# End of the Code

## *Down-coding hurts group revenues*

**By Robert E. Matthews**


iStock.com/AaronAmat/ivstiv

As we emerge from the COVID-19 crisis, America's physicians and medical groups face challenges going forward. For most groups, financial problems are high on the list. At PriMED Physicians, we have found meaningful opportunities.

The Centers for Medicare & Medicaid Services (CMS) promised that the revised 2021 Evaluation and Management (E/M) guidelines would be generous in recognizing the cognitive work that physicians do and easy to use. The new 2021 E/M guidelines are more generous for many specialties, but they are not easy to see, especially if groups want to bill for all of the complexities in the patients' disease burden.

In an era when every penny of revenue is important, two obstacles are blocking groups from needed revenues that are rightfully theirs. First, groups often are blinded to and unable to take advantage of the full earning power of the 2021 E/M guidelines. Second, commercial insurers often put unfair pressure on physicians and groups that are billing accurately under the CMS-adopted guidelines. Lacking confidence about documentation and E/M coding, groups may intentionally or unintentionally under-bill for services their providers performed.

## A Little History

The 2021 E/M guidelines are the first change in E/M standards since 1997 and, thus, disrupted long-established physician understandings. In our work to help more than 4,000 physicians and advanced practitioner professionals (APPs) adopt the 2021 guidelines, we find that most have not yet made the transition from their former documentation and coding habits to fully realize the new opportunities for high-level codes.

In the 1995/1997 guidelines, the history and exam taken by the physician or APP were two-thirds of the final E/M code. In 2021 E/M guidelines, history and exam aren't in the code calculation. Documentation of the disease burden that patients bring to care is what drives the 2021 E/M code. Sometimes, a Level 4 code is obvious, but in many instances, physicians don't understand how the new standards afford increased Level 4 and Level 5 encounters.

## Increased Disease Burden

For many reasons—high patient copays, high out-of-pocket deductibles, clinics in retail stores, online telehealth provided by insurers, etc.—the disease burden seen by our primary care physicians has markedly increased in the past several years. Physicians often complain about the work burdens of seeing patients but then don't recognize that the work they did makes them eligible for a high E/M code.

## Coders vs. Physicians

Most health systems retain coding experts to teach physicians. We've been successful employing a different approach. Our E/M CodeRight program, codeveloped by our management partner MediSync, was developed by physicians for physicians.

Certified coders typically approach E/M training by asking physicians to step into a coding mentality and language system. By contrast, E/M CodeRight honors the clinical thinking patterns physicians were trained to adopt. We fit the documentation and coding guidance into the native thinking patterns of physicians.

The 2021 E/M standards are clinically driven, and coders typically do not have advanced clinical training. Whereas coders struggle to explain the distinctions in pathologies that distinguish a Level 4 from a Level 5 coded visit, expert physician trainers excel (see "Peculiar Progressions").

Even if a practitioner recognizes the high-level codes, most do not effectively document an assessment to realize full credit. Keep in mind that, for Medicare, the difference between a Level 4 and a Level 5 is $54 (and likely more for commercial contracts), so even one such visit a day adds up.

## Adult Primary Care vs. Pediatrics

Based on our experience, a typical primary care physician who sees predominantly adult patients and who is well trained in documentation and E/M coding can expect to see about 75% of visits correctly documented and coded 99214. Some have over 80%. Visits coded 99215 fall in the range from 5% to 10% of all encounters. This is not up-coding—it is correctly coding and documenting the care provided based on the disease burden that patients present.

Pediatricians have often seen their E/M codes drop significantly due to changes in the 2021 E/M guidelines for two reasons. First, pediatricians routinely perform a thoroughgoing history and exam, in part because their patients cannot describe their own health status. In the 1997 E/M system, the history and exam counted significantly to a visit code, whereas in the 2021 guidelines, the history and exam do not count at all.

**E/M CodeRight honors the clinical thinking patterns physicians were trained to adopt. We fit the documentation and coding guidance into the native thinking patterns of physicians.**

# Peculiar Progressions

**The 2021 guidelines use terms such as "progression" and "severe progression" to define medical problems that have high code levels. These are not traditional terms of art in medicine, were not taught during physician training, and, therefore, doctors often feel uncertain about how to apply them.**

Second, we have found that many pediatricians are not used to documenting the complexities of a patient's pathology. In prior years, they performed a detailed history and exam and then wrote a short, often one- or two-word diagnosis. That approach does not work well with the new 2021 guidelines. With training, our pediatricians now average greater than 50% Level 4 visits, fewer than the old guidelines but far more than most pediatricians.

**Table 1**

## E/M Impact

*After 2021 guidelines, we see:*

| | |
|---|---|
| Adult primary care | 75% Level 4 codes |
| | 5–10% Level 5 codes |
| Pediatricians | 50%+ Level 4 codes |
| | 3% Level 5 codes |

## Insurance Companies Are Intimidating Physicians and Groups

Many physician group leaders prefer to avoid disagreements or even potential issues with CMS or carriers about documentation and coding. In our experience, we have found CMS to be knowledgeable and agreeable when we demonstrate that our doctors understand and apply the E/M guidelines.

This is less true of commercial carriers. Seeing high codes, some commercial carriers have been:

- **Down-coding visits without looking at the documentation.** This is particularly egregious.
- **Making groups go through reviews and appeals to get paid.** As they say in baseball, this is pushing the batter away from the plate. We have been in meetings with carriers where they assert completely inaccurate, even ridiculous, claims about the E/M standard. Commercial carriers can deliberately intimidate provider organizations, hoping they will down-code their own work.
- **Attempting to rewrite E/M guidelines to their own standards.** When CMS adopted the E/M standards, they made those standards obligatory for *all* payers. There is no Anthem, United, Humana, Aetna, or Cigna set of coding guidelines. The CMS guidelines, written and published by the American Medical Association, are the single source of truth.

## Two Fights with Commercial Carriers

When medical groups or health systems cannot agree with carriers on fees, the battle then becomes a public affair, with both sides threatening to end the contract. This often spills into the news media.

When an insurer down-codes visits and medical groups object, that conflict is not visible to the public. The carrier does not suffer any public damage to attempt this tactic, but conversely, it does not cost the provider organization any public respect to fight it.

## Our Position

Our PriMED physicians provide excellent care. Our care is high quality, and we reduce the total cost of care for populations. We earn every penny that we put on our claims.

Therefore, we are determined that insurers will pay every penny of the E/M rates that we correctly and rightfully bill. We are confident that our documentation and our E/M coding are correct, and when they disagree with us, the carriers are wrong. MediSync has now supported other client medical groups in their disputes with insurers.

Patiently demanding our rightful payments and confronting inaccurate coding standards has resulted in carriers suspending or delaying their down-coding programs.

All medical groups need the revenues that they rightfully earn. It would be a loss for groups to surrender to misguided and erroneous challenges, and doing so further reduces the ability of physicians to take the time and effort to properly care for patients. GPJ

***Robert E. Matthews*** *is vice president, Quality and Care Design, PriMed Physicians, and CEO and president of MediSync.*