How to Avoid Common Coding Errors

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VP, Membership and Certification
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Objectives

• Review steps to avoid coding mistakes
• Discuss common coding errors that result in a denial for medical necessity
• Discuss common coding errors for preventive services
• Discuss common coding errors with modifiers
• Discuss common coding errors for E/M services
Our Goals as Coders

• Maintain coding and billing compliance

• Capture **appropriate** revenue
Steps to Avoid Coding Errors

• Know the payer rules. Same codes but the rules for payment are different.
  – LCD/NCD for CMS
  – Medicare Claims Processing Manual
  – Private payer payment polices

• Do NOT apply CMS rules across the board for all payers.
LCD Cataract Extraction (L33808)

Indications

Cataract surgery will be considered medically necessary and reasonable for the following conditions:

- Symptoms such as blurred vision, visual distortion, reduced contrast sensitivity and/or glare with associated functional impairment.

Functional impairment due to cataracts refers to lost or diminished ability to perform everyday activities, participate in hobbies or other leisure-time activities, or to work in one's occupation. Several instruments such as the VF-14, the activities of daily vision scale and the visual activities questionnaire are available for assessing functional impairment related to cataract.

- Visual disability with Snellen acuity worse than 20/40 with impairment of ability to carry out needed or desired activities. The ocular exam should confirm that the best correctable visual acuity in the affected eye is worse than 20/40 and that the cataract is responsible for this.

- Visual disability with Snellen acuity of 20/40 or better. For patients with a Snellen acuity of 20/40 or better, the indicators are the same as for patients with Snellen acuity of worse than 20/40. In addition, documentation must support a visual impairment such as fluctuation of visual function because of glare or reduced contrast sensitivity, which can be supported with the use of (but not limited to) procedures such as glare testing, brightness acuity testing (BAT), or contrast sensitivity testing; complaints of monocular diplopia or polyopia; or visual disparity existing between the two eyes (anisometropia).

- Lens-induced disease. Phacomorphic glaucoma, phacolytic glaucoma and other lens-induced diseases may require cataract surgery.

- Concomitant ocular disease (e.g., retinal disease) that requires clear media. Cataract extraction may be required to adequately diagnose or treat other ocular conditions, such as diabetic retinopathy.

Surgery is not medically necessary just because the cataract is present.
LCD Cataract Extraction (L33808)

Limitations

Surgery should not be performed solely to improve vision under the following circumstances:

- The patient does not desire surgery,
- Glasses or visual aids provide satisfactory functional vision,
- The patient’s life-style is not compromised,
- The patient is medically unfit (e.g., conditions such as comatose patients, Organic Brain Syndrome, end stage Alzheimer’s, patients with no light perception, etc. in which cataract surgery will not improve the patient’s independence).

In most cases, a comprehensive eye examination (ocular history and ocular examination) and a single scan to determine the appropriate pseudophakic power of the IOL are sufficient. In most cases involving a simple cataract, a diagnostic ultrasound A-scan is used. For patients with a dense cataract, an ultrasound B-scan may be used.

Accordingly, where the only diagnosis is cataract(s), Medicare does not routinely cover testing other than one comprehensive eye examination (or a combination of a brief/intermediate examination not to exceed the charge of a comprehensive examination) and an A-scan or, if medically justified, a B-scan. Claims for additional tests are denied as not reasonable and necessary unless there is an additional diagnosis and the medical need for the additional tests is fully documented.
Second-eye Surgery

Patients with significant bilateral cataracts meeting surgical criteria for extraction are common. Patients with a significant cataract in the second eye at the same time that the first eye cataract extraction is scheduled to be performed are also common. Assuming that the indications for surgery in the second eye are documented, the second eye surgery is delivered by standard protocols for delayed sequential bilateral cataract (DSBCS) surgery—so second eye surgery days to weeks later as a completely separate procedure after post-operative follow-up and assessment of the first eye. Protocols for immediately sequential bilateral cataract surgery (ISBCS) are an acceptable option for certain beneficiaries. ISBCS requires special precautions with complete sterile separation of the two eyes with rescrubbing, and new sets of instruments and fluids.

A thorough review of information from their ophthalmologist regarding known conditions and risks in their specific case must be discussed with the beneficiary for either DSBCS or ISBCS. An intra-operative complication on the first eye may necessitate deferral to a delayed protocol. Any surgical protocol is expected to be aligned to patient quality of care and outcomes as well as meet all the requirements of the Medicare program.
Steps to Avoid Coding Errors

- Review denials
  - Analysis denials by payer and denial code
  - Make sure all denials are posted with zero payment and reason for denial for easy report generation
- Identify errors
  - Internal
  - Payer
Steps to Avoid Coding Errors

• Review audit findings
  – Comprehensive Error Rate Testing (CERT)
  – Recovery Audit Contractor (RAC)
  – Office of Inspector General (OIG)
  • Work plan
  • Audit findings
2015 CERT Report

- E/M services 12.1 percent improper payment rate, approximately $43.3 billion
  - 99233 50.5% error rate
  - 99214 14.3% error rate
2016 HHS OIG Work Plan

- Hospitals—**REVISED** Medicare oversight of provider-based status
- Hospitals—**NEW** Medicare payments during MS-DRG payment window
- Physicians—**NEW** Physicians—referring/ordering Medicare services and supplies
- Physicians—**NEW** Physician home visits—reasonableness of services
- Physicians—**NEW** Prolonged services—reasonableness of services
OIG Audit Findings

06-21-2013 Meritus Medical Center Refunded Overpayments for Physician Claims With Place-of-Service Coding Errors For 2009 Through 2012

Meritus Medical Center (the Hospital) (operating in Maryland) submitted 17,000 claims with overpayments of $568,000 for physician services for calendar years 2009 through 2012. The Hospital, billing on behalf of its wound care facility physicians, incorrectly coded these claims by using nonfacility place-of-service codes for services that were actually performed in the Hospital's wound care center. The Hospital refunded the overpayments.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>36410, 36415</td>
<td>Routine blood draws</td>
<td>Not separately reimbursed when billed with laboratory or E/M services</td>
</tr>
<tr>
<td>36416</td>
<td>Collection of capillary blood specimen</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>36620</td>
<td>Insertion of an arterial catheter</td>
<td>Separately reimbursed when billed with an emergency department E/M code</td>
</tr>
<tr>
<td>99000, 99001</td>
<td>Handling fees</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>99050</td>
<td>After-hours services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday) in addition to basic service</td>
<td>Reimbursed when provided in addition to basic services, on Sundays and the following holidays; New Years Day, President’s Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Thanksgiving Day, and Christmas Day.</td>
</tr>
<tr>
<td>99051</td>
<td>Services provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>99053</td>
<td>Services provided between 10 p.m. and 8 a.m. at a 24-hour facility in addition to basic service</td>
<td>Not reimbursed</td>
</tr>
<tr>
<td>99070</td>
<td>Materials charges; generic supplies</td>
<td>Not reimbursed; a specific HCPCS code is required for reimbursement consideration</td>
</tr>
<tr>
<td>81002</td>
<td>UA dipstick, non-automated without microscopy</td>
<td>Not separately reimbursed when billed with an E/M service</td>
</tr>
<tr>
<td>96372</td>
<td>Therapeutic SubQ or IM injection</td>
<td>Not separately reimbursed when billed with an E/M service</td>
</tr>
</tbody>
</table>
Injections

(Rev. 968. Issued: 05-26-06; Effective/Implementation Dates: 06-26-06)

If a significant separately identifiable evaluation and management service is performed, the appropriate E/M code should be reported utilizing modifier 25 in addition to the chemotherapy administration or nonchemotherapy injection and infusion service. For an evaluation and management service provided on the same day, a different diagnosis is not required.

MCM 100.04 Ch. 12 30.5
EKG Denials

Diagnosis does not meet medical necessity

• Evaluation of a patient with known Coronary Artery Disease (CAD) and/or heart muscle disease that presents with symptoms such as increasing shortness of breath (SOB), palpitations, angina, etc.

• Pre-operative Evaluation of the patient when:
  – undergoing cardiac surgery such as CABGs, automatic implantable cardiac defibrillator, or pacemaker, or
  – the patient has a medical condition associated with a significant risk of serious cardiac arrhythmia and/or myocardial ischemia such as Diabetes, history of MI, angina pectoris, aneurysm of heart wall, chronic ischemic heart disease, pericarditis, valvular disease or cardiomyopathy to name a few.

• Include the ordering/rendering provider and NPI
Preventive Services

• Preventive and problem driven E/M on same date.
  – Modifier 25

• Appropriate ICD-10-CM codes
  – Z00.00
  – Z00.10
Nurse Note:
Patient presents for annual physical. States also that he had Rt knee surgery a few years ago and has been having trouble with it for the last 2 weeks. States that he was helping someone move and was doing a lot of heavy lifting.
Subjective
HPI: Healthy in general, stays active despite the hip surgery, although he does not engage in contact sports, basketball, etc. anymore. Right knee bothering him as above. This was the one he had surgery on in the past. Seems to be getting a little better, but he has a high tolerance for pain and re-injury is obviously a concern. He has been taking Motrin which provides a little relief. Would like an X-ray to make sure all is clear with the knee. Also would like to discuss his prostate. Also would like to discuss possibly reversing the vasectomy that he had done.
ROS:
Denies chills and fever.
Denies visual disturbance.
Denies chest pain and palpitations.
Denies cough, dyspnea and wheezing.
Denies constipation, diarrhea, dyspepsia, dysphagia, hematochezia, melena, nausea and vomiting.
Urinary: Denies dysuria, frequency, hematuria, incontinence, nocturia and urgency.
Right knee pain as above.
Denies any skin rashes.
Current Meds: Viagra 100 mg, Lamisil 250 mg, Ibuprofen 800 mg, Allergy Shots
Allergies: NKDA
PMH:
Surgeries:
Bilateral Foot, RT Knee, L Rotator Cuff
FH:
Father: Congestive Heart Failure (CHF) - age 52. He died at this age from CHF.
SH: Marital status: divorced. Occupation: Warden at Venango County Jail. The patient
does not have an advance directive. No history of abuse; feels safe at home.
Personal Habits: Cigarette Use: Never smoked cigarettes. Smokeless Tobacco: Never
used smokeless tobacco.
Alcohol: Occasionally consumes alcohol. Drug Use: Denies drug use.
Objective
BP: 116/74 Pulse: 76 T: 97.3 Resp: 16 Ht: 71.75” 5’11.75” without shoes Wt: 196 lbs Wt Prior: 197 lbs as of 01/18/xx Wt Dif: -1 lb BMI: 26.8
Exam:
Const: Appears well. No signs of apparent distress present.
ENMT: Auditory canals normal. Tympanic membranes are intact. Nasal mucosa is pink and moist. Dentition is in good repair. Posterior pharynx shows no exudate, irritation or redness. Neck: Palpation reveals no lymphadenopathy. No masses appreciated. Thyroid exhibits no thyromegaly. No JVD.
Resp: Respiration rate is normal. No wheezing. Auscultate good airflow. Lungs are clear bilaterally.

CV: Rate is regular. Rhythm is regular. No heart murmur appreciated.

Extremities: No clubbing, cyanosis or edema.

Abdomen: Bowel sounds are normoactive. Palpation of the abdomen reveals no CVA tenderness, muscle guarding, rebound tenderness, or tenderness. No abdominal masses. No palpable hepatosplenomegaly.


Skin: Skin is warm and dry.
Assessment #1: Examination General Medical Routine at Healthcare Facility
Plan for #1: Comments: Healthy 52-year-old, active on the new hip, counseled on safe exercises to perform to preventive joint injury.

Assessment #2: Knee Pain
Plan for #2: Comments: Let’s get a new MRI (last one 20xx) to make sure no new injuries. X-ray: MRI Right Knee

Assessment #3: Benign Localized Hyperplasia Prostate w/o Urinary Obstruct.
Plan for #3: Comments: Refer to eval for BPH and the vasectomy reversal issue. Referral: Urology
Follow-up: Yearly on labs, otherwise as needed
Preventive Services

• Know the payer policy for appropriate codes
  – G0101 *Cervical or vaginal cancer screening; pelvic and clinical breast examination*
    • Not just for Medicare
  – Lab denials
    • Providers must indicate when labs are screening
    • Z00.00 *Encounter for general adult medical examination without abnormal findings*
### Service

<table>
<thead>
<tr>
<th><strong>Cardiovascular Screening Blood Tests</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCPCS/CPT codes</strong></td>
</tr>
<tr>
<td>80061–Lipid panel</td>
</tr>
<tr>
<td>82465–Cholesterol</td>
</tr>
<tr>
<td>83718–Lipoprotein</td>
</tr>
<tr>
<td>84478–Triglycerides</td>
</tr>
<tr>
<td><strong>ICD-9-CM codes</strong></td>
</tr>
<tr>
<td>Report one or more of the following codes:</td>
</tr>
<tr>
<td>Z13.6</td>
</tr>
<tr>
<td><strong>Who is covered</strong></td>
</tr>
<tr>
<td>All Medicare beneficiaries without apparent signs or symptoms of cardiovascular disease</td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
</tr>
<tr>
<td>Every 5 years</td>
</tr>
<tr>
<td><strong>Beneficiary Pays</strong></td>
</tr>
<tr>
<td>Copayment/coinsurance waived</td>
</tr>
<tr>
<td>Deductible waived</td>
</tr>
<tr>
<td>Service</td>
</tr>
<tr>
<td>------------------</td>
</tr>
</tbody>
</table>
| **HCPCS/CPT codes** | 82947– Glucose; quantitative, blood (except reagent strip)  
82950– Glucose; post-glucose dose (includes glucose)  
82951– Glucose; tolerance test (GTT), 3 specimens (includes glucose) |
| **ICD-9-CM codes** | Z13.1                                                                                   |
| **Who is covered** | Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes  
Beneficiaries previously diagnosed with diabetes are not eligible for this benefit |
| **Frequency**    | Two screening tests per year for beneficiaries diagnosed with pre-diabetes  
One screening per year if previously tested, but not diagnosed with pre-diabetes, or if never tested |
| **Beneficiary Pays** | Copayment/coinsurance waived  
Deductible waived |
## Preventive Services - United Healthcare

<table>
<thead>
<tr>
<th>Service</th>
<th>Codes</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cervical Cancer Screening, Pap Smear</strong></td>
<td><strong>Procedure Code(s):</strong>&lt;br&gt;<strong>Code Group 1</strong> <em>(payable regardless of diagnosis code):</em>&lt;br&gt; G0101, G0123, G0124, G0141, G0143 – G0145, G0147, G0148, Q0091, P3000, P3001&lt;br&gt;<strong>Code Group 2</strong> <em>(requires a diagnosis code from list below):</em>&lt;br&gt; 88141 – 88143, 88147, 88148, 88150, 88152 – 88155, 88164 – 88167, 88174, 88175&lt;br&gt;<strong>Diagnosis Code(s) Code Group 2:</strong>&lt;br&gt; Z00.00, Z00.01, Z01.411, Z01.419, Z12.4</td>
<td>Females, no age limits.</td>
</tr>
</tbody>
</table>
### How to Avoid Top Coding Errors

**Preventive Services-United Healthcare**

| Service: Cholesterol Screening (Lipid Disorders Screening) | Codes: Procedure Code(s): 80061, 82465, 83718, 83719, 83721, 84478, 36415, 36416  
| Diagnosis Code(s) (Required for all): Z00.00, Z00.01, Z13.220  
| Males age 20-34 if at increased risk for coronary heart disease.  
| Females age 20 and up if at increased risk for coronary heart disease.  
| NOTE: These will only pay as preventive if there is no prior history of a lipid disorder. |
E/M Prior to Colonoscopy

• E/M is included for Medicare
• Non-Medicare
  – S0285 Colonoscopy consultation performed prior to a screening colonoscopy procedure
  – E/M service if the payer does not accept S0285
Modifier 25

Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service

- Appended to the E/M code
- Used to indicate a minor procedure or additional E/M is performed on the same date of service
- E/M must be separately identifiable
SUBJECTIVE:
Mrs. X is a 43-year-old Caucasian female in for follow-up. She presents with knee pain and swelling. She is here for arthrocentesis of the left knee.
OBJECTIVE:

Procedures: Joint pain, lower leg

Procedure Note: Arthrocentesis/Injection

Arthrocentesis of left knee joint is performed. Written informed consent was obtained. The site is prepped with betadine and sterile drape is placed. The site is anesthetized with 4 cc of 2% lidocaine. The needle is carefully introduced into the joint space. Aspiration of 20 cc of amber fluid is obtained. No complications. Estimated blood loss: 2 cc. The specimen is sent for routine path plus special studies (acid fast bacilli, cell count and differential, bacterial culture, and fungal culture).
Documentation Example Continued

- Correct coding for this case: 20610-LT

- The E/M for this case is not reported. The documentation does not support a significant and separately identifiable E/M.
S. Continues to have achiness in her knees. Her current meds include ALEVE only as needed a few days out of the week as before. She is on LEXAPRO at night, XANAX, and CLONAZEPAM as needed. She is on a B12 injection once a month. We had given her a prescription for VICODIN but she lost the prescription.

O: Weight is 188 pounds. Blood pressure is 112/74. Pulse is 60. There is some crepitus at the knees without tenderness elicited. There is no active synovitis noted at this time. There is no alopecia noted on exam.
S. Continues to have achiness in her knees. Her current meds include ALEVE only as needed a few days out of the week as before. She is on LEXAPRO at night, XANAX, and CLONAZEPAM as needed. She is on a B12 injection once a month. We had given her a prescription for VICODIN but she lost the prescription. (PAST)

O: Weight is 188 pounds. Blood pressure is 112/74. Pulse is 60. There is some crepitus at the knees without tenderness elicited. There is no active synovitis noted at this time. There is no alopecia noted on exam. (Expanded Problem Focused: limited three system review)
Review of lab work from April 29, 2013 revealed a negative ANA. Urinalysis had no blood or protein. Normal liver and renal function tests. Uric acid was normal with normal CRP, rheumatoid factor, anti-CCP, and TSH. Hemoglobin was 10.8 with MCV of 79.6 and normal white count and platelets.

A: Osteoarthritis of knees, Anemia
Review of lab work from April 29, 2016 revealed a negative ANA. Urinalysis had no blood or protein. Normal liver and renal function tests. Uric acid was normal with normal CRP, rheumatoid factor, anti-CCP, and TSH. Hemoglobin was 10.8 with MCV of 79.6 and normal white count and platelets.

A: Osteoarthritis of knees, Anemia
P: Patient was prescribed an IRON supplement, which she plans to start tomorrow. I did ask her to check with Dr. R about actual use of ALEVE given her anemia.

Will start HYALGAN injections today. After informed consent, the left knee was steriley prepped. Used 1 cc LIDOCAINE for anesthesia. Injected the first of five HYALGAN injections, 2 cc, into the left knee without complications, followed by ice and rest. Follow up weekly for HYALGAN.
Documentation Example Continued

- Correct coding for this case:
  - 99213-25, 20610-LT
  - 99213
  - 20610
- The E/M for this case is supported.
- Wrong reporting: 99213, 20610-25
  99213-25, 20610-59
Distinct Procedural Service

- Procedures not normally reported together
- Different session or patient encounter
- Different procedure or surgery
- Different site or organ system
- Separate incision/excision
- Separate lesion
Modifier 59

- **XE** – “Separate encounter, A service that is distinct because it occurred during a separate encounter” This modifier should only be used to describe separate encounters on the same date of service.
- **XS** – “Separate Structure, A service that is distinct because it was performed on a separate organ/structure”
Modifier 59

- XP – “Separate Practitioner, A service that is distinct because it was performed by a different practitioner”
- XU – “Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service”
National Correct Coding Initiative (NCCI)

- Implemented by CMS
- Promotes correct coding methodologies
- Controls the improper assignment of codes that results in inappropriate reimbursement

Medicare publishes NCCI: [http://www.cms.hhs.gov/NationalCorrectCodInitEd/]
Failure to Review Details

Procedure Performed: Implantation of dual chamber pacemaker.

Indications for Procedure: Sick sinus syndrome with Mobitz type II block with symptoms of fatigue.

Indications for Procedure: The risks, benefits and alternatives to the procedure were explained to the patient prior to the procedure and accepted.
Description of Procedure: The patient was brought to the Electrophysiology Lab where he received 1.5 grams of IV Cefuroxime. The left pectoral area was prepared in the usual fashion. The area was infiltrated with a 2% Xylocaine solution ordered by local anesthesia. A 4 cm incision was made in the left deltopectoral groove. The cephalic vein was isolated and ligated distally with 0 silk. Guide wire was introduced into the cephalic vein. The 9-French peelaway introducer was used to place the ventricular lead and using retained guide wire technique a 7-French peel-away introducer was used to place the atrial lead. The atrial lead was the Pacesetter 1488T/46 cm, The ventricular lead was the Pacesetter 1488T/52 cm, These were active fixation leads. Atrial and ventricular mapping was performed.
Failure to Review Details

Thresholds were as follows; in the atrium pacing 0.5 volts, current 1.3 ma, impedance 400 ohms, P-waves 4.6 millivolts.

In the ventricle, pacing 0.5 volts, current 0.7 ma, resistance 720 ohms, R-waves were 7.4 millivolts. The leads were sutured to the pectoralis muscle using 0 Ethibond over a suture sleeve.
Failure to Review Details

The pocket was created by blunt dissection over the pectoralis muscle and irrigated with a Polymyxin solution. The pacemaker was connected appropriately to the lead, setscrews were fastened and confirmation of good connection was performed. The pacemaker was the Pacesetter, The pacemaker was placed in the pocket. The pocket was closed in three layers using 2-0 Vicryl for the first two layers and 4-0 Vicryl for the subcuticular layer. The incision was dressed in a sterile manner. There were no complications.
## Coding Error?

An example of a coding error is shown below:

<table>
<thead>
<tr>
<th>POS</th>
<th>Proc</th>
<th>Mod</th>
<th>Units</th>
<th>From</th>
<th>Thru</th>
<th>Billed</th>
<th>Paid</th>
<th>Detail EOBS</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>92941</td>
<td>LC</td>
<td>1</td>
<td>05/02/16</td>
<td>05/02/16</td>
<td>1711.00</td>
<td>0.00</td>
<td>4257</td>
</tr>
</tbody>
</table>

**4257 Invalid Procedure Code Modifier**
Modifier PT versus 33

- Proper codes and sequence for a cold biopsy polyp removal and snare polyp removal performed during a screening colonoscopy. The diagnoses include polyps, diverticulosis and internal hemorrhoids.
Sources

• Medicare Preventive Services Quick Reference Information
• The Guide to Medicare Preventive Services
• Medicare Coverage Database (LCD and NCD search)
• United Healthcare Summary of Preventive Services
Thank You!

Time for Questions