BY EMILY HILL

THE OFFICE

Coding Blunders

The inadequate use of modifiers ranks high on coding expert Emily Hill's list of the top 10 mistakes that physicians make when documenting patient visits. Marrying ICD-9 codes with appropriate CPT codes is tricker than it seems, she says. In this month's column, she gives some common scenarios of what goes wrong.

In most offices I visit, inappropriate use of modifiers is an issue. We see denials based on the lack of medical necessity, when in fact it is solid justification for the care that was given that is lacking.

For most practices, the mistake lies in not having the proper diagnosis associated with the ICD-9 code, or in not knowing how to associate those on the claim form. Using modifiers correctly is critical to the bottom line. Payers expect the CPT (Current Procedural Terminology) code to reflect medical necessity and to justify treatment choice or the course of investigation, so it pays to learn the modifier rules.

The challenge is that many clinical encounters don't follow the expected scenario—patients often have more than one diagnosis—and are thus difficult to modify.

As many as four diagnoses may be listed on the CMS-1500 paper claim form, and just as many diagnosis codes can be linked to each CPT code. However, many payers use only the first ICD-9 code linked to a CPT code, so multiple diagnoses need to be prioritized accurately.

Take the patient who presents with a cough and mild chest pain. Investigating the possibility of pneumonia, you may order an x-ray and some lab work. But that chest pain needs to be investigated as a possible cardiovascular disease. Billing for an EKG will be denied unless an appropriate diagnosis is listed. You would need to associate the EKG with the chest pain and the x-ray with the cough.

Then there is the symptom that is mentioned incidentally. A mother brings her child in for an upper respiratory infection and mentions in passing that the child is wetting the bed. A suspected upper respiratory infection won't justify a urinalysis, so a second diagnosis of enuresis is in order. The ICD for enuresis should be associated with the CPT code for the urinalysis.

Another common mistake occurs when a physician orders several lab tests but lists only a primary diagnosis that does not justify the lab work. So ordering a thyroid panel during a wellness visit may not work if there isn't another diagnosis to justify the panel. If the patient has signs and symptoms suggestive of a thyroid disorder, they must be documented. If the panel is being done for screening purposes, an ICD for screening services must be reported (though some payers may not reimburse for certain screening tests).

Reimbursement denials are inevitable when physicians fail to complete encounter forms thoroughly during the office visit. If there isn't a diagnosis for the office visit on the form when the patient leaves, the claim is more likely to be denied.

Most of the coding changes have introduced greater specificity, so there is now an overwhelming choice of codes. However, most ICD-9 codes do allow options that are unspecified or nonspecific. The temptation is to pick the least specific code. But that in itself can create denials.

Practices should use their billing software to run a production report to find out how many times each ICD-9 code is used. Doing so annually can help you determine if there is a preponderance of nonspecific codes and can help identify opportunities to improve reimbursement. Do the codes reflect the patient population? In a primary care practice, are there enough wellness visits? If there aren't, this could be a flag to a payer that preventive services are not being adequately provided. Also update the encounter form to make it more user friendly and remove codes that are seldom used.

Finally, be sure to keep up to date on coding changes. New ICD-9 codes will go into effect on Oct. 1, so it's important to look for any changes that may alter the specificity. Changes and clarifications to the CPT codes are due out next year. ■

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