# Ethical Coding in the Physician Office



*by Peg Austin, RHIA, CPC, and Mary H. Stanfill, RHIA*

---

Data quality has never been more scrutinized than it is today. Health Care Financing Administration rules and contractual obligations from various insurance companies complicate the notion of correct coding. At the same time, numerous trade associations publish coding guidelines that occasionally differ from the HCFA, American Medical Association, or American Hospital Association (AMA) interpretation. However well-meaning, the intent of some guidelines is to get a claim paid. There have been numerous discussions recently in coding and compliance circles regarding the contradictions that exist between the Health Information Management (HIM) coding perspective and the Balanced Budget Act (BBA) billing perspective.

The medical code of ethics directs the physicians to "first do no harm," so he or she will act in the best interest of the patient and think about documentation secondarily. Physicians may feel pressured by coding staff who continually ask for more complete documentation or appear to be questioning the physician's medical judgment. Meanwhile, the coder's intent may be simply to instruct or notify the physician of proper coding practices. Thus, the development of an honest, supportive relationship with physicians will help them understand the importance of proper documentation and its trickle-down effect on coding and resulting reimbursement. Threats about the consequences of false claims and improper coding make the most negative impression on physicians. Instead, they need someone to guide them through the labyrinth of coding guidelines and government regulations regarding reimbursement.

In some cases, however, all efforts at physician education are met with resistance or threats along with explicit instructions to "code it anyway." Or the inquisitive nature of coders may reveal a coding practice that had previously been regarded as insignificant until someone researched it further and discovered an inappropriate monetary result.

So, what should the coding professional do when faced with ethical dilemmas? Consider the following scenarios, which are followed by an analysis and ethical response based on the AHIMA Standards of Ethical Coding.

## *Scenario 1*

*Dr. Miller codes an office visit 99215 with a long list of diagnoses that are minor or "history of" conditions. The only diagnosis that Jill, the coder, can find that was actually treated was vaginitis (616.10). Because this is a Medicare patient, she is concerned about billing for a level V office visit. After discussion with Dr. Miller, it appears that the patient was actually in for an annual physical, and Jill suggests a preventive medicine code. Dr. Miller is adamant that this patient not have to pay and says, "Just tell me what I need to dictate to be able to bill the 99215 without getting into trouble."*

Several of AHIMA's Standards of Ethical Coding can be applied in this situation. Jill correctly applied standard #4: only codes that are clearly and consistently supported by physician documentation in the medical record should be coded. Standard #5 indicates that the coder should consult physicians for clarification and additional documentation prior to code assignment when there is ambiguous data in the health record. What should she tell Dr. Miller to dictate and how far does her responsibility extend in this case? Jill also needs to keep in mind standard #6, which directs the coders not to change codes or the narrative of codes so that meanings are misrepresented, #7, which calls on coders to advocate proper documentation practices, and #10, which cautions the coders to remember that it is unethical and illegal to maximize payment by means that contradict regulatory guidelines. Above all, Dr. Miller should be advised to document the service he provided to this patient and not embellish the details in order to justify the claim.

The ethical response to this scenario:

- advise Dr. Miller to document the service he provided, point out specific areas in his dictation where his services are unclear, and obtain a dictated addendum
- obtain coding advice on this visit from an appropriate source, such as a coding supervisor, peer coder, or coding consultant on retainer
- follow up with Dr. Miller regarding what codes are appropriate for the documented service, provided it is consistent with official coding guidelines and Medicare requirements. A possible solution might be use of HCPCS level II codes for a pap, pelvic, and breast exam along with the appropriate level office visit and modifier -25 to treat the vaginitis

**Ethical Coding Best Practices**

•Educate coders on the ethical standards and annually review them at the time of performance evaluations.

• Follow official coding guidelines and advice published in resources such as *CPT Assistant* and *Coding Clinic*.

• Develop tools to provide solutions to ethical dilemmas such as a compliance plan, facility-specific coding guidelines, facility-specific procedures for responding to coding errors or potential false claim submissions.

• Establish a good working relationship with the compliance officer and compliance committee.

• Physicians are best influenced by peers: find an advocate in the medical staff and work to keep this individual informed of ethical coding practices.

• Avoid focusing on penalties, such as fines and imprisonment, as a way to motivate physicians.

• Focus on consistent and accurate reporting of coded information for the purpose of quality healthcare data.

• Limit presentations to physician groups to 30 to 45 minutes, and avoid sandwiching presentations on ethics and compliance into larger meeting agendas.

• Tailor presentations to "real" practice-specific problems, rather than broad or general issues, with specific recommendations and tools for data quality improvement.

## *Scenario 2*

*Coders at XYZ clinic are responsible for coding from the dictated office notes and assigning CPT codes for ancillary services. Dr. Smith always circles the CPT code for his office visit appropriately, but does not circle anything else. When the coders review his dictation, they correctly circle other services provided and assign ICD-9 codes as dictated. Dr. Smith becomes very angry with the coding staff, saying that he told his patients that he would only charge them for the office visit, and the coders are creating additional charges for which patients will subsequently complain to him.*

Analysis of this scenario shows that coding standards #1 and #3 have been appropriately applied. As coding professionals, they are expected to support the importance of accurate, complete, and consistent coding practices for the production of quality healthcare data. Also, coding professionals should use their skills and knowledge of currently mandated coding and classification systems and official resources to select the appropriate diagnostic and procedural codes. Standard #6 states that coders should not change codes or the narratives of codes on the billing abstract so that meanings are misrepresented. Diagnosis or procedures should not be inappropriately included or excluded because payment or insurance policy coverage requirements will be affected. Standard #10 states that coding professionals should strive for optimal payment for which the facility is legally entitled, remembering that it is unethical and illegal to maximize payment by means that contradict regulatory guidelines.

The ethical response to this scenario:

- Reassure Dr. Smith that coding guidelines for the clinic are being followed to report codes accurately, regardless of payment source, and he is being treated the same as all of the clinic's physicians.
- Caution Dr. Smith that the coding system cannot be used to manage accounting issues, and that acts of benevolence can be handled appropriately on the accounting side, in accordance with insurance plan requirements.
- Discuss the issue with the appropriate compliance plan representative of the practice or the practice administrator for resolution by the medical staff.

These type of scenarios can be very difficult for any coding professional, yet turning a blind eye to questionable claims and coding practices can lead to serious consequences for the physicians.

***Cases to Consider***

Court cases involving the Office of the Inspector General (OIG) can take years to resolve. Following are two current cases:

*A urologist in Arkansas was charged with Medicare overpayment by unbundling lab codes and performing medically unnecessary tests. Review of claims paid over a period of six years showed overpayment of $708,812. Medicare argued that the physician had reason to be aware of the coding changes during that timeframe, but submitted erroneous claims regardless and was paid for tests he did not perform. In addition, some tests were done for screening purposes, and occasionally tests were repeated at close intervals without justification. The physician appealed, stating that the sampling methodology was flawed, but the original decision was upheld. This particular case has been ongoing since the mid-1990s.1*

*A physician in La Mesa, CA, pled guilty in December 2000 to charges of fraudulently billing Medicare for medically unnecessary cardiac rehabilitation, billing for office visits plus other procedures when only the rehabilitation procedure was done, and billing for monitored cardiac rehabilitation when only unmonitored rehabilitation was performed. The physician agreed to reimburse Medicare $50,000 and will be sentenced/fined in April 2001.2*

Circumstances like the above would certainly present an ethical challenge to an alert coding staff employed by these physicians. Regardless of whether or not your facility has an active compliance plan and committee, the following are general steps the coding professional should take when approaching a tough situation:

•Gather the facts regarding the situation and the standards that may apply. Get copies of the standards from their source

• Follow the chain of authority specific to your organization. Do not surprise your immediate supervisor by going over his or her head, but use hotlines or other anonymous reporting mechanisms, if necessary, to get the issues addressed

• At each level, explain the problem and the risk to the organization. Offer a solution, rather than just reporting the problem

• Document each meeting or conversation including date, time, issues discussed, who was involved with the discussion, and whether the problem was resolved

• If the practice continues, a formal letter is recommended to those in the chain of authority summarizing all of the previous steps

• If there is no hope of resolution, it is suggested that the coder should terminate his or her position, rather than condone the practice by continued employment

•The worse case scenario would obligate the coder to report the problem to the OIG or to the US Attorney's office

Coding professionals will inevitably be faced with ethical gray areas in their career. Diligence is necessary to apply guidelines in a consistent manner and to remain alert for questionable practices, even when no fraudulent intent exists. By using the resources available and establishing a positive working relationship with physicians, most coders will succeed in their efforts to code ethically and preserve data quality.

***Additional Resources for Ethical Coding***

The following are additional resources for ethical coding:

•AHIMA's Standards of Ethical Coding

• "Ethics in the Age of Compliance" Program in a Box by Linda Kloss, MA, RHIA, available at www.ahima.org

• Ethical Challenges in the Management of Health Information by Laurinda Harman, PhD, RHIA, available from Aspen Publishers in March 2001

• Health Care Compliance Association Web site at http://www.hcca-info.org.

• Health Information Management Compliance: A Model Program for Healthcare Organizations by Sue Prophet, RHIA, CCS, available at www.ahima.org

• Fighting Fraud and Abuse: Medicare Integrity Program available at http://www.hcfa.gov/medicare/fraud

• Office of the Inspector General. Available at http://www.oig.hhs.gov/index.htm. Contains the OIG Work Plan, fraud and abuse guidelines, and other reference materials

## Notes

1. CCH Research Network. Available at http://health. cch.com/network.

2. Health Care Compliance Association. This Week In Corporate Compliance 2, no. 50 (December 22, 2000).

---

***Peg Austin*** *(peg.austin@ahima.org) and* ***Mary Stanfill*** *(mary.stanfill@ahima.org) are AHIMA coding practice managers.*

---

**Article citation**:
Austin, Peg, and Mary H. Stanfill. "Ethical Coding in the Physician Office." *Journal of AHIMA* 72, no.3 (2001): 65-67.

---