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Coding for E&M Services - Should We Be Using Level-of-Service Wizards?

Yogi Berra is credited with the saying, "It's tough to make predictions, especially about the future." Actually, it was Niels Bohr, a brilliant physicist who received the Nobel Prize in physics in 1922, who is responsible for this quote, but more power to Yogi for getting the credit. A derivative of this might go something like this; "It's tough to code, especially E&M codes." (credit to Frank Cohen).

E&M codes are strictly bound to a set of complex and sometimes confusing criteria found within one of two sets of guidelines. There are the 1995 guidelines, which were really introduced in 1994, and the 1997 guidelines, which were really introduced in 1996. Either (or both) are made of a series of tables, lists and grids that must be followed to determine the correct code. This is particularly true for, say, office and hospital encounters. For both, there are three key components; history, physical exam, and medical decision-making. Which code you choose depends upon a very complex and combinatorial matrix of grids, which convert these into key components. In fact, I once did an informal calculation of the complexity of coming up with the proper E&M code and I figured that a provider (or coder) has to go through some 1,600 decision points before

assigning the code. And even then, if you believe several good scholarly studies that have been done

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on the subject, 42% of those that reviewed the chart would disagree with the other 58%, who also reviewed the same chart, at least within on code level. God bless coders. I don't know how you do it but I'm glad it's you and not me. I'll stick to simple areas, like applied statistics and predictive analytics. It may not sound easy, but at least I am bound to a set of rules that are relatively axiomatic rather than elastic.

There's the history lesson on E&M codes; at least that's all I really care about. The point is, it's tough to code, especially for E&M codes. As such, human beings have forever been searching for an easier and more consistent method to code correctly. I guess we should forget about scrapping the incredibly poor method of guidelines we use now because, well, nobody seems to talk about that much. Instead, the industry has created a niche market of 'cheat sheets' and even though I am not a coder, I have seen hundreds if not thousands of these over the past 20 years. Go to any medical conference and probably half the vendors are giving them away for free. They are cards of varying size that have, in their own way, found a method to create grids to simplify the process. Great. Works for me.

Now comes along technology, because if a little is good then a lot is better, right? Right? Wrong. But there are those that see it as the silver bullet to the E&M coding problem. As it goes, there are some EMR systems that purport the ability to select the most correct and appropriate E&M code based on the information the provider enters into the program. The question is, does it work and even more important, if it does work, how well does it work? This, my friends, can be a compliance nightmare. I have worked with many organizations that have faced this dilemma; shoot or don't shoot. Should they employ the automatic level of service wizard or not? My experience has been that, without knowing whether there is a negative or positive impact; meaning whether the wizard would create a greater risk through an increase in coding error, it is best not to use these automated systems. Now, I didn't say you should use them; I said that, without some evidence that they don't increase risk, you shouldn't use them. And this is where statistics comes into play.

I have designed and run several experiments for clients to determine whether the wizard would prove to be a benefit or a hazard and this is a summary of how it would work. There are two parts to these types of studies. One looks at visible risk and the

other at inherent risk. For the former, it can be as simple as trending the average level of code within each category before and after the wizard is turn on within the system. The goal is assessing whether a change in utilization patterns will pose a visible risk; that is, will it look different enough to draw attention. Even if the coding is correct and without error, the auditor doesn't know that unless and until he or she reviews your charts. This is about being the squeaky wheel and at the outset, if there is a large positive shift, puts you on notice that your risk for a review may increase. But this is not a reason to scrap the wizard. That comes in the second part.

For the second part of the study, the goal is to test the system for error frequency, not to conduct a statistically valid analysis of error by provider as the purpose is to test risk, not to create it. To begin, we need to establish some baseline error rate. To do this, I take a random sample of, say, office and hospital visit codes from some group of providers within the practice. It can be all providers, or it can be some providers. If some, then you are getting into more complex sampling methods, but since this isn't really a statistically valid study, do your best to pick a random group of providers. How large should the sample size be? That depends on how precise you want your measurement to be. For example, if you estimate a starting error rate of, say, 20% and you want to be accurate within plus or minus 5%, you will need a minimum of 528 units. If you are ok with plus or minus 10%, then you can go with a minimum of 137 units.

In any case, you take this sample and sterilize it; meaning that you don't want to know the names of the docs since the purpose is not to conduct a qualitative analysis by provider but rather a quantitative analysis for the group. Audit the charts and record the error rate. Let's say, for sake of argument, you get an error rate of 15%. Then, you turn on the wizard. Train for the first 30 days, normalize for the next 30 days and then take another random sample (same number of units from same group of docs) from the next 30 days. Audit these and compare the results. If the error is the same or less, then the wizard doesn't introduce any additional risk. If the error rate is higher (in my case, I like to see it as statistically significantly higher), then forget the wizard as it will introduce more error and likely increase your risk.

The point here is that before you employ new technology, test it to see what impact it will have on your organization. It is my experience that CMS is

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not a fan of automated level of service wizards so if you are bent on using it, at least make sure that when the auditor comes knocking you can say a test was conducted and you found that there were no statistically significant differences between using the wizard and not using the wizard. And a point of clarity here; the test itself can be significant without the review of the docs being significant. This is important because remember, the goal is not to identify individual charting and coding issues but rather to establish a benchmark for comparison and testing. And what about that 15% error? Well, fix it and that's one less thing to worry about.

This Week's Audit Tip Written By:

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