Tips for Avoiding Coding Mistakes

These common errors can cost you dearly.

BY MARK TERRY

As anyone who has spent any time at all delving into the world of medical coding realizes, coding is complicated, not always logical, and always changing. It's also a source of a great deal of frustration and revenue loss.


Dr. Lehrman

In the new fiscal year that began October 1, 2018, there were 473 code changes to the ICD-10 codes. That included 279 new codes, 143 revised codes and 51 codes that were deactivated. Thankfully, not all of those changes were relevant to podiatry. Below are lists of the changes most relevant to podiatrists, provided by Jeffrey D. Lehrman, DPM, CPC, of Lehrman Consulting (Fort Collins, CO), and a Certified Professional Coder.

Changes

New ICD-10 Codes that Became Effective on October 1, 2018

F12.23—Cannabis dependence with withdrawal

F12.93—Cannabis use, unspecified with withdrawal

G71.00—Muscular dystrophy, unspecified

G71.01—Duchenne or Becker muscular dystrophy

G71.09—Other specified muscular dystrophies

G79.10—Myalgia, unspecified site

R93.89—Abnormal findings on diagnostic imaging of other specified body structures

T81.40X__ (requires seventh character) Infection following a procedure, unspecified

T81.41X__ (requires seventh character) Infection following a procedure, superficial incisional surgical site

T81.42X__ (requires seventh character) Infection following a procedure, deep incisional surgical site

T81.44X__ (requires seventh character) Sepsis following a procedure

T81.49X__ (requires seventh character) Infection following a procedure, other surgical site

Changes to Existing ICD-10 Codes that Became Effective on October 1, 2018

G71.0—(Muscular dystrophy) now requires a fifth character

M79.1—(Myalgia) now requires a fifth character

R93.8—(Abnormal findings on diagnostic imaging of other specified body structures) now requires a fifth character

T81.4—(Infection following a procedure) now requires a fifth character

*Revisions to Existing ICD-10 Codes that Went into Effect on October 1, 2018 (changes in **bold** are **new**)*

L98.495 Non-pressure chronic ulcer **of skin** of other sites with muscular involvement without evidence of necrosis

L98.496 Non-pressure chronic ulcer **of skin** of other sites with bone involvement without evidence of

Continued on page 124

Mistakes (from page 123)

necrosis

L98.498 Non-pressure chronic ulcer **of skin** of other sites with other specified severity

Top 5 Mistakes in Coding

Although having a short list of changes to coding is useful, real-world coding of medical procedures is ever-changing. Here's a look at the top five mistakes and what you can do about them.

Lehrman notes, "There are codes that podiatrists use a lot more than others. The first group would be Evaluation & Management (E/M) services, both in the office and in the hospital, and home visits and nursing home visits. There's a different set of codes based on where the E/M service takes place. The #1 podiatric offering by far, with #2 not even being close, is foot care. And by foot care we mean nail and callus care. So there are codes for nail care as well as callus care. Those would be the two most commonly submitted groups of codes. And there is a long list of procedural codes for both surgeries performed in the operating room and procedures performed in the office."

Lehrman notes that these aren't specific to podiatry, but "the most common errors are not picking the correct code for the service provided; and very much related, not having the proper documentation to support the code that was selected."

Gloryanne Bryant, an American Health Information Management Association (AHIMA)-Approved ICD-10-CM/PCS Trainer, and National Director Coding Quality, Education, Systems and Support for Kaiser Permanente Hospitals & Health Plan in Oakland, California agrees, saying, "Common mistakes with ICD-10-CM (diagnosis coding) are incorrect assignment of the 7th character, not assigning the laterality (LT/RT), not coding to the specific condition and using 'unspecified,' and leaving a diagnosis code off the claim / bill."

Modifiers

CPT codes must have ICD-10 code(s) pointing to them. That seems simple enough, but there are variations and exceptions, and often, related services (with global periods to deal with) that a podiatric physician performs. Modifiers are designed to clarify extenuating circumstances.

Betsy Nicoletti, a Medical Coding & Compliance Expert in Northampton, Massachusetts says, "The other problem is the use of modifier -25. This relates to foot care and debridement, care of ulcers, and injuries on the foot. When do we bill for both an E/M visit and a procedure? When a podiatrist goes to a nursing home, for example, and is scheduled to provide foot care on a group of patients, it is not considered by Medicare to be medically necessary to bill a nursing home visit, an E/M service visit, in addition to that foot care." The exception to this guidance is if the E/M is separately identifiable from the procedure and the documentation supports this.

She goes on to say, "Podiatrists should be looking at the frequency of using modifier -25 and making sure if they bill for an E/M service on the same day as a scheduled routine foot care, it's because they're taking care of something different, not just the foot care itself."

-25 Modifier

The -25 modifier appears to be the one most likely to be used incorrectly. Lehrman says, "Any time you see a patient, you can only submit an E/M at the same time of the procedure, if an evaluation in management was separately identifiable from the procedure. That applies to both new and established patients."

So, for example, for established patients, if a podiatrist has legitimately performed, documented, and demonstrated the medical necessity of a separately identifiable E/M, that is coded by appending a -25 modifier to the E/M and is submitted at the same time as the procedure. Lehrman adds, "People often make the mistake of submitting an E/M with a 25 modifier when a separately identifiable E/M wasn't performed or the documentation isn't there to submit it, or it wasn't medically necessary."

RT or LT Modifiers

Confusion can also occur on whether to use a RT or LT modifier compared to the -50 modifier when performing bilateral services. If you incorrectly select the wrong modifier, the claim may be denied. And there doesn't seem to be much intuitive logic as to when to use the RT/LT modifiers versus the -50 modifier.

The best approach is to check the Correct Coding Initiative edits, available at the Centers for Medicare and Medicaid Services (CMS) website or a podiatry-focused resource such as the American Podiatric Medical Association (APMA) Coding Resource Center.

From this, you will be able to determine whether a specific CPT code, when performed bilaterally, requires billing on a single line with the -50 modifier or if you should bill two separate lines with the RT and LT modifiers.

The -51 Modifier

Also, generally speaking, don't use the -51 modifier for Medicare

Continued on page 126

"People often make the mistake of submitting an E/M with a 25 modifier when a separately identifiable E/M wasn't performed or the documentation isn't there to submit it, or it wasn't medically necessary."—Lehrman

Mistakes (from page 124)

claims. The -51 modifier states that multiple procedures occurred at the same visit. Insurance company software typically considers that issue when processing the claim and decreases payment on the secondary billing lines.

T Codes

T codes are used to differentiate billing for separate digits, i.e., for services distal to the metatarsophalangeal joint. So, for example, don't use a TA modifier for bunion surgery. T codes can be used to differentiate surgery performed on multiple toes.

Down-coding Mistakes

Another common coding mistake is down-coding, which, not surprisingly, is the opposite of upcoding. Upcoding suggests that you are billing for a higher level of service than is appropriate. Sometimes physicians or coders think that if you down-code and bill for a lower level code, such as an E/M service, you will decrease the odds of being audited.

Coding experts suggest that either being too high or too low, such as by two standard deviations in either direction, may stimulate unwanted attention—meaning, trigger an audit.

Another problem with down-coding is you might be cheating yourself out of money owed.

Explanation of Medicare Benefits (EOMB)

There's a risk in throwing up your hands when small claims are denied and saying, "It's not worth the time and effort to appeal." Yes, almost all businesses at one time or another will have to say, "I've put too much time into getting paid for this, let's move on." But it definitely should not be your default position when a claim is denied.

A denial means the insurance carrier believes the bill was inappropriate. They are not always correct. Carriers do process claims incorrectly. But… you might have made a mistake.

Carefully read the explanation of benefits. This will, in many cases, provide insight about why the claim was denied. That gives the podiatrist the basis for an appeal.

But appealing based on an incorrect denial rationale won't always get the claim paid. Your appeal letter has to address the specific question the carrier has mentioned. Sometimes it's an incorrect modifier; sometimes it may be an issue of medical necessity.

Coding experts suggest that either being too high or too low, such as by two standard deviations in either direction, may stimulate unwanted attention—meaning, trigger an audit.

The key here is to identify the mistake and correct it—and then note it for future reference to fix the processes that led to that mistake.

Local Coverage Determination

According to the Social Security Act, the term local coverage determination means "a determination by a fiscal intermediary or a carrier under Part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary—or carrier-wide basis under such parts…"

Nicoletti says, "I think podiatrists have to make sure they've familiarized themselves with their local coverage determinations, with their medical policies about foot care. I think they should pay really close attention to denials. If they're doing something frequently and they do it the same way every week, week in and week out, and they see denials from their payer, which is feedback from their payer that the payer doesn't think it's medically necessary or that they

Continued on page 127

Mistakes (from page 126)

billed it wrong."

Of course, she notes, that's really frustrating. "I think it's important to use that as intelligence. Call them if you have to. Find out if there's a reason why: a modifier issue, a coding issue, a compliance issue."

"The answer is to have the appropriate resources available. And too many people make the mistake of guessing."—Lehrman

The Codes May Change…

"but the problems really stay the same," Lehrman says. "I've been doing this for a long time and in 15 years, the problems are the same and they're the same reasons for audits." He says for podiatrists the most common problems are "inappropriate coding for foot care services and inappropriate coding and documentation for E/M."

So in order to minimize the coding problems, Lehrman suggests, "The answer is to have the appropriate resources available. And too many people make the mistake of guessing. Too many people are guided by, 'Well, I was told this 20 years ago and I've always done it this way.' And some people make the mistake of saying, 'Well, I haven't been audited yet.' Which doesn't mean they won't show up tomorrow. The way to avoid errors is to have adequate resources and not use outdated books and don't rely on Google."

Lehrman is very active in the coding area for podiatry and discloses that he's involved in most of the services that assist in the area. With that in mind, they include:

The APMA Coding Resource Center

Lehrman notes that it requires a monthly subscription, but it narrows down the 60,000+ ICD-10 codes to those most pertinent to podiatrists. This resource, among many other things, also provides a list of suggested ICD10 codes to use with each listed CPT code.

Codingline

This website (www.codingline.com) is an online Q&A forum. Members can ask questions and they are presented before a panel of coding experts, three of whom are actually CPCs. Lehrman is one of the panelists on Codingline.

"The other good resource would be in-person events," Lehrman says, "going to talks that are run by respected and certified coders. Many are podiatry-specific. The APMA also does a designated coding seminar the Sunday of the APMA National meeting and puts on other coding seminars in different cities throughout the year."

Lehrman concludes, "The #1 thing I would hope to convey is 'don't guess'. It's important to get it right because audits are ugly."

The other thing he suggests is, "A lot of podiatrists think something isn't fair or isn't cool or the rule stinks but complaining about it in your office to your walls or your staff accomplishes nothing. The APMA has a very active coding committee and a very active health policy committee. If you are disenchanted and you don't like something that's going on, or you don't like what you're getting paid, speak up. Don't complain to your friends or to your walls. Let us know. We, meaning APMA, want to hear. We want to know what's going on and want to help. There's also an opportunity if someone wants to get involved and play a role in helping." **PM**

Mark Terry is a freelance writer, editor, author and ghostwriter specializing in healthcare, medicine and biotechnology. He has written over 700 magazine and trade journal articles, 20 books, and dozens of white papers, market research reports and other materials. For more information, visit his websites: www.markterrywriter.com and www.markterrybooks.com.