Coding Pitfalls

JENNY GUTHRIE, MBA, RHIT, CHC
CONSULTANT
REVENUE INTEGRITY MANAGEMENT RESOURCES

1

Goals of this Education:

- Understand common coding issues and strategies to combat
- Understand the importance of coding audits
- Understand the vital role of the chargemaster in ensuring coding compliance
- Summary

2

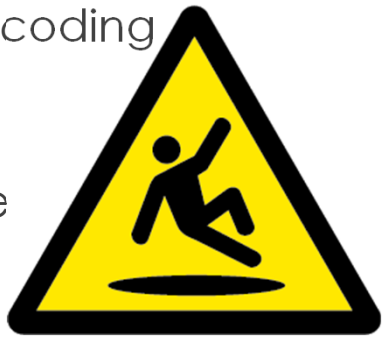
Before we get started…

Who's in our audience?

3

Common Pitfalls

- Not knowing the basics!!
- Upcoding or Downcoding
- Unbundling
- Outdated Software



4

Pitfalls are COSTLY

- Overpayments to MA plans due to coding errors in the U.S. 2008-2024 | Statista
  - Coding errors resulted in $2B in total overpayments to Medicare Advantage (MA) plans in 2008
  - That number grew to $34B in 2022
  - It is estimated that $50B in overpayments were made to MA Plans in 2024.
- Medical Coding: Solutions for Avoiding Revenue Loss – ICD10monitor
  - American Academy of Family Physicians study estimates coding errors cause a single practitioner a loss of $50,000 annually
  - Clinics experience a 10-30% decrease in revenue due to coding errors

5

U.S. Department of Health and Human Services
Office of Inspector General

False Claims Act [31 U.S.C. § § 3729-3733]

The civil FCA protects the Government from being overcharged or sold shoddy goods or services. It is illegal to submit claims for payment to Medicare or Medicaid that you know or should know are false or fraudulent. Filing false claims may result in fines of up to three times the programs' loss plus $11,000 per claim filed. Under the civil FCA, each instance of an item or a service billed to Medicare or Medicaid counts as a claim, so fines can add up quickly. The fact that a claim results from a kickback or is made in violation of the Stark law also may render it false or fraudulent, creating liability under the civil FCA as well as the AKS or Stark law.

Under the civil FCA, no specific intent to defraud is required. The civil FCA defines "knowing" to include not only actual knowledge but also instances in which the person acted in deliberate ignorance or reckless disregard of the truth or falsity of the information. Further, the civil FCA contains a whistleblower provision that allows a private individual to file a lawsuit on behalf of the United States and entitles that whistleblower to a percentage of any recoveries. Whistleblowers could be current or ex-business partners, hospital or office staff, patients, or competitors.

There also is a criminal FCA (18 U.S.C. § 287). Criminal penalties for submitting false claims include imprisonment and criminal fines. Physicians have gone to prison for submitting false health care claims. OIG also may impose administrative civil monetary penalties for false or fraudulent claims, as discussed below.

6

Pitfalls Effect Quality of Care

- Correct coding is essential to quality patient care!
- Patients depend on accurate bills
- Patients depend on accurate medical records
- Exact cost depends on the specific error, patient, and insurance, but medical coding errors can lead to:
  - Denied claims
  - Overcharged bills
  - Delayed Payments

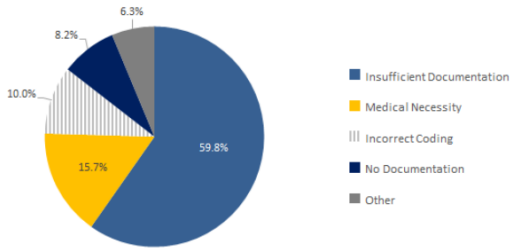
7

According to CMS' 2024 Report

Medicare Fee-for-Service Supplemental Improper Payment Data

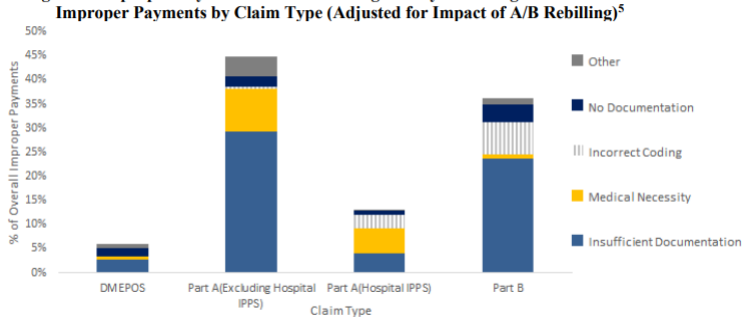
Common Causes of Improper Payments

Figure 2: Improper Payment Rate Error Categories by Percentage of 2024 National Improper Payments[4]



8

Figure 3: Improper Payment Rate Error Categories by Percentage of 2024 National Improper Payments by Claim Type (Adjusted for Impact of A/B Rebilling)[5]



9

Pitfall #1: Not Knowing the Basics

- Coding:
  - ICD-10-CM: Used for coding diagnoses in all healthcare settings.
  - ICD-10-PCS: Used for inpatient hospital procedure coding.
  - CPT: Services provided by healthcare professionals.
  - HCPCS: Represents medical procedures, products, supplies, and services not included in the CPT codes ,such as medications and durable medical equipment.
- Must keep up with Annual Code Updates!
- ICD-CM Changes are effective October 1 each year.
- CPT changes are effective January 1 of each year
- HCPCS updates quarterly
- Knowledge of annual changes is necessary to stay in compliance.

10

What's new in 2025?

- ICD 10 – CM Changes (effective October 1, 2024)
  - 252 additions
  - 13 deletions
  - 36 revisions
- CPT Changes (effective January 1, 2025)
  - 270 new codes
  - 112 deletions
  - 38 revisions
- HCPCS changes (updated quarterly)

11

Polling Question #1

- Who publishes ICD -10?

A: Wal-Mart

B: The American Medical Association

C: The World Health Organization

D: Walt Disney

12

Polling Question #2

- Who publishes CPT?

  A: The American Medical Association

  B: The CDC

  C: The World Health Organization

  D: HFMA

13

Pitfall #2: Upcoding or Downcoding

- What is it upcoding?
  - Upcoding occurs when a healthcare provider submits codes for more severe and expensive diagnoses or procedures than the provider diagnosed or performed.
- What is downcoding?
  - This occurs when a patient's condition and the care provided are not completely captured.
- How does it happen?
  - Wrong codes selected by staff not adequately trained in medical coding and billing procedures (usually happens due to error)
  - Intentional selection of higher pay codes or risks there are instances where the service provider intentionally indulges in this practice so that he can receive maximum reimbursements.
  - Misinterpretation of medical documentation
  - Software errors

14

Examples of Upcoding

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That MediGold (Contract H3668) Submitted to CMS

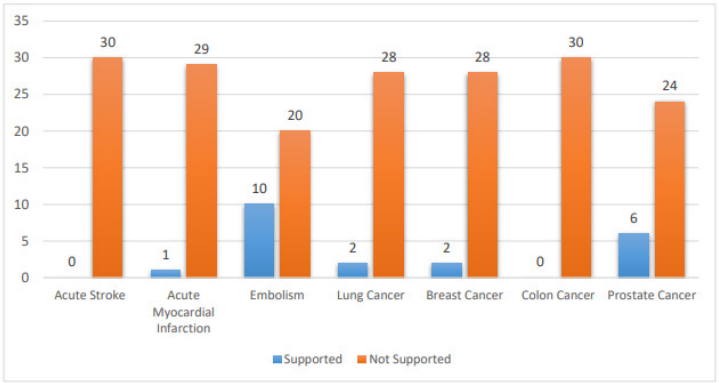
Issued on 02/16/2024 | Posted on 02/16/2024 | Report number: A-07-20-01198

- Findings:
  - 210 Samples Audited from 2017 and 2018
  - 21 Medical Records validated the HCCs reviewed
  - 189 Medical records did not support diagnosis codes and associated HCCs
  - $469,907 in net overpayments for the sample
  - Total refund recommended $2,183,514

15

MediGold Audit

Figure: Analysis of High-Risk Groups



16

Findings Explained…

- Acute Stroke

For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that will result in the assignment of [the] HCC [for Ischemic or Unspecified Stroke]."

- For 1 enrollee-year, MediGold submitted an acute stroke diagnosis code (which was not supported in the medical record) instead of a diagnosis code for hemiplegia (which was supported in the medical record).[19] The independent medical review contractor stated that "there is no evidence of an acute stroke, however the patient has paralysis affecting [the] left non dominant side from an old stroke . . . and would result in the assignment of [the] HCC [for Hemiplegia/Hemiparesis] which should have been assigned instead of the . . . HCC [for Ischemic or Unspecified Stroke]." Accordingly, MediGold should not have received an increased payment for the acute stroke diagnosis but instead should have received a lesser increased payment for the hemiplegia diagnosis.

17

Findings Explained…

- Acute Myocardial Infarction

- For 17 enrollee-years, the medical records indicated in each case that the individual had an old myocardial infarction diagnosis, but the records did not justify an acute myocardial infarction diagnosis at the time of the physician's service.[20]

  For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that will result in the assignment of [the] HCC [for Acute Myocardial Infarction]. There is documentation of a past medical history of myocardial infarction [diagnosis] that does not result in an HCC."

- For 4 enrollee-years, the medical records in each case did not support an acute myocardial infarction diagnosis. However, for each of these enrollee-years, we identified support for another diagnosis that mapped to an HCC for a less severe manifestation of the related-disease group. Accordingly, MediGold should not have received an increased payment for the acute myocardial infarction diagnosis but should have received a lesser increased payment for the other diagnosis identified.

18

Examples of Upcoding #2

Medicare Advantage Compliance Audit of Specific Diagnosis Codes That UCare Minnesota (Contract H2459) Submitted to CMS

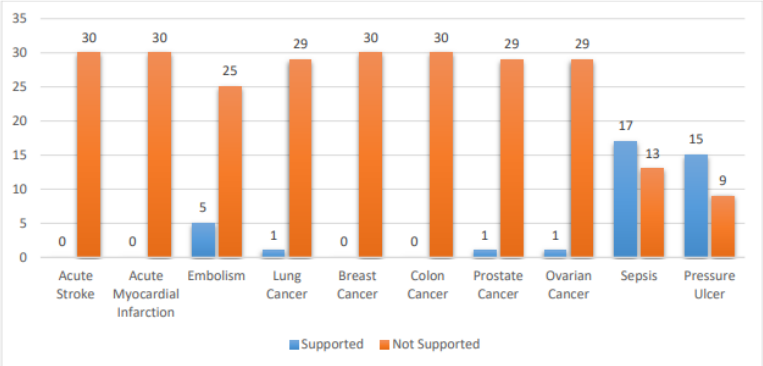
Issued on 12/23/2024 | Posted on 12/26/2024 | Report number: A-07-22-01209

- Findings:
  - 294 Samples Audited from 2017 and 2018
  - Only 40 Medical Records validated the HCCs reviewed
  - 254 Medical records did not support diagnosis codes and associated HCCs
  - $869,498 in net overpayments for the sample
  - Total refund estimated at $4.7 million

19

UCare Audit

Figure: Analysis of High-Risk Groups



20

Findings Explained…

- Embolism
  - For 22 enrollee-years, the medical records indicated in each case that the individual had previously had an embolism, but the records did not justify a diagnosis that mapped to an Embolism HCC at the time of the physician's service.

    For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a past medical history of deep vein thrombosis [diagnosis] which does not result in an HCC."[20]

21

Findings Explained…

- Lung Cancer
  - For 18 enrollee-years, the medical records indicated in each case that the individual had previously had lung cancer, but the records did not justify a lung cancer diagnosis at the time of the physician's service.

    For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a past medical history of lung cancer [diagnosis] which does not result in an HCC."
  - For 6 enrollee-years, the medical records in each case did not support a lung cancer diagnosis.

    For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review."

22

Findings Explained…

- Sepsis
  - For 8 enrollee-years, the medical records in each case did not support a sepsis diagnosis.

    For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of the patient having a diagnosis of acute gram negative bacteremia without sepsis [diagnosis] which does not result in an HCC."[23]
  - For 5 enrollee-years, the medical records indicated in each case that the individual had previously had sepsis, but the records did not justify a sepsis diagnosis at the time of the physician's service.

    For example, for 1 enrollee-year, the independent medical review contractor stated that "there is no documentation of any condition that results in the assignment of the HCC under review. There is documentation of a past medical history of sepsis [diagnosis] which does not result in an HCC."

23

Examples of Upcoding #3

- Back to CMS' 2024 Report…
- CPT 99214 was the top Driver in Improper Payments = $564 million
- Projected Dollars Overpaid Totaled $557,968,020

Upcoding

Medicare pays for many physician services using Evaluation and Management (E/M) codes. New patient visits generally require more time than established patient follow-up visits. Medicare pays new patient E/M codes at higher reimbursement rates than established patient E/M codes.

Example: Billing an established patient follow-up visit using a higher-level E/M code, such as a comprehensive new-patient office visit.

24

Findings Explained…

- What is 99214?
  - 99214: Established patient office visit, 30-39 minutes
- Typically describes a patient with an acute injury or progressing illness that requires medical attention or possible surgery.
- Certain components must be met:
  - Established patient
  - Requires history and physical exam
  - Moderate Level Decision Making
  - Time based and must meet 30 minutes

25

Findings Explained…

Appendix K: Coding Information

Table K1: E&M Service Types by Improper Payments

E & M Codes	Projected Improper Payments	Improper Payment Rate	95% Confidence Interval	Percentage of Service Improper Payments by Type of Error					Percent of Overall Improper Payments
				No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Office o/p est mod 30-39 min (99214)	$564,563,132	5.0%	3.8% - 6.2%	20.1%	16.5%	0.0%	63.4%	0.0%	1.7%

26

Examples of Downcoding #1

- Let's go back to the example of 99214
- Remember coding of 99214 resulted in $564 million in improper payments…
- Total Underpayments for 99214 were projected at $6,595,112

27

Appendix M: Underpayments

The following tables provide the service-specific underpayment rates for each claim type. The tables are sorted in descending order by projected dollars underpaid. All estimates in these tables are based on a minimum of 30 claims in the sample with at least one claim underpaid.

Table M1: Service-Specific Underpayment Rates: Part B

Part B Services (HCPCS Codes)	Claims Reviewed	Lines Reviewed	Sample Dollars Underpaid	Total Sample Dollars Paid	Projected Dollars Underpaid	Underpayment Rate	95% Confidence Interval
All Codes With Less Than 30 Claims	5,993	12,523	$3,116	$1,465,120	$68,063,684	0.2%	0.0% - 0.3%
Office o/p est low 20-29 min (99213)	293	293	$226	$24,112	$59,433,559	1.0%	0.2% - 1.8%
Sbsq hosp ip/obs moderate 35 (99232)	239	414	$248	$30,125	$25,514,129	1.1%	0.1% - 2.1%
Office o/p new low 30-44 min (99203)	123	123	$217	$12,123	$15,263,677	1.5%	(0.2%) - 3.2%
Office o/p est sf 10-19 min (99212)	186	186	$549	$9,057	$14,274,549	3.7%	0.9% - 6.5%
Psytx w pt 45 minutes (90834)	108	155	$258	$11,862	$6,621,726	2.0%	0.0% - 3.9%
Office o/p est mod 30-39 min (99214)	786	786	$56	$92,619	$6,595,112	0.1%	(0.1%) - 0.2%

Your logo here

28

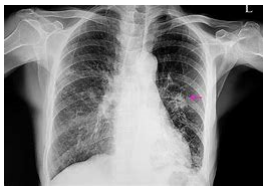
Table 7: Top Root Causes for Office visits - established

Root Cause Description	Error Category	Sample Claim Count
Documentation supports lower level of E/M service than what was billed*	Incorrect Coding	179
Documentation supports higher level of E/M service than what was billed*	Incorrect Coding	22
Documentation for the billed date of service - Inadequate	Insufficient Documentation	11
Attestation for unsigned documentation - Missing	Insufficient Documentation	10
Documentation to support the services were provided or other documentation required for payment of the code - Missing	Insufficient Documentation	9
Separately identifiable E/M service documentation - Inadequate	Insufficient Documentation	8
Documentation to support the services were provided or other documentation required for payment of the code - Inadequate	Insufficient Documentation	7
Documentation for the billed date of service-Missing	Insufficient Documentation	7
LCD/LCA requirements, other documentation required for payment - Missing	Insufficient Documentation	7
A separate and identifiable service is not supported as billed (i.e., removal of a modifier as a coding error)*	Incorrect Coding	5
Note: Root causes frequently associated with partial improper payments are identified with an asterisk.		

29

Examples of Downcoding #2

- Millions of dollars are lost annually due to downcoding of pneumonia DRG.
- Estimated $10,000-$50,000 per hospital bed each year
- Scenario
  - Patient admitted to the hospital with pneumonia. It is documented that patient has shortness of breath, an SPO2 of 84%. Physician is monitoring blood gases and respiratory status. Patient continues to decline and is intubated for two days due to acute respiratory failure.



30

Downcoding…

- DRG 195 SIMPLE PNEUMONIA AND PLEURISY WITHOUT CC/MCC
  - Relative Weight 0.6183
  - LOS 2.3
  - Patient has respiratory distress with pneumonia
- DRG 194 SIMPLE PNEUMONIA AND PLEURISY WITH CC
  - Relative Weight 0.8160
  - LOS 2.8
  - Patient has COPD exacerbation with Pneumonia
- DRG 193 SIMPLE PNEUMONIA AND PLEURISY WITH MCC
  - Relative Weight 1.3122
  - LOS 4 days
  - Patient has Acute respiratory failure with Pneumonia

31

Pitfall #4: Unbundling

- Unbundling occurs when a single medical procedure is incorrectly coded as multiple separate procedures.
- This inflates costs.
- NCCI edits will tell you!

Medicare NCCI Procedure to Procedure (PTP) Edits

National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits prevent inappropriate payment of services that should not be reported together. Each edit has a Column One and Column Two HCPCS/CPT code. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the Column One code is eligible for payment, but the Column Two code is denied unless a clinically appropriate NCCI PTP-associated modifier is also reported.

32

Examples of Unbundling

Basic Metabolic Panel 80048

- Calcium, total 82310
- Carbon dioxide (bicarbonate) 82374
- Chloride 82435
- Creatinine 82565
- Glucose 82947
- Potassium 84132
- Sodium 84295
- Urea nitrogen (BUN) 84520

Comprehensive Metabolic Panel 80053

- Albumin 82040
- Bilirubin, total 82247
- Calcium, total 82310
- Carbon dioxide (bicarbonate) 82374
- Chloride 82435
- Creatinine 82565
- Glucose 82947
- Phosphatase, alkaline 84075
- Potassium 84132
- Protein, total 84155
- Sodium 84295
- Transferase, alanine amino (ALT) (SGPT) 84460
- Transferase, aspartate amino (AST) (SGOT) 84450
- Urea nitrogen (BUN) 84520

33

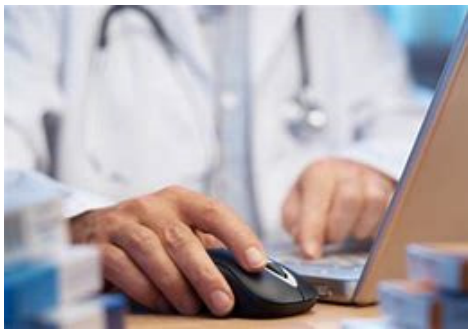
Examples of Unbundling

- For example, if a physician performs a unilateral partial mastectomy with axillary lymphadenectomy, the provider/supplier shall report CPT code 19302 (Mastectomy, partial...; with axillary lymphadenectomy).
  - A provider/supplier shall not report CPT code 19301 (Mastectomy, partial...) plus CPT code 38745 (Axillary lymphadenectomy; complete)
- A provider/supplier shall not unbundle a bilateral procedure code into 2 unilateral procedure codes.
  - For example, if a physician performs bilateral mammography, the provider/supplier shall report CPT code 77066 (Diagnostic mammography... bilateral).
  - The provider/supplier shall not report CPT code 77065 (Diagnostic mammography... unilateral) with 2 UOS or 77065 LT plus 77065 RT

34

Pitfall #5: Outdated Software

- Outdated software interrupts patient care and cash flow!!
- Results in claim denial rates as high as 30-40%



35

Pitfall #5: Outdated Software

- Electronic Medical Record
  - Estimated loss of 5-15% of total revenue when outdated
- Coding Software
  - It is estimated that outdated coding software costs healthcare providers an estimated loss of 5-15% of total revenue.
- Pharmacy Management Systems
  - Estimated revenue loss ranges from 2-5% of total revenue.

36

Outdated Software…

- Chargemaster
  - RIMR 2024 Reviews:
    - 1,380 Deleted CPT/HCPCS still present in CDM
    - 2,008 Items missing CPT/HCPCS codes
    - 1,944 Invalid or questionable Revenue Codes
    - 256 pharmacy items with missing or incorrect drug multipliers
    - $11.6 Million in gross revenue due to missed charges or underbilled services

Your logo here

37

Summary

38

Coding Pitfalls

- Hurt the provider by impacting cash flow
- Hurt the patient by impacting quality of care
- Are avoidable with appropriate knowledge and strategies

39

Must Do's:

- Regular Training
  - Stay updated on coding guidelines
  - Know what is on the OIG workplan
  - Know what your payers are auditing
  - Educate coders on best practices
  - And not just coders! EVERYONE.

40

Must Do's:

- Internal and External Audits
  - Regularly audit and review coding work
  - External audit by outside party
- Technology
  - IT must be your friend!
  - Stay on top of updates

41

Must Do's:

- Regular reviews and updates are necessary for compliance!
  - ICD 10 CM and PCS
  - DRG's
  - CPT codes
  - HCPCS
  - Modifiers
  - Revenue Codes

42

Must Do's:

- Accurate and Complete Documentation
  - We all know… If it's not documented, it didn't happen!

DOCUMENTATION MATTERS TOOLKIT

Providers are responsible for documenting each patient encounter completely, accurately, and on time. Because providers rely on documentation to communicate important patient information, incomplete and inaccurate documentation can result in unintended and even dangerous patient outcomes. Accurate documentation supports compliance with federal and state laws and reduces fraud, waste, and abuse.

43

Must Do's:

- Implement a Clinical Documentation Improvement Program
  - A study by the American Health Information Management Program found that Hospitals who did:
    - Saw an average annual revenue increase of $1.5 million to $2.7 million
    - Saw a 5-20% increase in their Case Mix

44

Resources

- FY 2025 IPPS Proposed Rule Home Page | CMS
- Work Plan | Office of Inspector General | U.S. Department of Health and Human Services
- Medicare NCCI Procedure to Procedure (PTP) Edits | CMS
- Documentation Matters Toolkit | CMS
- cdi-toolkit-for-beginners_final.pdf
- MLN Homepage | CMS
- https://www.novitas-solutions.com/webcenter/portal/MedicareJH

45

Questions?

Revenue Integrity Management Resources
Vonda Walters, President
P: 870-460-5208
Email: vonda@rimresources.org
www.rimresources.org

46

47