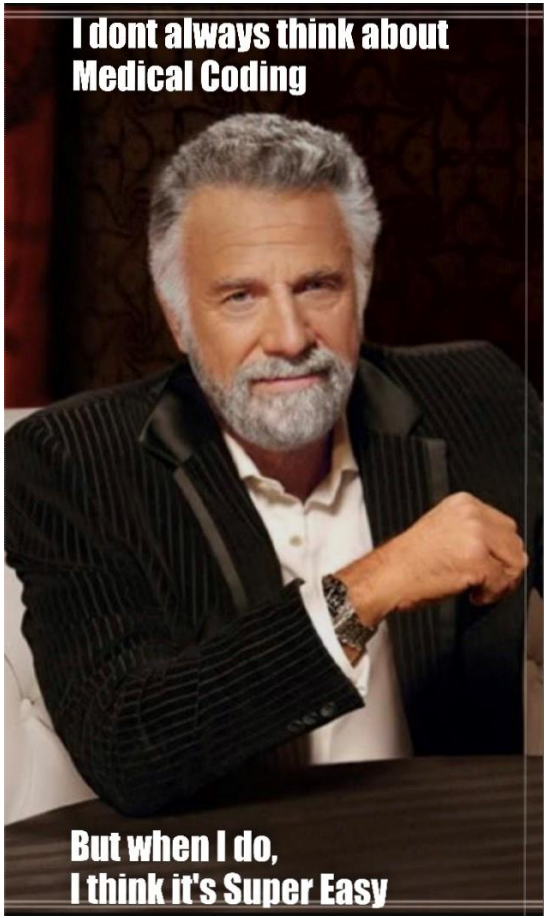
10 Most Common Coding Mistakes

Presented by Kate Gilman, CPC and Julia Konovalov

Medical Business Partners

General Assumption:



Overview:

- Modifiers: 24, 25 and 59
- Over coding
- Under coding
- Wrong Levels of E&M codes
- Medicare vs Commercial Payer Coding
- Diagnosis codes
- Coding Resources

#1: Modifier 24

Should be used to report an **unrelated E/M service** performed the day after the procedure, by the same physician, during the 10 or 90-day post-operative period.

***Example**: The patient had a right knee replacement surgery on 05/20/2017. The procedure has a global period of 90 days.*

YES: The patient is presenting to the office today for a left knee replacement evaluation.

NO: The patient is presenting to the office today for a follow up of the right knee surgery performed last month.

#2: Modifier 25

Should be used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.

***Example**: The patient presented to the office for ear wax removal.*

YES: The patient is presenting to the office for ear wax removal. The patient also complains of a high blood pressure.

NO: The patient is scheduled for ear wax removal and s/he is being evaluated by the physician before/after the procedure.

#3: Modifier 59

Should be used to identify procedures/services that are commonly bundled together but are appropriate to report separately under some circumstances.

***Example**: The patient presented to the office for a scheduled debridement of the nails.*

YES: The patient is presenting to the office, complaining of a severe foot pain. Trigger point injection was performed to reduce the pain. Also, the doctor performed a scheduled debridement of the nails due to onychomycosis.

NO: The patient is being evaluated by the doctor before/after the debridement.

#4: Over coding: Billing for services that were performed, but not documented.

Example: The patient presented to the office for a follow up of the hypertension.

YES: E&M visit should be used to code for the documented service.

NO: E&M visit and EKG code

Example: The patient presented to the office for a foot strapping.

YES: Strapping code should be used to code for the documented service.

NO: E&M visit and Strapping code

#5: Under coding: Not billing for services that were performed and documented.

Example: The patient presented to the office for a follow up of the hypertension and EKG was performed.

YES: E&M visit and EKG code should be used to code for the documented service.

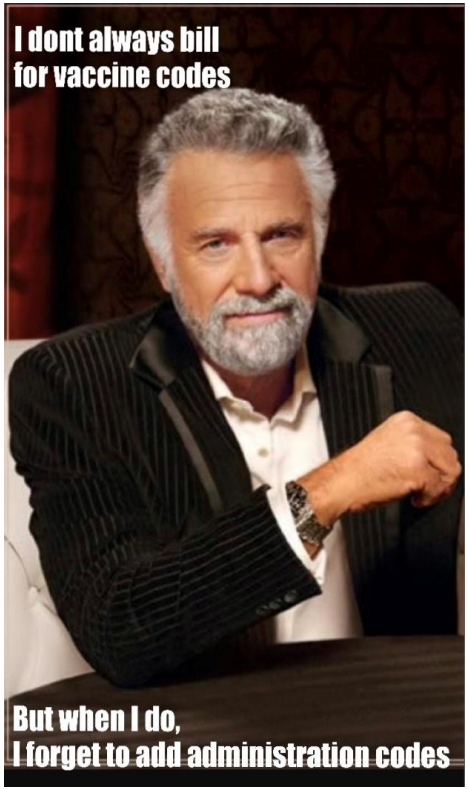
NO: E&M visit only.

Example: The patient presented to the office for a follow up of the right foot pain and left foot strapping.

YES: E&M visit and Strapping code should be used to code for the documented service.

NO: E&M visit only.

#6: Under coding: Vaccine codes



#7: Wrong levels of E&M visit codes

- **New patient visits**: 99201-99205
- *Every 3 years*
- **Established visits**: 99211-99215

Deliberate under coding is, in reality, "making a false statement" about the services provided, and is ultimately a "misrepresentation" of the facts. The fact sheet gives an example of fraud as "knowingly billing for services that were not furnished," which would apply if services are purposefully under coded.

- *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.Pdf*

#8: Medicare vs Commercial Payer Coding

G0402- Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment.

G0438- Annual wellness visit; includes a personalized prevention plan of service (PPPS), initial visit.

G0439- Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit.

99384-99386: Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; the patient's age defines the specific code.

99394-99397*:* Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; the patient's age defines the specific code.

#9: Diagnosis Codes: LCD Policy

A **Local Coverage Determination** (**LCD**) is a decision by a Medicare Administrative Contractor (MAC) whether to cover a particular service on a MAC -wide, basis.

Example: Patient presents with chest pain. Stress test is being performed.

Yes: Chest pain (found on LCD Policy) is an indicator for the procedure.

No: Rule out heart disease.

#10: Diagnosis Codes: ICD-10-CM

The first step in choosing the proper ICD-10-CM code is reading the medical documentation to identify the diagnosis the provider documents and confirms. If there is no confirmed diagnosis, look for the sign or symptom that brought the patient in or other reason for the encounter.

- Format and Structure
- Abbreviations
- Punctuation
- Notes

Rule of thumb: Do not guess the code!

Great resources to help you with reducing coding mistakes:

- MedicalBusinessPartners.com ☺
- AAPC.com (Education)
- AHIMA.gov (Training and Education)

Questions

Medical Business Partners

Contact Info

Julia Konovalov
202-390-3966
Julia@medicalbusinesspartners.com

Medical Business Partners

Kate Gilman, CPC
410-404-7464
kate@medicalbusinesspartners.com