The Best Practice Principles of Coding
Adapted from the AAP Coding for Pediatrics 2005
(pages 4-7)

1. **The physician should select the diagnosis and procedure codes.** Only the physician can determine what services were performed and how they should be coded to ensure that carriers obtain an accurate and precise description of the amount and intensity of the work performed. Because the physician is legally responsible for any coding submitted by the practice, the physician must direct coding decisions.

2. **Document patient services to justify the codes.** It has become more important for physicians to adequately document in the medical record, especially with regard to justification for the selection of a particular code. At a minimum, the record should contain the date of service; complaint with appropriate history; physical examination findings; laboratory test results; impression; and differential diagnosis, treatment recommended or prescriptions prescribed and follow-up plans. For services requiring counseling or coordination of care when the code selection is based on time, a notation of the total length of time spent and time counseling is required along with a description of the counseling and/or activities to coordinate care.

3. **Use separate codes for different encounters** Not all office E/M services are 99213s! Each encounter should be evaluated independently to determine which level of service is appropriate and your coding practice should reflect these differences. For most patient encounters, the nature of the visit will prompt the amount and type of work done and the selection of the appropriate code for that service.

4. **Set a separate fee for each code.** Because there is great discrepancy in the amount of work required for the various levels of office encounters, setting the same fee for each code will overcharge patients for the low-end visits and undercharge patients for the high-end visits. As a basis for a fee schedule, the total values created by the Resource Based Relative Value Scale (RBRVS) can be used to provide values for most CPT codes and establishes sound relativity among codes you will bill.

5. **Always use a modifier when altering a standard fee** Carrier reimbursement is computer driven and are programmed to recognize CPT codes and ICD-9-CM codes. Use of modifiers informs the carrier’s computer that “this one is different” and should result in alternative processing through a different subroutine on the computer or even manually.

6. **Set the fee schedule independent of the carrier reimbursement levels** Pediatricians should determine fees by their perception of the relative value of their services. While physicians cannot tell carriers what they must reimburse, carriers often tell physicians how they will be reimbursed and may set fee schedules by adopting the RVRVS from CMS, or by some function of prevailing rates. Physicians will receive a variety of fee schedules from various carriers; these should not be interpreted as an accurate reflection of the value of a pediatrician’s services.

7. **Know local variations in reimbursement** Carriers are notoriously independent in their reimbursement schedules. For a given service, one carrier may reimburse only if particular codes are submitted. Another carrier may require totally different codes or modifiers for the same service.

8. **Inquire about lowered or changed reimbursements** Review your payments (explanation of benefits) on a regular basis. Never assume that a change in reimbursement levels is correct.

9. **Review codes and fees regularly** This should be done at least annually with the office manager or billing clerk, ideally after the new AMA CPT codes are released after the first of the year.

10. **Design a superbill** that includes preprinted information on diagnosis and procedure codes to facilitate accurate charge capture when the physician selects the codes.