

Correctly Coding Problematic Procedures and Modifiers

Presented by:

Jonnie Massey, AHFI, CPC, CPC-P, CPC-I

Disclaimer

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Goal today

To provide an overview of the red flags an auditor may identify, the procedures that if not properly coded and documented may put you at risk. Case examples will be shared.

'Excellence in medical documentation reflects and creates excellence in medical care. At its best, the medical records forms a clear and complete plan that legitimately communicates pertinent information, credits competent care, and forms a tight defense against allegations of malpractice by aligning patient and provider expectations.'

Peter G. Teichman, MD, MPA

Documenting Tips for Reducing Medical Malpractice Risk Family Practice Management
March 2000

The Electronic Medical Record (EMR) potential risk areas

- The University of Colorado survey found the following missing clinical data in 13.6% of EMR visits:
 - Laboratory results (6.1%)
 - Letters / dictation (5.4%)
 - Radiology reports (3.8%)
 - History and Physical Exams (3.7%)
 - Medications (3.2)

**Seminar tip #1: lack of proper
documentation is a risk area !**

The importance of an accurate
and thoroughly documented
medical record

True Story

- An orthopedist's office was audited due to a tip that he was implanting non-FDA approved devices. Records were copied, thoroughly reviewed by CPC's and MD's and determined to be ineligible services. A request for \$85,000 in refunds was made. 18 months later, the office produced x-ray evidence that the orthopedist dictated the WRONG DEVICE, but actually implanted the approved device. The case was closed.
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Moral of the story?

- Convince the physician to dictate properly
 - Higher a CPC
 - Produce all the records when audited
 - Ensure thorough and accurate coding at all times
 - Don't use a code just because you get paid
 - All of the above
-

Risk areas –% of missing

Studies show:

- ❑ A bill was generated for lab, but the results are not in the chart (6.1%)
- ❑ The visit for a consultation, but the letter to the referring physician is not in the chart (5.4%)
- ❑ An x-ray is billed, but the film or report is not in the chart (3.8%)
- ❑ The History and Physical is not in the chart (3.7%)
- ❑ The medications listed in the chart, but not evaluated or reviewed (3.2%)

Seminar tip #2: Remember if it is not documented, it did not happen! Or did it? How can you tell?

Survey information

- Results of missing clinical information in charts showed
 - Somewhat likely to adversely affect patients - 44% of the time
 - Potentially resulted in the delay of care / more services - 59.5% of the time
 - Time spent unsuccessfully looking for missing information - 30% of the time

Seminar tip #3 : could these results indicate both patients and practitioners are at risk?

Medical Records as Legal Documents

- ❑ May be needed to support / defend the physician in the legal arena
 - ❑ Do not erase, white out or delete an entry
 - ❑ Corrections should be made with a single line-then date and initial
 - ❑ Routine record keeping procedures apply to all patients (family members, office staff)
 - ❑ Records should comply with state and federal laws
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Medical Records

'The good medical record'

- Is a legal document and will clearly support the services
 - Is complete
 - Legible
 - Correct date
 - Contains the patient name
 - Is in chronological order
 - Is signed or initialed
 - Coded accurately
-

More reasons for good medical record keeping

- Quality of care includes accurate and thorough documentation
- Medical records are important for continuity of care
- Records follow patients for a life time

Seminar tip #4: Remember the coding rule: if it is not documented, it did not happen! (and you can't bill for it)

Examples of problematic record keeping

- Handwritten records – can't read the writing
- Note is not signed or initialed – who provided the service?
- Patient name missing
- Date of service missing
- Coding does not match documentation
 - Up coded?
 - Under coded?
- Service does not match diagnosis

Seminar tip #5: if an auditor cannot determine the service, the service may not be eligible for payment. Would you pay for something you could not identify?

The Electronic Medical Record

- Increases office efficiency and convenience
 - Increases revenue through coding / charge capture
 - Decreases cost of transcription
 - Increases satisfaction of providers and patients
 - Creates a legible record
 - Records are easily reproduced
 - Records are easily transferred
 - More efficient record storage and retrieval
 - "Greener" – reduces paper
-

More risk areas – the EMR

- ❑ Data is carried over from previous visit
 - Same BP each visit? Same weight?
- ❑ Check list without ability to use free text
- ❑ Notes appear 'canned' or cloned
- ❑ Lack of integration with ancillary services (lab)
- ❑ Accuracy – were all elements on the template performed?
- ❑ Is the temptation to code based on meeting documentation guidelines?

Seminar tip #6: risk area, carry over data is apparent, visit not documented. Is this a trigger for additional review / audit?

Canned or Cloned Records

- ❑ Be wary of programs that carry over default information
 - ❑ Remember, documentation should be patient specific
 - ❑ Cloned or canned records may be considered misrepresentation of the medical necessity required for covered services
 - ❑ Discovery of this will lead to denial of services for lack of medical necessity and recovery of overpayments
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Statistically Speaking.....

- ❑ Medicare recipients account for the majority of patients
- ❑ Evaluation and Management codes 50% of services

Seminar tip #7: with these kinds of statistics, could you be at risk for a Medicare audit of E&M codes?

Documentation and medical necessity

- ❑ Documentation of medical necessity is the criteria for payment in addition to meeting documentation guidelines to support the codes used
 - ❑ Providers must maintain records that contain sufficient documentation to support diagnosis, admissions, treatments and continued care
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Common errors, red flags, audits

The most common errors from an auditors experience

#1 Billing for services not rendered

■ *What does this mean?*

There is no documentation in the chart for the codes billed or it appears the patient was not present for the visit

E&M billed for phone call/rx refill

Lab

X-ray

Surgical Procedure

Supply or Service

The most common errors

#2 Misrepresenting a diagnosis to justify payment

□ *What does this mean?*

The chief complaint, or reason for the visit was not documented or billed accurately

Claim is coded to 'get it paid'

A 46 y.o. female is getting weight loss services from a physicians office. The office codes the claim with 'hypertension' as a diagnosis to get the claim to be paid. (weight loss treatment is not a benefit). The patient now has a false medical diagnosis (hypertension) that will follow her around. Later she applies for life insurance and is declined because she did not disclose the hypertension on her insurance app. TRUE STORY

True Story

- A 35 y.o. male newly diagnosed with diabetes goes to the doctor for evaluation and treatment of his condition. The patient has a benefit for diabetic education that includes a 'no copay' provision. The physician intentionally bills office visits and charges a co-pay for each visit. The patient has a \$25 copay for medical visits. The physicians gains by billing all diabetic patients in this manner. TRUE STORY
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It gets better (or worse?)

- A 24 y.o, healthy pregnant woman is given a routine ultrasound at her routine OB/GYN visit to determine the sex of her baby. As she is leaving, she catches a glimpse of her chart and notices the diagnosis is 'fetal abnormalities'. This causes her great concern, when she asked the physicians office, they advises 'we code it that way to get it paid'. TRUE STORY
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More coding errors / red flags

Examples of misrepresenting diagnosis:

- Service is cosmetic, billed as medical
 - Lesion removal – mole removal at request of patient (cosmetic)
 - Patients presents for routine exam, but no benefits are available, diagnosis is billed as 'medical'
 - Billing for medically necessary nail care, not routine nail trimming
 - Diagnosis is changed, claim resubmitted after claim denial (did chief complaint change?)
 - Dental services billed as medical
 - In cases of no medical coverage or benefits exhausted
-

Coding errors / red flags – con't

- ❑ Remember – the primary diagnosis code is always the reason for the visit – this should not change
 - ❑ Be careful to code correctly and accurately the first time
 - ❑ Include all other appropriate diagnosis codes
 - Even those indicating accident related – work, auto, etc.
 - Seminar tip #8: if auto or work related, indicate this on claim form and bill all insurance coverage on file, do not commit a 'sin of omission'
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The most common errors

- #3 Soliciting, offering, or receiving kickbacks

What does this mean?

Example:

- Vendor offers something of value (bribe, rebate, trips) for using services
 - Radiology group / Lab paying for patient referrals
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The most common errors

□ #4 Unbundling charges, splitting claims

What does this mean?

Examples:

- Bundled lab codes are split out and billed individually
 - Same day services are billed on separate claim forms
 - office surgery and office call same day
 - multiple office surgeries
-

The most common errors

- ❑ #5 Falsifying certificates of medical necessity, treatment plans, and medical records to justify payment

What does this mean?

- Diagnosis does not match treatment or level of services coded / billed
 - Service appears to be outside of expected treatment for condition compared to peers
 - ❑ Higher level codes consistently billed, not documented
 - ❑ Excessive visits, unclear treatment
 - ❑ Continued treatment, no documented goals or improvement
-

The most common errors

- ❑ #6 Billing for additional services not furnished as documented / billed
What does this mean?
- ❑ Examples
 - Using procedure codes not appropriate for the service or item actually provided
 - Misrepresenting the identity of the patient
 - ❑ Billing individual therapy for family / group therapy
 - ❑ Billing for the child not the adult
 - ❑ Knowingly providing or billing for services not eligible

Seminar tip #9: beware of treating/billing for the benefit plan, not the patient

Coding is based on the documentation

- The volume of the documentation does not generate the coding level
 - Think quality, not quantity
 - It is what the records states, not how long it takes to dictate the record
 - Only pertinent documentation may be considered

Seminar tip #10: medically reasonable and necessary services for the condition of the particular patient during the documented encounter can be considered when assigning the appropriate level of an E&M service

A few words about audits

- What triggers an audit? (see previous 27 slides!)
 - Unusual billing patterns compared to peers
 - Modifiers – used incorrectly?
 - Claims for investigational services
 - Diagnosis codes and procedure codes mismatched
 - Pattern of resubmitted claims with altered diagnosis
 - Tips from patients
 - Tips from former / disgruntled employees
 - Excessive charges
 - Sometimes it is just routine !
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Auditing considerations

- Employ reputable certified coders!
 - Consider self audits
 - Consider outside audit firm
 - Compliance officer?
 - What kind of tools do you have to ensure correct documentation, correct coding and billing
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Common audit findings

- Unknown provider – record does not indicate who provided the service
 - No documentation
 - Insufficient documentation-record does not support the level of service billed
 - Up coded
 - Services considered investigational
 - Services considered contract exclusion
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Will you be audited?

- Prevention is the best**
 - Ensure documentation is complete
 - Document what you do, do what you document
 - Be aware of Medicare Policy and carrier policy
 - Communicate with carrier – provider rep?
 - Be thorough and accurate during preauthorization process
 - Ensure waivers (ABN's) are detailed, use exact descriptions
 - Keep track of who you talk to and when
 - Keep documentation on file
 - Continued Education is critical
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Risky Business – modifiers 25 and 59

MODIFIERS

- Know the basics, but don't forget to follow the rules!
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Most commonly red flagged modifiers (25 and 59)

- 25 – can only be used for a **significant, separately identifiable E&M** service by the same physician on the same day as another service or procedure
 - Used only on E&M codes
 - For use with minor procedures, usually 0-10 day global
 - Documentation must be very clear that the physician services were required above and beyond the other service
 - Do you consistently bill a 25 modifier? Why?
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...more on Modifier 25

□ Use when

- Established patient , new condition, requiring patient evaluation
- New patient who needs to be evaluated during a procedure
- May have different or same diagnosis codes

Seminar tip #11: a small E&M is inherent in all procedures. Be sure the documentation meets all requirements. Remove everything you would expect in a procedure note, is there enough to support an E&M?

....even more on modifier 25

□ 25 and Preventive Services

- When billing modifier 25 with a preventive visit, append to the E&M code
- Must be a significant problem that justifies the E&M
- The E&M must be above and beyond what you would expect to see at a preventive visit
- Documentation must support both visits

Seminar tip #12: red flag for misuse

Case Example

- Patient reports co-pay for planned office surgery
 - Adhoc and record review indicates pattern of 25 modifier is appended to E&M visit same day as office surgeries. Reason for visit (cc) is removal of skin lesions (previously diagnosed).
 - Codes billed or 99213-25 (E&M) and 11300(lesion removal). Allowed code is 11300 because the physician did not do the evaluation and management.
-

...what about modifier 59?

- ❑ Modifier 59 is used for a distinct or independent procedural service
 - ❑ Used when the procedure is done
 - At a different encounter
 - At a different site / organ system
 - For a different lesion
 - For a different incision / excision
 - For a different injury or if extensive injuries
-

...more on modifier 59

- ❑ Modifier of last resort – only if no other is appropriate
- ❑ This modifier can bypass unbundling edits

Seminar tip #13: audit risk. Ensure documentation supports this modifier

At risk specialty coding

Common definitions

- Up coding – coding at a higher level than the documentation supports.
 - Example: E&M codes, # of physical therapy units , # of levels manipulation was done
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Avoiding Common Physical Therapy coding/documentation errors

- Ensure the records are accurately documented– some basics to start with:
 - Referral/prescription from a physician present
 - Treatment Plan documented
 - Goals documented
 - Progress notes, rehab card, flow sheet
 - Is medical necessity established for the visits? Continued treatment?
 - Know the carrier rules
 - Treat that patient

Seminar tip #14: be wary of home grown abbreviations and documentation short cuts. Is the record legible? Be wary of treating the maximum number of visits, not the patient

Physical Therapy Codes

- Watch for the 'timed codes' or constant attendance codes 97032-97039
 - Time is reportable for direct one on one patient care only
 - The therapist must be with the patient at all times
 - The 'eight minute rule' applies – notes must indicate a minimum of 8 minutes per unit billed

Seminar tip #15: make sure the constant attendance is documented

PT timed code examples

- 97032 x 3 = indicates electrical stim (or e stim) was applied for 45 minutes while the therapist was in constant attendance.
 - At minimum going by the 8 minute rule – 24 minutes
 - The chart notes should clearly indicate time spent with patient
 - If less than 8 minutes is documented, the service is bundled into another procedure
-

Determining what counts towards the 15 minute timed codes

- Actual time delivering the service
- No prep or step up time
- The patient should be in the treatment area and prepared to start (not in the waiting room)
- The beginning and ending time of the treatment should be documented or total minutes treatment delivered

Seminar tip #16 for time codes, did the patient arrive on time and tx started and stopped on time? Really?

PT Examples – the tip and the audit

- ❑ Auditors acted on a tip that a PT was providing 'gym' services. The onsite audit identified treadmills, and stairmasters ...appeared to be a gym. Patient goals were to increase downhill skiing endurance, increasing running from 5-10 miles per day. Patient's self referred. No loss of function or treatment plans identified.
 - ❑ Q: Should this be billed to the insurance company, or should a fitness club membership be paid for?
-

Codes 97014 and 97032

Electrical Stimulation (attended, not attended)

■ Not attended example:

Tens unit

■ Attended requires constant attendance by therapist

Chiropractic Manipulative Treatment

- Code Range 98940 – 98943

 - The codes include a pre-manipulation assessment and should not be billed with an E&M code - unless a modifier 25 is used
 - Remember, modifier 25 is only allowed for a separately identifiable procedure
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Chiropractic coding

- Frequently chiropractic offices employ Licensed Massage Therapists (LMT's)
 - LMT's should report using 97124
 - Follow all state, federal and licensing board rules
 - **Know the patient benefits and carrier policy**

Seminar tip #17 : some insurance plans do allow massage therapy if billed by an LMT, even if supervised by a provider. This is an audit risk area if there is not benefit, and the LMT is not indicated on the claim form

New patient vs. established patient visit

- ❑ A new patient visit is eligible if the physician has not seen that patient for 3 years or more
- ❑ A new patient visit is a higher reimbursement, but is it justified?
- ❑ If this physician has seen the patient in the last 3 years (any location, any diagnosis) then the visit is established patient visit.

Seminar tip #18: New patient vs. established patient is an audit risk. See pg 1 in CPT book for definition of new patient

True Story

- ❑ A small community facility frequently has new physicians. When established patients call for an appointment they are informed they must schedule a consult first with the new physician and a medical visit 2 days later for the actual visit since the doctor is new. (same clinic, same chart, same specialty within 3 years of last visit)
 - ❑ Q: is this ok?
-

New patient vs. Consultation – the 3 'R's (request, render, report)

- ❑ Consultation is a service provided by a physician whose opinion or advise regarding evaluation and/or management of a specific problem is requested by another physician or appropriate source
- ❑ Appropriate source includes other healthcare professionals- see your coding book
- ❑ The request may be written or verbal
- ❑ A written report to the requesting physician must be documented
- ❑ 'Consultation' requested by family is excluded from this code set

Seminar tip #19: watch for Consultation vs. new patient visit !! This continues to be a red flag issue

The mental health arena

□ 90808

- Multiple providers have been indentified using code 90808 (highest level psychotherapy code)
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Top reasons for billing 90808?

- That is the code that pays
 - Somebody told me to use that code
 - I don't know any other codes
 - I don't have a CPT book
 - What is a CPT book?
 - Are there other codes?
-

90808 – in short

- ❑ Documentation should indicate 'crisis'
- ❑ 75-80 minutes face to face with patient

- ❑ Actual review of records (true stories)
 - 'unremarkable' (the only word on the page)
 - 'Patient was crying today'
 - No documentation was found in chart
 - No chart was found

.....And finally the provider asked 'This should be documented?'

Summary

Today we talked about:

- ❑ Medical records standards – benefits and risks
 - ❑ Common coding areas – red flags, audits
 - ❑ Detecting and avoiding coding and billing errors
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Questions???

Thank you!

Jonnie Massey

Email: Jonniecodes@comcast.net
