

8 medical coding mistakes that could cost you

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Government and private insurers' audits have revealed unfortunate cases of fraudulent or abusive medical billing practices. You deserve to be paid for the medical care you provide, but it is essential that you avoid improper billing practices to steer clear of trouble and maintain a flourishing practice.

When it comes to medical coding errors, they fall into the broad categories of "fraud" and "abuse."

The former involves intentional misrepresentation. The latter means "the falsification was an innocent mistake, but nonetheless representative," according to the AMA's *Principles of CPT® Coding*, ninth edition. An example of abuse could involve coding "for a more complex service than was performed due to a misunderstanding of the coding system," the text notes.

The AMA has several resources to help you accurately bill procedures and services with the Current Procedural Terminology (CPT) code set and Healthcare Common Procedure Coding System (HCPCS) codes.

Visit the AMA Store for coding resources from the authoritative source on the CPT code set. You'll find print and digital versions of the codebook, online coding subscriptions, data files and coding packages.

Here are some of the most common mix-ups to avoid in medical coding.

Unbundling codes. When there is a single code available that captures payment for the component parts of a procedure, that is what should be used. Unbundling refers to using multiple CPT codes for the individual parts of the procedure, either due to misunderstanding or in an effort to increase payment.

Upcoding. Example: You are a physician in a specialty, such as oncology, that often has highly complex patients. Due to this, you always report the highest-level evaluation-and-management (E/M)

service regardless of the actual condition your patient presents with. While this isn't always upcoding, you should accurately report the level of E/M code based on the patient's condition and not just based on your specialty.

And of course, there are examples of outright fraud in terms of upcoding. Take this case as a warning. One psychiatrist was fined \$400,000 and permanently excluded from taking part in Medicare and Medicaid in part due to upcoding. He billed for 30- or 60-minute face-to-face sessions with patients when, in reality, he was only meeting with patients for 15 minutes each to do medication checks.

Failing to check National Correct Coding Initiative (NCCI) edits when reporting multiple codes.

The Centers for Medicare & Medicaid Services developed the NCCI to help ensure correct coding methods were followed and avoid inappropriate payments for Medicare Part B claims. These are automated prepayment edits that are "reached by analyzing every pair of codes billed for the same patient on the same service date by the same provider to see if an edit exists in the NCCI," the AMA's text notes. "If there is an NCCI edit, one of the codes is denied." NCCI edits will also typically provide a list of CPT modifiers available that may be used to override the denial. In certain cases, clear direction is stated that no modifier may be used to override the denial.

Example: You bill for a lesion excision and skin repair on a single service date. But CPT coding guidelines say simple repairs are included in the excision codes, so separately coding the repair would be wrong and generate an NCCI edit. But if the repair was performed on a different site from where the lesion was removed, it is appropriate to bill for both and append a modifier to let the payer know the procedure was indeed separate from the excision.

Failing to append the appropriate modifiers or appending inappropriate modifiers. Related to the case outlined above, this could involve reporting modifier 50, *Bilateral Procedure*, to a procedure code that already includes bilateral service.

Overusing modifier 22, *Increased Procedural Services*. You must include proper documentation to explain why the procedure requires more work than usual.

Example: You excise a lesion located in the crease of the neck of a very obese patient. The obesity makes the excision more difficult. In such a case, appending the modifier 22 to the code used to report the removal can indicate the increased complexity of the service.

Improper reporting of the infusion and hydration codes, which are time-based. Good documentation of the start and stop times are essential for medical coders to properly bill for these services. And then there are wrinkles involving services that are provided over two days of service.

Example: A continuous intravenous hydration is given from 11 p.m. to 2 a.m. In that case, instead of continuous infusion, the two administrations should be reported separately as initial (96374) and sequential (96376).

Improper reporting of injection codes. Only report one code for the entire session during which the injections take place instead of multiple units of a code.

Reporting unlisted codes without documentation. If you must use an unlisted code to properly bill for a service, you must properly document it.

Learn more about implementing CPT evaluation and management (E/M) revisions and the latest technical corrections.