How to Avoid Top Coding Errors

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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 policies
- Do NOT apply CMS rules across the board for all payers.

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

2012 CERT Report

• E/M services 14.0 improper payment rate, approximately $4.2 billion
  – Incorrect coding
  – Insufficient documentation
  – Lacked records for E/M performed outside of the office (eg, hospital visits)

2012 CERT Report

• Split/Shared E/M
  – Documentation submitted contained provider signature on the NPP clinical note, no other documentation supported physician involvement
Documentation Requirements

- All documentation must be maintained in the patient’s medical record and available to the contractor upon request.

- Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.

- The submitted medical record must support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code must describe the service performed.

Mosh Micrographic Surgery (MMS) (L32627)

- The medical record documentation must support the medical necessity of the services as directed in this policy.

- The physician must document in the patient’s medical record that the diagnosis is appropriate for MMS and that MMS is the most appropriate choice as the treatment of the particular lesion.

- The surgeon’s documentation in the patient’s medical record should be legible and support the medical necessity of this procedure. Operative notes and pathology documentation in the patient’s medical record should clearly show MMS was performed using accepted MMS technique, in which the physician acts in two integrated and distinct capacities: surgeon and pathologist (e.g., should show that true MMS was performed).

Mosh Micrographic Surgery (MMS) (L32627)

- If the 59 modifier is used with a skin biopsy/pathology code on the same day the MMS was performed, physician documentation should clearly indicate:
  - The biopsy was performed on a lesion other than the lesion on which the MMS was performed.
  - If the biopsy is of the same lesion on which the MMS was performed, a biopsy of that lesion had not been done within the previous 60 days.
  - Or, if a recent (within 60 days) biopsy of the same lesion on which MMS was performed had been done, the results of that biopsy were unobtainable by the MMS surgeon using reasonable effort.
How to Avoid Top Coding Errors

Guidance To Reduce Mohs Surgery Reimbursement Issues

The Identified Coding Problems

During an audit of the CPT® codes associated with MMS across several states in a region, Medicare Recovery Auditors found instances in which the preparation and/or interpretation of the slides of tissue removed during the procedures was performed by someone other than the surgeon (or his/her employee).

This is often referred to as modified Mohs which should not be reported with codes 17311-17315.

MLN Matters® Number: SE1318

2013 HHS OIG Work Plan

• Hospitals—Hospital-Owned Physician Practices Using Provider-Based Status (New)
• Physicians—Error Rate for Incident-To Services Performed by Nonphysicians
• Physicians—Place-of-Service Coding Errors
• Evaluation and Management Services—Potentially Inappropriate Payments in 2010
• Evaluation and Management Services—Use of Modifiers During the Global Surgery Period

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.

How to Avoid Top Coding Errors

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

Cosmetic Procedures

• Diagnosis determines medical necessity
  – Review payer policies
  – Review LCDs/NCDs
  – Proper use of ABN for Medicare patients

• Modifiers for claim submission
  – GA Waiver of liability statement issued as required by payer policy, individual case
  – GX Notice of liability issued, voluntary under payment policy
  – GY Item or service statutorily excluded, does not meet the definition of any Medicare benefit or, for non-Medicare insurers, is not a contract benefit
  – GZ Item or service expected to be denied as not reasonable and necessary
Skin Tag Removal - Medicare

- **701.9 Unspecified hypertrophic and atrophic conditions of skin**
  - Requires a secondary diagnosis to support medical necessity

Secondary Diagnosis for Skin Tag Removal

- 682.0 CELLULITIS AND ABSCESS OF FACE
- 682.1 CELLULITIS AND ABSCESS OF NECK
- 682.2 CELLULITIS AND ABSCESS OF TRUNK
- 682.3 CELLULITIS AND ABSCESS OF UPPER ARM AND FOREARM
- 682.4 CELLULITIS AND ABSCESS OF HAND EXCEPT FINGERS AND THUMB
- 682.5 CELLULITIS AND ABSCESS OF BUTTOCK
- 682.6 CELLULITIS AND ABSCESS OF LEG EXCEPT FOOT
- 682.7 CELLULITIS AND ABSCESS OF FOOT EXCEPT TOES
- 682.8 CELLULITIS AND ABSCESS OF OTHER SPECIFIED SITES
- 682.9 CELLULITIS AND ABSCESS OF UNSPECIFIED SITES
Aetna Policy

Aetna considers medically necessary removal of seborrheic keratoses (also known as basal cell papillomas, sebaceous warts or brown warts), sebaceous cysts (pilar and epidermoid cysts), acquired or small (less than 1.5 cm) congenital nevi (moles), dermatofibromas (skin tags), and pilomatrixoma (slow-growing, hard mass underneath the skin that arises from hair follicle matrix cells), or other benign skin lesions if any of the following criteria is met:

- Biopsy or clinical appearance suggests or is indicative of pre-malignancy (e.g., dysplasia) or malignancy; or
- Due to its anatomic location, the lesion has been subject to recurrent trauma; or
- Lesion appears to be pre-malignant (e.g., actinic keratoses (see CPB 0567 - Actinic Keratoses Treatment), Bowen's disease, dysplastic nevus syndrome, family history of melanoma, or history of melanoma); or
- Skin lesions are causing symptoms (e.g., bleeding, burning, itching, or irritation); or
- The lesion has evidence of inflammation (e.g., edema, erythema, or purulence); or
- The lesion is infectious (e.g., warts (verruca vulgaris)); or
- The lesion restricts vision or obstructs a body orifice.

Aetna Policy

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>078.10 - 078.19</td>
<td>Viral warts [* note - report 17110-17111 per AMA CPT guidelines]</td>
</tr>
<tr>
<td>214.0 - 214.9</td>
<td>Lipoma [lipomata]</td>
</tr>
<tr>
<td>216.0 - 216.9</td>
<td>Benign neoplasm of skin [nevi, moles] [dermatofibromas] [pilomatrixoma]</td>
</tr>
<tr>
<td>232.0 - 232.9</td>
<td>Carcinoma in situ of skin [Bowen's disease, lentigo maligna]</td>
</tr>
<tr>
<td>528.6</td>
<td>Leukoplakia of oral mucosa, including tongue</td>
</tr>
<tr>
<td>702.0</td>
<td>Actinic keratosis</td>
</tr>
<tr>
<td>702.11 - 702.19</td>
<td>Seborrheic keratosis</td>
</tr>
<tr>
<td>706.2</td>
<td>Sebaceous cyst</td>
</tr>
</tbody>
</table>
### Aetna Policy

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>686.9</td>
<td>Unspecified local infection of skin and subcutaneous tissue [inflammation]</td>
</tr>
<tr>
<td>695.9</td>
<td>Unspecified pruritic disorders [itching]</td>
</tr>
<tr>
<td>701.9</td>
<td>Unspecified hypertrophic and atrophic conditions of skin [skin tags]</td>
</tr>
<tr>
<td>702.8</td>
<td>Other specified dermatoses [leukoplakia]</td>
</tr>
<tr>
<td>757.39</td>
<td>Other congenital anomalies of the integument [accessory skin tags]</td>
</tr>
<tr>
<td>782.0</td>
<td>Disturbance of skin sensation [burning]</td>
</tr>
<tr>
<td>782.2</td>
<td>Localized superficial swelling, mass, or lump</td>
</tr>
</tbody>
</table>

### Anesthesia Denials

- **Transesophageal Echocardiography (TEE)**
  - Diagnostic 93312-93317
  - Monitoring 93318
  - Can not be billed separately when performed for monitoring
- **Labor epidurals** and the reporting of time
  - Face to face time
  - Flat rate
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, aneurysm of heart wall, chronic ischemic heart disease, pericarditis, valvular disease or cardiomyopathy to name a few.
• Include the ordering/rendering provider and NPI

EKG Denials

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
    • V72.62 Laboratory examination ordered as part of a routine general medical examination

<table>
<thead>
<tr>
<th>Service</th>
<th>Cardiovascular Screening Blood Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCPCS/CPT codes</td>
<td>80061–Lipid panel</td>
</tr>
<tr>
<td></td>
<td>82465–Cholesterol</td>
</tr>
<tr>
<td></td>
<td>83718–Lipoprotein</td>
</tr>
<tr>
<td></td>
<td>84478–Triglycerides</td>
</tr>
<tr>
<td>ICD-9-CM codes</td>
<td>Report one or more of the following codes: V81.0, V81.1, V81.2</td>
</tr>
<tr>
<td>Who is covered</td>
<td>All Medicare beneficiaries without apparent signs or symptoms of cardiovascular disease</td>
</tr>
<tr>
<td>Frequency</td>
<td>Every 5 years</td>
</tr>
<tr>
<td>Beneficiary Pays</td>
<td>Copayment/coinsurance waived</td>
</tr>
<tr>
<td></td>
<td>Deductible waived</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
How to Avoid Top Coding Errors

Service: Diabetes Screening Tests

<table>
<thead>
<tr>
<th>HCPCS/CPT codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82947 – 82948</td>
<td>Glucose; quantitative, blood (except reagent strip)</td>
</tr>
<tr>
<td>82950 – 82951</td>
<td>Glucose; post-glucose dose (includes glucose)</td>
</tr>
</tbody>
</table>

ICD-9-CM codes: V77.1

Who is covered: Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes
Benefits 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

Service: Cholesterol Screening

<table>
<thead>
<tr>
<th>Service</th>
<th>Procedure Code(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol Screening</td>
<td>Code Group 1: Code Group 2:</td>
</tr>
<tr>
<td>Lipid Disorders Screening</td>
<td></td>
</tr>
<tr>
<td></td>
<td>G0101, G0123, G0124, G0141, G0143 – G0145, G0147, G0148, G0091, P3000, P3001</td>
</tr>
<tr>
<td></td>
<td>Code Group 2: Requires a diagnosis code from list below:</td>
</tr>
<tr>
<td></td>
<td>88141 – 88143, 88145, 88146, 88150, 88152 – 88155, 88156 – 88167, 88174, 88175</td>
</tr>
</tbody>
</table>

Diagnosis Code(s): Code Group 2: V70.0, V72.31, V72.32, V72.6

Preventive Services - United Healthcare

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How to Avoid Top Coding Errors

Medicare Example

- MUE change went into effect 4/1/2013
- For Medicare, report bilateral procedures with modifier 50 and 1 unit
- Letter to AMA can be found at:

Bilateral Procedures

- 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

Modifier 25
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).

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.
How to Avoid Top Coding Errors

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

Documentation Example Continued

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.

E/M Exam Component

• How many bullets are assigned for the following documented exam findings:
  – Cardiovascular-no murmurs, rubs or gallops
  – Respiratory- lungs clear to auscultation, normal effort
  – ENT- ear canals clear
  – Eyes- EOMI
1997 CMS Documentation Guidelines

Cardiovascular
- Palpation of heart (eg, location, size, thrills)
- Auscultation of heart with notation of abnormal sounds and murmurs
- Examination of:
  - carotid arteries (eg, pulse amplitude, bruits)
  - abdominal aorta (eg, size, bruits)
  - femoral arteries (eg, pulse amplitude, bruits)
  - pedal pulses (eg, pulse amplitude)
  - extremities for edema and/or varicosities

Respiratory
- Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)
- Percussion of chest (eg, dullness, flatness, hyperresonance)
- Palpation of chest (eg, tactile fremitus)
- Auscultation of lungs (eg, breath sounds, adventitious sounds, tubers)

Ear, Nose, Mouth and Throat
- External inspection of ears and nose (eg, overall appearance, scars, lesions, masses)
- Otoendoscopic examination of external auditory canals and tympanic membranes
- Assessment of hearing (eg, whispered voice, finger rub, tuning fork)
- Inspection of nasal mucosa, septum and turbinates
- Inspection of lips, teeth and gums
- Examination of oropharynx, oral mucosa, salivary glands, hard and soft palate, tongue, tonsils and anterior pharynx
How to Avoid Top Coding Errors

1997 CMS Documentation Guidelines

<table>
<thead>
<tr>
<th>L01</th>
<th>L02</th>
<th>L03</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inspection of conjunctiva and lid.</td>
<td>Examination of pupils and iris (e.g. reaction to light and accommodation, size and symmetry)</td>
<td>Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)</td>
</tr>
</tbody>
</table>

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

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

National Correct Coding Initiative (NCCI)

How to Avoid Top Coding Errors

Preoperative Diagnosis: Actinic keratosis x 3 of the left medial cheek.

Procedure #1: Cryotherapy of 3 lesions.

Procedure Note: The patient’s face was examined. He was found to have 3 areas of actinic keratosis of the left cheek.

They were treated with 20 seconds of liquid nitrogen. The patient tolerated the procedure well.

Procedure #2: Wide local excision of squamous cell carcinoma of the left face. Total excision 3 cm (lesion 2.0 cm and margins .5 cm) with a 3.5 cm intermediate layer of closure.

Documentation Example

Procedure Note: The patient’s left face was examined. The site of the lesion was noted. The site of intended excision was marked out in elliptical fashion surrounding the lesion. This was done with Betadine then injected with 1% Lidocaine with 1:100,000 epinephrine. The patient was prepped in the usual fashion. A #15 blade scalpel was used to make the incision at the previously marked site. The incision was carried down to the subcuticular tissue. It was tagged and handed off the field for pathologic examination. Frozen sections were taken. They returned with clear margins. At this point the wound edges were widely undermined using an iris scissors. The wound was then closed using 3-0 Vicryl for the deep layer, followed by 5-0 Prolene for the skin. The patient tolerated these procedures well and he should follow up with me in approximately 5 to 7 days time for suture removal.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Non-facility RVU</th>
<th>Facility RVU</th>
</tr>
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<tbody>
<tr>
<td>12052</td>
<td></td>
<td>8.83</td>
<td></td>
</tr>
<tr>
<td>17000</td>
<td></td>
<td>2.45</td>
<td></td>
</tr>
<tr>
<td>17003</td>
<td></td>
<td>0.20</td>
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</table>
How to Avoid Top Coding Errors

Coding Error?

<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>26</td>
<td>05/02/13</td>
<td>05/02/13</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
  http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/Products/downloads/mps_guide_web_06/06.pdf
• Astra Policy for Benign Skin Lesion Removal
• Medicare Coverage Database (LCD and NCD search)
• United Healthcare Summary of Preventive Services
Thank You!
Time for Questions