAPC).

Ms. Enos notes that doctors should make sure their medical record meets two requirements: Is it complete and did I prove the treatment was necessary?

Even when doctors do a good job documenting the physical exam, they sometimes fail in documenting the history. Ms. Felger says the area that physicians have the most trouble documenting is history of present illness. “If patients have a multitude of problems, they’ll likely need the highest level of service and should code for that,” Ms. Felger says. “If [doctors] haven’t documented the history of present illness well enough, it’s going to limit [patients] to a lower level of service.”

She gives an example of abdominal pain as the chief complaint. “That’s one element of the HPI, but that’s not enough to get to a higher level. They have to say something like ‘lower abdominal pain, moderate severity, going on for two days, and it’s constant.’ Those are enough elements to get to that higher level. If the rest of the exam points them to a 99214 or higher, they’ll be able to bill it,” Ms. Felger says.

Ms. Hubbard gives the example of a hysterectomy, a procedure that may normally take 90 minutes. If the patient has extensive pelvic adhesions, it may take the physician more than two hours. She says that if the physician carefully documents this extra time and work, the coder can account for this in the claim, ethically asking the payer for additional money. “Otherwise, the coder doesn’t have the information needed; and the physician loses money,” she explains.

In October 2006 the medical severity DRG, or MSDRG, was instituted. The system is similar to the ICD-9 system, says Dr. Russo. Doctors and hospitals have to accurately document the
conditions they’re treating so the correct ICD-9 and MSDRG codes are assigned. He notes that with the old system, congestive heart failure would be a reimbursable diagnosis. The new system requires documentation to include left- or right-sided, systolic or diastolic congestive heart failure.

“You can lose credit because you haven’t been as specific as you should be,” says Dr. Russo. “You’ll be paid less, and it will affect your quality rating. It will appear you’re treating patients with a lower severity of illness, and it looks like your complication rates are high.”

Dr. Russo gives the example of an orthopedic surgeon’s performing a joint procedure on a patient with diabetic bone changes. This condition makes the bone more brittle, fracturing easily, which makes the surgery more extensive. It’s a higher-level surgery with additional expected complications. “If you just diagnose osteoarthritis, but you don’t diagnose diabetic bone changes, it will look like the patient wasn’t as ill, but the complication rate will be higher,” Dr. Russo says.

Detailed documentation in the hospital helps both the facility and the physician. Dr. Huff says it’s important to do the assessment in the SOAP format, with particular focus on the assessment or plan. “In the assessment, they need to provide a list of the current problems they’re addressing on that day. It protects them on their coding and helps the hospital arrive at their reimbursement,” he says.

There’s a reason for all this documentation. “It’s extremely important to hospitals, with the movement toward the MSDRG. If the doctor doesn’t document a condition on admission, the hospital may not be paid for it,” says Dr. Russo.

Dr. Huff recommends that physicians pay attention to the questions that hospital coders pose to them, in order to improve
documentation. This is not only a time-saving measure, but the codes become part of the permanent record tracking the doctor’s and the hospital’s performance.

Multiple Services on the Same Day

When multiple services are provided on the same day, E/M coding can get confusing, says Ms. Grider. “There are a lot of issues doctors need to understand when they bill more than one CPT code together.”

Modifiers are often required in this situation. Ms. Enos says that doctors shouldn’t rely on the billing department to fill them in. “Modifiers usually flag special circumstances, and the billing department can’t know when those special circumstances exist, as when the patient has an unrelated post-op complication,” she says.

Ms. Grider adds that modifiers are also important to avoid claims denials and compliance problems. Billing for each component of service using an unbundled approach goes against Medicare’s Correct Coding Initiative. “When I train doctors, I talk about the National Correct Coding Initiative and how modifier usage is important,” says Ms. Grider, author of the book, Coding With Modifiers: A Guide to Correct CPT and HCPCS Modifier Usage (American Medical Association, 2004).

Modifiers 25 and 59 are used to signal payers that multiple services or procedures were provided on the same day and that they meet criteria for separate payment. Without these modifiers, charges may be denied. Dr. Russo points out the use of these two modifiers is targeted by the Office of the Inspector General (OIG) for incorrect usage.

CPT’s definition of modifier 25 states that a physician may need to indicate that on the day of a procedure or other service identified by a CPT code, the patient’s condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure performed. This circumstance may be reported by adding modifier 25 to the E/M service on the claim. A 2005 OIG report based on 2002 data showed that 35 percent of claims using this modifier didn’t meet Medicare guidelines.

Modifier 59 is used to bill two distinct and separate proce-
What Doctors Need to Know About ICD-10

The current diagnostic coding system, ICD-9-CM, was developed primarily for classification of inpatient data and has been in use since the 1970s. Codes are added and revised annually, but much of the terminology is outdated; and the three-digit Tabular List is running out of numbers to assign for new codes.

Even with more than 13,000 diagnostic codes and 11,000 procedure codes, ICD-9 cannot provide sufficient detail for describing the severity, complexity, and status of disease conditions. “It’s outdated and doesn’t reflect the current state of medical care,” says Patricia Hubbard, CPC, CPC-OBGYN, a medical practice manager in New York State. “Consequently, third-party payers are increasingly demanding additional documentation in order to support claims.”

The U.S. government wants to adopt the ICD-10-CM system, with 68,000 diagnosis codes and 87,000 procedure codes. The Department of Health and Human Services (HHS) has announced that the implementation date for ICD-10 will be October 1, 2013.

ICD-10 is not just an expansion of ICD-9, but a whole new code set. ICD-10 codes begin with an alpha character followed by a combination of numerals and letters. Valid codes can be three to seven characters in length. There will be a steep learning curve while providers, facilities, and payers acclimate to the new system. For example, under ICD-9, Essential (primary) Hypertension is found under category 401. Under ICD-10, this diagnosis is found in category I10.

Marie Felger, CPC, CCS-P, an Indiana-based coding instructor and medical office auditor, says the ICD-10 system does have advantages, but she feels the gains are mostly for statisticians. “They want to be able to track

dures occurring on the same day. Modifier 51 is used to indicate multiple procedures at the same session, often for the same (or related) condition.

Modifiers are sometimes required to separate treatment of the left and right sides. “For ophthalmology and podiatry, there’s a modifier for left and right,” Ms. Sword notes. “If you bill the same code for left and right without a modifier, it’s seen as a duplicate entry and won’t be paid.”

Under- and Overcoding

While overcoding is certainly a concern, undercoding is also very common, says Ms. Felger. “It comes from a couple of rea-
sons. One is fear; [doctors are] afraid they’ll be audited. So to
be safe, they pick the lower-level code. The second reason is that
they don’t understand the documentation guidelines. [Doctors]
derunder-code because they don’t know what they need to write
down. They are doing the work for a higher level but aren’t cap-
turing information [to support charging at that level],” Ms. Fel-
ger says.

Dr. Russo says that lack of knowledge can lead to what he
calls “bar coding.” Each of the five office visit levels has associ-
ated components that must be documented to justify the level of service chosen. And the level chosen must correspond to med-
ical necessity as well.

THE PHYSICIAN’S ROLE IN CODING

the disease base more accurately. In five to ten years, this may improve
quality of care, but is it worth the billions of dollars? Could this money be
better spent? We’ve got all these uninsureds. Yes, the rest of the world is
using ICD-10, but most of the rest of the world is a single-payer system.”

The increased detail required by ICD-10-CM means that most physi-
cians will need to pay even closer attention to their documentation. “For
example, the diagnosis “acute otitis media” may be sufficient under ICD-
9 but does not provide enough information for a code assignment under
ICD-10-CM rules,” says Ms. Hubbard. “Under ICD-10, you will need to
document whether the infection is initial or recurrent and whether right/left
ear or bilateral.”

A 2004 Rand Corporation study, The Costs and Benefits of Moving to the
ICD-10 Code Sets, estimates the benefits of making the switch: more
accurate payments for new procedures; “fewer miscoded, rejected, and
improper reimbursement claims; better understanding of the value of new
procedures; improved disease management; and better understanding of
healthcare outcomes.” After an initial adjustment period of up to five years,
the change would result in benefits to the healthcare system of between
$200 million and $2,500 million, the report says.

How will ICD-10 affect a physician’s practice? Nachimson Advisors, a
strategic healthcare technology consulting firm in Maryland, analyzed the
cost for implementing ICD-10 in physician offices. They found that for a
typical small practice (three physicians and two administrative staff mem-
biers), it would cost $83,290. For a medium practice, consisting of ten
providersons, a full-time coder and six administrative staffers, the cost would
run $285,195. For a large practice with 100 providers and 64 staff mem-
biers, implementing ICD-10 would cost $2.7 million.
Some doctors don’t want to be bothered trying to figure out a level-one versus level-five office visit,” he says, so some of them bill all visits as a level three. “They think it will even out, and they won’t have to worry.”

But that’s not the case. “The doctor is probably losing reimbursement overall,” says Dr. Russo. “He might be losing out on the opportunity to bill level four or five. And it stands out as a red flag for an audit.”

Ms. Hubbard has seen this as well. She says that when auditing office records and sampling claims and associated billing records, she finds that physicians are leaving a lot of money on the table because they don’t understand the components of the various codes.

Undercoding can be dramatic in the case of surgeries, where each detail can make hundreds of dollars of difference for each procedure. “I’ve seen doctors lose $800 on each operation

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### ACCURATE BILLING AND CODING

#### Primary Differences Between ICD-9 and ICD-10

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<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>ICD-10-Diagnosis Codes</th>
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</thead>
<tbody>
<tr>
<td>13,000 Diagnosis Codes</td>
<td>68,000 Diagnosis Codes</td>
</tr>
<tr>
<td>Uses 3-to-5 digit codes</td>
<td>Uses 3-to-7 digit codes</td>
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</tbody>
</table>
| Chapters 1-17 use all numeric characters, supplemental chapters use an alpha first digit (E or V) | • Digit 1 is alpha (A-Z, not case sensitive)  
  • Digit 2 and 3 are numeric  
  • Digits 4-7 are alpha or numeric |

<table>
<thead>
<tr>
<th>ICD-9-CM Procedure Codes</th>
<th>ICD-10-PCS Codes</th>
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<tbody>
<tr>
<td>11,000 Procedure Codes</td>
<td>87,000 Procedure Codes</td>
</tr>
<tr>
<td>Uses 3-to-4 digit codes</td>
<td>Uses 7-digit codes</td>
</tr>
<tr>
<td>All 4 digits are numeric</td>
<td>Any of the digits can be alpha or numeric. Letters O and I are not used to avoid confusion with number 0 and 1.</td>
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because they don’t include the detail of excision of one particular organ or the extent of the surgery, and it makes a difference in the reimbursement,” says Ms. Enos. “If they don’t say what they did, they’ll be coding lower by default.” She adds that the coder can’t add in those codes unless documentation proves it.

It can go the other way, too. Some doctors bill for a higher level of care than medical necessity allows. “A lot of doctors make the mistake of documenting a comprehensive physical and history, and billing everything as a level four or five,” says Dr. Russo. “If a patient comes in with an ear infection, which shouldn’t be more than a level three, and I bill level four or five, I’m not meeting medical necessity. I’m doing more than I need to do. That could get you caught up in an audit.”

Ms. Felger adds that some patients feel they haven’t been to the doctor unless he or she has listened to their heart and respiratory sounds. “It might not be medically necessary, but you may do that if your patient expects it. Just don’t count it by coding for that level of service,” she says.

With increased education in recent years, many physicians better understand what needs to be documented, Ms. Felger says, and bell curve studies show the results, with family practice physicians’ coding their visits at a higher level. “You see a shift: 99214 established patient visits have risen, and the number of 99213 visits have gone down a bit,” she says. “Physicians are learning the documentation guidelines and feeling comfortable accurately reporting their services at these higher levels when they actually did this work.”

**Staying Current on Coding**

After taking a basic course on coding, doctors and their staff should continually attend seminars to refresh themselves on the rules. “Codes continuously change from year to year, so a code from five years ago might not be valid today,” Ms. Enos says. “There’s a ton of that information that comes out, and not all of it will pertain to that particular physician.” She advises that a staffer find what’s pertinent to the physician’s practice, and give it to the physician to read.

Both CPT and ICD-9 codes are updated annually, incorporating additions, deletions, and revisions. CPT changes are effec-
ICD-9 changes are effective on October 1. Specialty societies send out applicable updates to their members and offer courses on coding changes for the upcoming year. Practices should replace their manuals and update coding software every year. HCPCS manuals, which contain codes for reporting supplies and injections, should be replaced annually, as well. When codes change, claims will be denied if the practice continues to use invalid codes. The books cost less than $100 each.

Many specialties offer fact sheets or coding resources on their websites. There are many places to find coding courses. Marie Felger, CPC, CCS-P, an Indiana-based coding instructor and medical office auditor, notes that most state medical associations sponsor seminars on coding and documentation guidelines, as do specialty societies and specialty boards like AAFP and ACOG. "Family practice physicians don’t get this in their residency; they need to actively seek out courses where they’ll get the basics," she says. By taking coursework designed for physicians, doctors can often earn CME credits as well.

Many courses are now conducted through Webinars and audio conferences. Deborah Grider, president of the AAPC, recommends courses run by the AAPC, Ingenix, and the AMA. She also thinks highly of the audio conferences produced by Decision Health. Consider attending a course that relates to your specialty so the information is targeted to codes you’ll actually be using. CMS offers free coding and Medicare compliance online courses as well.

While classes are great ways to learn coding, it often helps to learn one-on-one. Some practices arrange for a coder to tag along with a doctor for a set amount of time. That staff member can show the doctor how to code each visit and can continue to audit the coding until the physician is proficient. For practices with several doctors, one doctor might become a certified coder. That physician would then become the point person for other physicians to consult with questions, and that physician could conduct peer-to-peer seminars as well. A coder (either a certified coder physician or certified staff member) might lead a lunchtime auditing session. After pulling a few charts, the coder can ask how each physician would code the visit. Then the coder can give an opinion, or the attending physician can discuss his or her thoughts.
Websites. For example, the American Academy of Pediatrics offers a fee-based newsletter on billing for pediatric services. Many specialty societies offer online assistance with coding issues. The American Society for Reproductive Medicine, for example, offers members specific coding guidance on questions like how to code for in vitro fertilization or which CPT codes should be used for donor eggs. The AMA provides coding and billing resources on its Website.

Ms. Felger urges physicians and staffers to do more than use ICD-9 and CPT manuals as references in specific coding questions. “A lot of people just look up the codes, but they’ll never read the guidelines or introduction,” Ms. Felger explains. “There’s a wealth of information in the books on how to code accurately and in what order, particularly in the diagnosis coding. If you sit down and read that, that will be a good education in and of itself.”