Part B Insider (Multispecialty) Coding Alert

Revenue Booster: Make Accurate Coding a Priority and Boost Your Profits

Use this expert's reference guide to improve your cash flow.

If you're not going over provider notes before you send the claims, then you may need to revaluate your practice's claims submission process. Here's the reality if your documents aren't in order and the codes don't match the notes, you're not going to get the Part B payment you deserve.

This way of thinking might come as a surprise to practices that are so busy that they haven't read their doctors' files in years, but it underscores the reality of how coding was meant to be performed. That's the word from **John Rumpakis, OD, MBA**, president and CEO of medical consulting firm Practice Resource Management, Inc. and founder of CodeSAFEPLUS®, a cloud-based system that provides zip code-specific CPT® and ICD coding information.

Rumpakis offers the following tips that can help you ensure that you collect the most accurate revenue while maintaining clean records.

Rule 1: Don't Equate Correct Coding With Cash

Although some practices look at a code for a complex procedure and instantly see dollar signs, that's not how it should be, Rumpakis says. "Coding is about accurate translation of the standard of care that was provided to that individual patient on that individual day, and translating the medical record of the care provided into accurate codes. If you are providing care that is medically necessary, and following the proper coding protocols for both the visit and any ordered procedures, you will be taking the first step in preventing lost revenues."

Checklist: Therefore, instead of looking at how much you'll be collecting after the doctor performs a specific service, you should be checking the records to ensure that the codes on the claim match the documentation in the chart and work from there. Typically, the reimbursement side will fall into place if you're coding correctly and the record is thorough. "While coding is not specifically about revenue generation, improper coding does cost a practice a significant amount of revenue from a cash flow perspective, and also puts past and future earning at risk due to audit exposure," Rumpakis says.

Rule 2: Stop Stressing About Audits

Many practices have been led to believe that the absolutely worst thing that can happen is to be audited by an insurer, but the reality is that if you follow tip one then an audit shouldn't worry you in the slightest.

"You should have no fear of an audit if you're doing the things required in performing medically necessary care and if you're a good recordkeeper," Rumpakis says. "An audit is nothing more than a system of checks and balances for care that you have previously provided. Your medical record should clearly identify the patient problem, the examination, and any additional medically necessary care that you have provided. If you're doing those things, then you should have nothing to fear."

Reasoning: Of course, not every practice has been keeping meticulous records that include ironclad proof of medical necessity for every procedure they perform. "In my experience, there are a significant amount of practitioners providing a lot of care that's not actually necessary and the record doesn't reflect the medical necessity, but they do it because it generates revenue and if there isn't a reason to do a particular test, that puts them at risk," Rumpakis says. These are the practices that should be worried about an audit, and if your practice falls into this category, now is the time to change your ways so you can ensure compliance down the road.

"My general advice is not to go into an audit alone," Rumpakis adds. "Assemble a team of people that have the expertise to assist in your situation. Have an attorney and consultant on your side that have this type of experience. Consultants like myself have been through hundreds of audit situations and are one of your best resources to mitigate as many issues as possible."

Rule 3: By All Means, Stop Downcoding

Most coders have been there you are unsure whether a chart warrants 99213 or 99214, so you play it safe and report 99213. But in reality, you should have scrutinized the chart more carefully and then cross-referenced the documentation against the E/M guidelines, which are clear enough that you should be able to determine the most accurate code by counting the elements of history, exam, and medical decision-making. Not only are you potentially wasting money by downcoding, but you're also being non-compliant.

"Undercoding would fall into the general category of improper coding, and is not any more safe than overcoding," Rumpakis says. "HIPAA requires physicians to follow the rules of CPT® and of the ICD, and practitioners must be aware and knowledgeable 100 percent of the time in every rule. If you undercode, you're no more safe in an audit than if you overcode. The only difference is that if you are undercoding, you wouldn't have to pay back an overpayment."

Reminder: In the end, following the rules set out by the CPT®, ICD, and your contracted insurer(s) will keep you on the right compliance track and allow you to bring in the accurate amount of revenue. "A lot of people undercode because they think it keeps them safe," Rumpakis says. "No, you've just hurt yourself and hurt your practice because you haven't done what the rules require."