THE MOST COMMON CODING ERRORS

Phillip Ward, DPM
CPT Editorial Board Advisor for Foot and Ankle
Assistant Editorial Board Member

APMA
General Problems

- Not appealing denied claims
- Appealing denied claims without making any changes in the claim
- Poor / no documentation
- Using improper terminology
- Incorrectly billing services
Not Appealing Denied Claims

• The definition of insanity is doing the same thing over and over without changes and expecting different results (Einstein)
• All denied claims should be reviewed by the physician and the billing specialist for correctable errors
• Correct the errors and resubmit the claim as a corrected claim
Poor Documentation

• The documentation should support the level of service coded
• Document what you do, and code to the documentation
• Separate the documentation of E/M service from radiology and procedure(s) in the medical record
Not Getting All Charges Billed

• Audit the transfer of information from “routing slip” to billing program
• Make sure all charges get appropriately billed
Problems Related to E/M Coding

• Improper use of -25 modifier
• Not documenting the ROS
• Not documenting the PFSH
• Using a single level of E/M coding
New Patient Outpatient Visits
The average podiatrist can get a total of 21 bullets in 7 systems

<table>
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<th>CODE</th>
<th>HPI</th>
<th>ROS</th>
<th>PFSH</th>
<th>EXAM</th>
<th># DX</th>
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## Patient Outpatient Visits

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Improper Use of -25 Modifier

• -25 modifier not used when needed
• -25 modifier overuse
• Use of -25 modifier on procedural codes
• 3 uses of -25
  – NP E/M with procedure
  – EST PT E/M with procedure for a new diagnosis
  – Unrelated E/M and procedure
Not Documenting ROS

- Failure to document the ROS can decrease the billable E/M service
- Documentation requirements
  - None
  - 1
  - 2
  - 10
Not Documenting the PFSH

- Family
- Social
- Past Medical History
- Surgical History
Single Level E/M Coding

• Inappropriate to pick one code consistently without regard to the level of history, exam and medical decision making

• Podiatrists cannot bill 99205 and have difficulty using 99215
  – (medical necessity and relevance)
Problems Related to Coding Procedures

• Including everything in the global period
• Not utilizing the -78 modifier
• Allowing untrained staff to select the code
• Not understanding the NCCI and -59
• Not Following the LCD
Including Everything in the Global Period

- Use the global days appropriately
  0, 10 and 90-days (for Medicare)
- Understand and use the GSSR
  – Download from www.apma.org
- When outside the global, or unrelated, it is appropriate to bill for services
Not Utilizing Modifiers

-58 staged procedure
-76 repeat procedure by same physician
-78 return to OR for related procedure
-79 return to OR for unrelated procedure
Allowing Untrained Staff to Select the Codes

• Either the physician or properly trained staff should code the service

• Get ready for ICD-10
  – Proposed to start in the US in 2013
Not Understanding the NCCI

• NCCI is designed to assure physicians do not inappropriately unbundle CPT codes
• NCCI is updated quarterly
• APMA Coding Resource Center
Not Following the LCD

• Make sure you follow the LCD guidelines of your MAC carrier
Radiology

- Sequential radiographs
- Bilateral views
- Intraoperative interpretation
- Technical vs. professional components
Sequential Radiographs

- Bill with -58 staged modifier
- Bill with -76 repeat procedure modifier
Bilateral Views

• First option (*Preferred)
  – Bill on 2 lines with -LT on one line and -RT on next line

• Second option
  – Bill with -50 modifier and 2 units
  – Some payers do not recognize the -50 modifier
Intraoperative Interpretation

• Bill with the -26 professional component modifier

• Facility would bill the -TC (technical component) modifier