The Top Five Most Common Coding Errors

Avoiding these mistakes will save you time and money.

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Note: *CPT codes are used in this article. CPT codes are owned and copyrighted by the American Medical Association and are being used in this article only for educational purposes.*

It has been reported throughout multiple publications that coding errors, across all providers, vary from 7% to 75% depending on the type of provider. For internists, the rate is closer to 10%. For surgeons, the rate is closer to 40%. The highest rates are for non-physicians. Podiatrists have historically had a rate in the 15% range despite extensive efforts at provider education through podiatric specialty societies. Fortunately, the claim trends show error rates are decreasing with the increased use of electronic medical records. Most current electronic health records programs include claim scrubbing technology which can catch simple technical coding issues. However, there are some aspects of coding that cannot be automated; therefore, this article will list the five most common podiatric coding errors, discuss why they occur, and present solutions for these errors.

1. Missing or Incorrect Information

Errors or omissions are a common cause of claim denials and can easily be prevented by double-checking all fields before submitting a claim. Examples of misinformation include: no date of birth, no insurance number, missing middle initial, incorrect date of service, missing or incorrect place of service. Most of these errors are clerical and not directly provider-related. These errors can be eliminated by careful data entry and review; nevertheless, the provider is ultimately responsible for the accuracy of the claim.

2. Non-specific ICD-10 Codes

With the initial transition to ICD-10 codes from ICD-9, most physicians were diligent and comprehensive in their diagnosis coding. But as we have gotten accustomed to ICD-10, the data has shown that providers have gotten more lackadaisical with the completeness of the codes they choose. Frequently, the laterality of the code will not be specified when it is integral to the linkage with the procedure code and or modifier. The choice of which diabetes diagnosis code to use is also important to claim processing. It is not appropriate just to use the E10 or E11 codes. The code should be extended to the level of the complication that exhibits itself on the day of treatment. Examples would be E10.51 (Type I diabetes with circulatory complications without gangrene) instead of E10 (Type I diabetes) or E10.5 (Type I diabetes with circulatory complications).

3. Incorrect Procedure Codes/ Modifiers

A simple slip of the finger can result in an incorrect entry of a procedure code. The difference between a CPT 29297 (bunionectomy with fusion of the first metatarsal/cuneiform joint) and a CPT 29298 (bunionectomy with phalangeal osteotomy) in the latter procedure is more extensive and has more potential complications. Another example of incorrect procedure codes would be if the wrong code was identified on the encounter form. Use of outdated CPT books can lead to improper CPT codes use.

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Modifier use is necessary when unusual circumstances occur—such as a return to the operating room, multiple procedures performed at the same surgical setting, or when laterality is relevant. Incorrect procedure coding can be decreased through the understanding and use of the proper current CPT codes, proper use of modifiers, and diligent data entry.

4. Improper ICD-10 and CPT Linkage

Every claim entry needs a diagnosis explaining what was treated and a CPT code (E/M or procedure) describing what was done to treat the problem. If the diagnosis and CPT code do not agree, the claim will be denied. Examples would be a bunion diagnosis code and a hammertoe procedure code, or a nail

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diagnosis code and a skin debridement procedure code. Another example would be a modifier indicating the injection was done on the right foot when the diagnosis code specified the left foot. Knowledge and usage of proper diagnosis and procedure codes will decrease the rate of claim denials.

5. Upcoding

Up-coding occurs when patients are billed for more complicated levels of service than were actually provided. This could occur through typographical errors, misunderstanding of procedure definitions, or miscommunication between the provider and the person entering the code on the claim.

Typographical errors happen in the best of situations, especially when the person entering the data is in a hurry. Careful proofreading of the entered data will decrease the possibility of a denied claim.

A complete understanding of the actual procedure code chosen by the provider will decrease the possibility of submitting an incorrect code and prevent upcoding. This most commonly happens with regard to Evaluation and Management codes (CPT 99211-99499). A full understanding of what is included in each E/M code regarding chief complaint, history, examination, medical decision-making, and time will decrease the possibility of upcoding. Other examples are billing nail debridement for 6+ nails when only 1 or 2 nails qualify for debridement. Billing for an E/M service instead of foot care services would also be inappropriate and considered upcoding.

Proper communication between the provider and the person entering the data on the claim will decrease coding errors. Typically, the code is chosen by the provider and written on a routing slip or superbill. Unfortunately, poor handwriting can make this a guessing game when it comes to interpretation. Development of a method of proper and consistent communication between the provider of the service and the person entering the data on the claim is paramount.

Continued education, careful data entry, and complete understanding of diagnosis and procedure codes should decrease the current coding error rate for foot and ankle services. **PM**

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