

Five Common Coding Mistakes That Are Costing You



Fix these problems to increase your bottom line.

One are the days when healthy third-party reimbursements meant practices could afford to miss revenue opportunities. Instead, physicians today face shrinking reimbursements and increased scrutiny of their coding practices.

The typical family medicine practice generates the majority of its revenue by submitting CPT and ICD-9 codes to third-party payers. In physician-owned practices, lost revenue opportunities affect physician income directly. For employed physicians, the effect is less apparent but no less real. In this case, reduced revenue can mean decreases in the number of support staff, limitations on supplies and equipment – and, yes, shrinking

physician bonuses and compensation.

Coding accurately for what you do is essential. The best coding staff and the latest electronic health record system (EHR) cannot substitute for physician involvement in the coding and documentation process. Who knows better than you what care you provide?

It's time to take a close look at your coding habits to see if you are missing revenue opportunities. You can start by reviewing and correcting the following five common coding mistakes. ➤

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1. Old codes, old rules

Are your practice's encounter forms up-to-date? If they haven't been updated for more than a year, you may be leaving dollars on the table. If it has been more than five years, you are definitely missing revenue opportunities. Unfortunately, out-of-date encounter forms are common. Although updating these forms can be time-consuming and tedious, it is an essential link between your work and getting paid for that work.

According to the Health Insurance Portability and Accountability Act, physicians and payers must use CPT and ICD-9 codes that are effective for the date of service. This means there are no longer grace periods for deleting old codes from your claims. Reporting codes that are not effective for the date of service means denied claims, while failure to incorporate new codes or new coverage rules results in lost revenue opportunities.

It only takes a few steps to update your forms. First, review the codes that are currently on your forms for deleted and revised codes, and update these accordingly. For help with this step, you can find summaries of each year's updates in Appendix B of the CPT manual and at the front of the ICD-9 manual. Next, review past *FPM* coding articles (see "*FPM* annual update articles on ICD-9 and CPT codes" on the facing page) to find additional codes and changes you want to

incorporate on your forms. If your forms are just a year behind, use the *FPM* 2011 ICD-9 update article and the *FPM* 2011 CPT update article to get caught up.

Once you've done this, you're ready for a simple check each year for new, revised and deleted codes.

2. Diagnosis coding and medical necessity

Payers are becoming increasingly concerned about the issue of medical necessity. Medicare generally defines medically necessary services as those that are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Other payers have their own variations on the definition, but in short, medical necessity is doing the right thing for the right patient at the right time and place. Claims for services that don't meet medical necessity requirements are typically denied straight out; if they're paid in error, the reimbursement may be recouped in the future. The denial explanation may be "non-covered service" or "not medically indicated."

So how do you substantiate the medical necessity of the services you provide? While it may involve coders and billers, this process must begin with you, the physician. You are in the best position to identify the rationale for a test or other service. In practical terms, that means selecting the ICD-9 code or codes that are valid for the visit or other service and linking them to the associated CPT code or codes. Incorporating this into your daily routine is simple once your encounter forms are up-to-date.

■ Coding accurately for what you do is essential to your practice's revenue.

■ Keep your encounter forms up-to-date with *FPM*'s annual coding update articles.

■ Proving medical necessity must begin with the physician, not the coding staff.

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If you have a paper system, simply number each ICD-9 code and associated CPT code on the encounter form with the same number. For example, your patient presents for his regular visit for diabetes monitoring and reports symptoms suggestive of angina. As part of the first step in the workup, you do an ECG in your office. You assign number 1 to the E/M code (e.g., 99214) and number 1 to the appropriate ICD-9 code for the patient's type of diabetes (e.g., 250.00-250.93). You indicate number 2 for the ECG (e.g., 93000) and number 2 for the ICD-9 code for chest pain (e.g., 786.50-786.59). If you use an EHR, you're probably aware of the need to associate a CPT code with an ICD-9 code because the system may not let you close the record before this is done.

This process ensures that each CPT code has an applicable ICD-9 code and that the reason for each service is accurately communicated to your staff and ultimately to the payer. When you don't make the association of the codes clear, you increase the chance that applicable diagnoses may not be identified and that your staff may make incorrect assumptions. In the example above, if diabetes is the only diagnosis noted on the encounter form, your staff may assume it is the indication for the ECG or assign a screening ICD-9 code. In either instance, the assumption is incorrect and your reimbursement could be affected.

Staff members commonly complain that they receive incomplete encounter forms and that they must take valuable time to determine the service provided or the reason for the service before entering the charges. Provide related codes to begin with, and the problem vanishes.

3. E/M coding: Stuck on 99213

Selecting and documenting appropriate levels of E/M services can be challenging for many physicians. Often, code 99213 becomes the default code because physicians think extensive documentation will be needed for coding anything higher and they believe 99213 is safe. I call it the "Goldilocks code" because it's not too high and not too low, and the assumption is that the coding will go unnoticed and reimbursement will be "just right." The problem is that physicians lose reimbursement when they get stuck on 99213.

Based on the national Medicare allowable amounts for established patient office and outpatient E/M codes, there's roughly a \$33 difference in reimbursement between codes 99213 and 99214. If your practice undercodes five patients a day by selecting 99213 instead of 99214, that means you've lost \$165 per day or approximately \$40,000 in a year!

To determine whether you're losing revenue opportunities by undercoding, gather data

from your billing system to determine your coding patterns. You'll need to know the number of times each physician has billed a 99201 through a 99215 during the selected time period. Once you have your data, you can compare it with national norms and then calculate your potential for lost revenue.

A coding frequency comparison spreadsheet updated with 2008 Medicare data (the most recent available) is available online in the

■ To help prove medical necessity, link the ICD-9 code to the CPT code on the encounter form.

■ Don't default to code 99213 – because you think it's safer – if the service actually qualifies for a 99214.

■ Gather data from your billing system to determine your coding patterns, including whether you're losing revenue by undercoding.

FPM ANNUAL UPDATES ON CPT AND ICD-9 CODING

If you've fallen behind in updating the codes on your encounter forms or superbills, consult *FPM's* most recent CPT and ICD-9 update articles.

CPT updates

2011: <http://www.aafp.org/fpm/2011/0100/p5.html>

2010: <http://www.aafp.org/fpm/2010/0100/p13.html>

2009: <http://www.aafp.org/fpm/2009/0100/p7.html>

ICD-9 updates

2010-2011: <http://www.aafp.org/fpm/2010/0900/p15.html>

2009-2010: <http://www.aafp.org/fpm/2009/0900/p8.html>

2008-2009: <http://www.aafp.org/fpm/2008/0900/pa3.html>

Reporting codes that are not effective for the date of service means denied claims.

FPM Toolbox at <http://www.aafp.org/fpm/20070400/codingfrequencycomparison.xls>. I recommend gathering several years of data to see if there are any outliers or problems. Doing this will also highlight other opportunities for improvement, such as the need to recruit new patients to the practice. For more on this, read “How to Analyze Your E/M Coding Profile,” *FPM*, April 2007, <http://www.aafp.org/fpm/2007/0400/p39.html>.

Remember that the risk for an audit is higher when the distribution of codes within a practice doesn't look reasonable. If a single code is predominant in a physician's profile, the assumption is that the physician isn't really coding for individual encounters. For more on coding 99213 or 99214, read “Coding ‘Routine’ Office Visits: 99213 or 99214?” *FPM*, September 2005, <http://www.aafp.org/fpm/2005/0900/p52.html>. You may also find the *FPM* “Level 4 Reference Card” helpful. A newly revised copy is included in this issue (see the insert between pages 36 and 37). It's also available in the *FPM* Toolbox at <http://www.aafp.org/fpm/990700fm/level4referencecard.pdf> and printed cards are available for purchase in the AAFP Products and Services Catalog at <http://bit.ly/Lvl4Card>.

4. Modifiers: Keys to reimbursement

Modifiers can be the difference between full reimbursement and reduced reimbursement—or denial. While some payers differ in their use of modifiers, taking the time to learn the rules will pay off. In the last five years, payers have increased their recognition of modifiers when processing claims, which makes it even more important to learn them and use them correctly.

Modifier 25. Anytime you provide more than one service at a single encounter, you must consider whether a modifier is needed. According to CPT, modifier 25 is 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.” In some cases when an injection or drug administration code is reported, modifier 25 is required to distinguish the E/M service from the actual injection. However, some immunization codes include counseling the patient, so to use modifier 25, you would have to provide an E/M service for another indication. When you provide a preventive medicine service (codes 99381 to 99397) and spend significant additional work addressing a problem, modifier 25 is again required. Remember, the modifier must be appended to the E/M code and the services must be clearly documented. For more on modifier 25, read “Understanding When to Use Modifier 25,” *FPM*, October 2004, <http://www.aafp.org/fpm/2004/1000/p21.html>.

Modifier 59. Modifier 59 is used for “distinct procedural services” that wouldn't otherwise appear to be distinct—that is, procedures and services that are not normally reported together, but are appropriately reported under the circumstances. According to CPT, this may represent “a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.” Medicare recognizes the modifier to indicate that two or more procedures are performed at different anatomic sites or different patient encounters.

For example, if you perform a destruction of a premalignant lesion (code 17000) on the same day you biopsy another lesion (code 11100), you will need to append modifier 59 to CPT code 11100 to indicate that the services were performed at different anatomic sites. The first step to determining

■ If a single code is predominant in your practice, auditors may assume you aren't coding individual encounters.

■ Anytime you provide more than one service at a single encounter, consider whether a modifier is needed.

■ Modifier 59 is used to explain why you reported two procedural services that are not normally reported together.

whether modifier 59 is needed is to refer to Medicare's Correct Coding Initiative (CCI), which is available online at <http://www.cms.gov/NationalCorrectCodInitEd/>. The CCI lists code combinations that are generally not reimbursed separately. Private payers often use the CCI as a guide for their own bundling policies. When reporting CPT codes with the designation "separate procedure" in conjunction with other procedure codes, be aware that these codes are often considered components of other services. If the procedures are distinct, then modifier 59 is required.

Modifier 24. This modifier is often overlooked. CPT suggests using it with an "unrelated evaluation and management service by the same physician during a postoperative period." For example, an excision of a benign lesion (codes 11400 to 11471) has a 10-day global surgical period. So if a patient returns to the office within 10 days of the excision for an unrelated condition, you will need to append modifier 24 to the E/M service to get paid for the visit. It is helpful to maintain an easily accessible list of the global periods for office-based procedures so you can remember whether a modifier is required. You can find global periods in the *Federal Register* at <http://edocket.access.gpo.gov/2010/pdf/2010-10814.pdf> (see the far-right column starting on page 12 of the pdf).

Modifier 53. Another forgotten modifier is modifier 53 for "discontinued procedure." It is used when the physician elects to terminate a surgical or diagnostic procedure because of extenuating circumstances or a threat to the well-being of the patient. It is not used for elective cancellation or cancellations that occur before surgical prep or induction of anesthesia. For example, modifier 53 could be appropriately appended to code 58100 when an endometrial biopsy cannot be performed without risking uterine perforation or other complications. The purpose of the modifier is to obtain some payment for the work and practice expense associated with the attempted procedure as well as to preserve the opportunity to report the code again later.

You should consider including the most common modifiers on your superbill or in your EHR and plan to conduct periodic quality checks to make certain modifiers are being reported correctly.


5. Missed charges

Busy practices can easily miss capturing charges for many of the services they provide. Lab and other ancillary services are the ones most often missed, simply because the order may be verbally communicated to clinical or lab personnel. To remedy this, the laboratory technician should maintain a central log of all the laboratory services performed. This gives staff a contingency method for capturing charges and the opportunity to identify those physicians prone to missing charges.

Injections are another area where charge capture errors tend to occur. If your practice is administering injections and providing the injectable medications, you should be reporting two codes – one for the administration and one for the medication. The HCPCS codes for the medications include the name and the dosage for each unit of service. Be sure your staff members understand how to determine the correct number of units to report. Make sure common conversions and drug calculation tables are available to assist staff with this.

Finally, don't forget hospital and nursing facility services. Most practices receive patient encounter information from the hospital only for those patients admitted by the practice. Failure to report an encounter in the emergency department is a sure way to miss getting reimbursed for the service. Be sure your superbills make it easy for physicians to capture services based in the hospital and nursing facility, and create a system for ensuring that all superbills are returned to your office for billing.

Getting it right

Identifying and correcting coding errors in your practice can significantly affect your income. To make sure you're on the right track, conduct a sample chart audit in your practice and report the findings to all physicians and staff. You might be surprised how simple awareness and focused education can impact your practice's bottom line. 

Send comments to fpmedit@aafp.org.



- Maintain a list of global periods for office-based procedures so you can remember whether a modifier is required.

- Consider including the most common modifiers on your superbill, and conduct periodic quality checks to determine if the modifiers are being reported correctly.

- Conduct a sample chart audit in your practice to make sure your coding is on the right track.