Code for What You Do

Appropriate documentation prevents audits and clawbacks.

BY MICHAEL J. KING, DPM

Have we lost our way in the coding world? Have all the changes, many for the better, caught us unaware? The E&M changes are better for DPMs, yet we have total panic over using level 3 and 4 codes, and God forbid, we use a 5. We have become a much more surgically-focused specialty with the universal 3-year training programs, it appears. From this change, we are now using much more sophisticated code sets—and some problems have arisen from this shift.

Here is the key: code for what you do! Document what you do! Don't back away from using the most precise code for the service you provide, and just document accurately and completely. Daily stories arise from the fear of providers, auditors, and billers in the use of higher level and more complicated code combinations. Billers tell the DPM, "you can't use that code in your specialty; you will be audited if you use that level 4 visit."

Auditors expect some kind of crazy level of bullet counting even though those parameters went away three years ago, The parameters used today are medical decision-making or time, at least in the E & M space. We just have to make sure we use either of those, document completely, and not be lazy in our documentation habits.

Why have we become paranoid in our billing habits? This author would opine that we, as a specialty, are often singled out, accosted if not attacked compared to our general medical colleagues. Do you think a dermatologist is getting audited on medical nail disease treatment like a DPM? Tales are out there on the orthopedist who bills everyone a level 5 visit and is never audited; the internist who manages a podiatric-centric problem, bills a level 4 and no one seems to look at their notes. The old system of E & M made it impossible to reach a level 5 new visit for us; the new one allows such. CMS attempted to develop G codes ONLY for podiatric medicine and surgery for our office care simply because we were one the most benefitted specialties with the changes to the E & M coding

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requirements. So, we have some reason to be concerned.

The point here is that proper coding and documentation should hold up regardless of one's specialty, coding patterns, or code use, providing we are truly documenting properly. Providers in general get a bit lazy or burned out with documentation requirements. These requirements are often onerous and over the top, but nevertheless required to be paid properly. Telling a story is the most typical term used for good documentation so that anyone could look at our notes and know exactly what transpired. Payer expectations often make that story seem much more requirement-laden than what clinically is necessary, and we have to understand such and roll with those punches.

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This column is not advocating for over-coding nor under-coding, but for proper coding and documentation to match. We providers work too hard to not be paid for our work. Documentation that is complete and comprehensive, and that shows the story of what occurred, fulfills the requirements of the payer, and gets the provider paid appropriately—is often laborious and time-consuming. That said, there still is no better way to be reimbursed fairly, easily, and without audit fears than absolute solid knowledge of coding, the guidelines for each code, and using the most precise code available.

Let's not be fearful of billing for what we do. Let's be diligent in our approaches to documentation and let's all keep current with just what that entails…even if sometimes it is plain painful. **PM**

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