Don’t Let Preventable CPT Coding Mistakes Cause Heartburn

By Crystal Clack, MS, RHIA, CCS

Every medical practice should have preventive measures in place to avoid costly coding and billing audits, errors, and subsequent delays in payment. Incorrectly coded claims, missing charges on a patient encounter, and other mistakes can take a substantial bite out of both practice and physician revenue.

Decreased revenue can set off a domino-like effect of potential decreases in practice resources such as staff, training, supplies, and equipment. Furthermore, it can raise red flags that catch the attention of coding watchdogs, such as the Office of Inspector General (OIG), and inadvertently prompt an audit. But there are some steps that practices can take now to avoid the headache that entirely preventable CPT coding mistakes can cause later on.

Update Coding Resources

If a practice is using code books from 1999, trouble is assuredly just around the corner. It is imperative that claims for all medical practices that seek reimbursement for patient services are submitted utilizing correct code sets. Current year coding resources are a must in any practice, large or small. Codes change yearly, and if claims are submitted with old codes, chances are that reimbursement is not at its full potential. Outdated encounter forms and code resource lists are also problematic. They need to be updated to the current year’s ICD, CPT, and HCPCS codes. A quick survey of various stages of a physician practice revenue cycle will determine where codes are used and what resources are referenced.

Take Care When Assigning Modifiers

The use of modifiers indicates the altering of a service performed by a provider. According to the *CPT Coder’s Desk Reference*, modifiers may state the following:

- A service or procedure represents only a professional or technical component
- A service or procedure was performed by more than one physician
- Only part of a service was performed
- An adjunctive service was performed
- A bilateral procedure was performed
- A service or procedure was provided more than once
- Unusual events occurred
- A procedure or service was altered in some way

The most commonly misused modifiers are –25 and –59. Use of either one can make the difference between reimbursement and denial, yet not knowing the rules behind their appendage to an E/M code can, once again, raise significant red flags to OIG. Modifier –25 is used when there is a “Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of a procedure or other service,” according to the *CPT 2015 Professional Edition: Current Procedural Terminology*. The modifier can also indicate required services during preoperative or postoperative that were substantially above what a normal procedure would provide. Modifier –59 is appended to a code that represents “a different session, different procedure or surgery, different site or organ system, system incision/excision, separate lesion or separate injury” that is not normally addressed on the same patient visit, according to the *CPT 2015 Professional Edition*. As with all procedures, it is very important that the provider clearly supports the assignment of either modifier with appropriate documentation in the patient’s record.

Watch Out for Inappropriate Fee Unbundling

The Centers for Medicare and Medicaid Services developed the National Correct Coding Initiative to support correct coding practices. Promotion of coding best practices pre-emptively controls over- or under-payments. If a patient has a colonoscopy, the appropriate CPT code assigned would include all items normally used for a colonoscopy case. The coder would not charge separately for supplies, anesthesia, or provider time, etc. If a coder inadvertently assigns separate codes to each of these areas, the resulting unbundling creates a greater out-of-pocket expense for the patient.

Medical Necessity and Diagnostic Coding

A diagnosis code indicates the reason for a procedure. If a provider orders a radiology exam for an anterolateral and lateral chest X-ray, and writes the reason for the exam as "toe pain," the submitting claim will be denied and returned to the provider due to lack of medical necessity. Toe pain is not normally associated with a chest X-ray. Diagnostic codes must support medical necessity. The Medicare Benefit Policy Manual defines medically necessary services as "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member."

Track Down and Capture All Missing Charges

Lab tests, supplies, injections, and vaccinations are all commonly missed charges in a busy medical setting. In order to avoid losing revenue on these items, it may be helpful to provide training and support to staff to ensure they capture these and any other commonly missed charges.

Ensure E/M Codes are Correct

According to an OIG study roughly 42 percent of evaluation and management (E/M) services submitted to Medicare are coded incorrectly.[1] Providers may be set on assigning a 99213 to all patient visits as a "catch-all" code, however this may raise a red flag to OIG. It is important that providers understand the different elements involved in each E/M code, and code according to the presenting problem, patient history, examination, and medical decision making. Over-coding or under-coding can also send smoke signals to OIG. Code according to documentation to avoid any potential headaches in the future.

Continuing Education is Important

Educating providers, as well as front and back office staff, on best coding practices is an important proactive step to take to ensure the entire office is on the same page. Offering continuing education and monitoring of documentation, claims, and denials will help keep a practice on track and avoid errors that may necessitate audits.

Note

1. Verdon, Daniel R. "Significant Medicare coding errors signal need for physician education, OIG says." *Medical Economics*. June 2, 2014. http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/coding/significant-medicare-coding-errors-signal-need-physician-educa?page=full.

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