# Response to a Health Plan Audit

Dear Health Plan:

I am responding to your letter regarding the results of your administrative data analysis. I am a practicing family physician and actively participate with my specialty society, the American Academy of Family Physicians (AAFP). The AAFP supports appropriate coding by its members and provides appropriate education and tools. As noted in its "Coding and Reimbursement" policy (<http://www.aafp.org/x16325.xml>), AAFP believes it is important for both physicians and health plans to abide by the principles of CPT.

Your analysis questioned my coding of evaluation and management (E/M) services. You should be aware that E/M coding is not an exact science and that physicians more often undercode than overcode. For instance, a study in 2000 examined 1,069 charts and revealed that 12 trained auditors disagreed with the code selected by the physician and nurse practitioner in more than 70 percent of the cases reviewed. (See Zuber TJ, Rhody CE, Muday TA, et al. Variability in code selection using the 1995 and 1998 HCFA documentation guidelines for office services. J Fam Pract. 2000;49:642-645.) The documentation supported selection of a higher code than originally billed four times as often as it supported a lower code. Undercoding what is adequately supported by medical necessity and chart documentation skews the E/M coding bell curve, causing physicians who bill high-intensity E/M codes to be falsely identified as outliers. Other studies reinforce this notion. If physicians consistently documented the services they provided, there would be a plateau in the bell curve between codes 99213 and 99214. (See King MS, Sharp L, Lipsky MS. Accuracy of CPT evaluation and management coding by family physicians. J Am Board Fam Pract. 2001;14:184-192.)

Any profiling of a physician should be consistent with the AAFP policy on "Physician Profiling" (<http://www.aafp.org/x6972.xml>). The data analysis should have an appropriate sample size to ensure statistical validity, use claims data that spans meaningful time periods, be case-mix adjusted, include evidence-based clinical guidelines, be based on episodes of care, and be compared to my family physician peers in the local market. Any re-analysis of claims data should be at least six months from the last analysis. Anything short of this is inadequate and could create a fallible analysis report. Furthermore, results of the data analysis should not be publicly disclosed without the physician's permission.

To better understand your data analysis process, I would like to request a copy of the list of patients included, claims data time period, metrics used, time line for the next data analysis, and the appropriate next steps. My aim is to provide my patients the highest quality and most cost-effective medical care possible.

Sincerely,  
[Your Name]

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Family Practice Management. June 2005:17-20; http://www.aafp.org/fpm/20050600/17arey.html.