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CONSULTING PARTNERS

Common Coding and Billing Errors
Outpatient Procedures

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HEALTHCARE EDUCATION FOUNDATION OF WEST VIRGINIA

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Outpatient Coding and Billing

- Objective
  - Understand requirements for proper coding
  - Provide billing guidance
  - Identify where coding and billing guidelines
    - Overlap
    - Conflict
  - Determine responsibilities for each team
  - Create best practices to work together and ensure total and compliant charge capture

Outpatient Coding and Billing

CPT and HCPCS codes are developed by AMA and CMS respectively. Coding guidelines are determined by the respective entities

Billing guidelines are set by payors

MACs and commercial payors make policies that may supersede CMS and AMA

Look at all requirements

Outpatient Coding and Billing

AMA establishes CPT

- Identify services and quality measures
- Publishes narrative explaining usage and justification for new codes each year
- Publishes CPT Assistant articles monthly to provide detail on common questions or identified misinterpretations

CMS creates most HCPCS

- Provides a Home Page to publish information on codes created or under consideration
- Identify quality measures, supplies, procedures and drugs
- Allow additional detail not provided in CPT such as:
  - Screening or diagnostic
  - Contrast
  - Services not identified by CPT such as packaging and conveyance

Outpatient Coding and Billing

- National Correct Coding Initiative (NCCI) guidelines maintained by CMS but used by most payors.
- Create rules under which multiple procedures should be evaluated and reported when performed in the same encounter
- Some Payors use McKesson guidelines which are very similar
- Medically Unlikely Edits are also NCCI guidelines and evaluate the number of times a single service should be performed during a single encounter or episode of care
- CMS purposefully leaves some MUE decisions to MACs
- Most payors follow the concept of MUEs, but may develop their own guidelines

Outpatient Coding and Billing

- Per Hospital NCCI Manual:
  - The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and shall not be reported separately as an E&M service.
  - If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. NCCI contains many, but not all, possible edits based on these principles
- Global Surgical Days for Critical Access Hospital (CAH) Method II - global surgical package, also called global surgery, includes all necessary services normally furnished by a surgeon before, during, and after a procedure.
  - 000 - Endoscopic or minor procedure
  - 010 = Minor procedure with preoperative relative values on the day of the procedure and postoperative during a 10-day postoperative period https://www.palmettogba.com/Palmetto/Providers.Nsf/files/July_2018_JJPart_A_Medicare_Advisory_Final.pdf/$File/July_2018_JJPart_A_Medicare_Advisory_Final.pdf
- Transmittal A0040: Medicare requires that modifier –25 always be appended to the emergency department (ED)E/M code (99281-99285) when provided on the same date as a diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s). https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/A0040.PDF

Outpatient Coding and Billing

- Emergency Department Clinical Vignette
- A 65-year-old male who presents to the emergency department after tripping while walking up stairs, sustaining a
  - mildly displaced right patellar dislocation, and a
  - superficial abrasion to the pretibial skin.
- The small right shin abrasion is cleansed by staff, an antibiotic topical ointment and band aid applied. Based on history,
  - Tetanus immune globulin is administered IM along with
  - Demerol 75 mg IM for pain. Following evaluation of the patient and review of radiographs,
- The emergency department physician calls an orthopaedic surgeon for a consultation.
- The orthopaedist evaluates the patient in the ED, and
  - performs a closed reduction of the right patellar dislocation.
  - A long-leg plaster cast is applied.
- The patient is instructed to follow up in the outpatient orthopaedic clinic in one week.

Outpatient Coding and Billing

Tetanus *immune globulin* is administered IM
Demerol 75 mg IM

→ 96372, J1670 – Tetanus per CPT
Tetanus was not vaccine
96372, J2175 x2 - Demerol

Closed reduction of the right patellar dislocation
A long-leg plaster cast is applied

→ 27560 - Closed treatment of patellar dislocation; without anesthesia (global period 90 days, major procedure)
9928X (25)
DO NOT report 29358 – Application of long leg splint

Code pair 27560, 29358: Modifier allowed, but per NCCI
"Casting/splinting/strapping shall not be reported separately if a restorative treatment or procedure to stabilize or protect a fracture, injury, or dislocation and/or afford comfort to the patient is also performed"

Outpatient Coding and Billing

- Office visit
- This 2-year old child presents refusing to move her right arm. She does not appear to be in acute distress and is not crying. The father stated that earlier today, while the child was having a temper tantrum, he forcefully pulled her by the hand. A half hour later, although she was not crying and did not appear to be in pain, she refused to move her arm. She only cried when the parents attempted to move her arm. She is holding her arm in an adducted, semi flexed, and prone position. On palpation there is no significant point tenderness or swelling.
- Assessment: Nursemaids' Elbow
- Treatment: I cradled the right elbow in my left hand and firmly pronated her wrist. She cried for a moment when the wrist was rotated. After 15 minutes, she was asked to move her arm and did so without discomfort. Father was advised that Nursemaids' elbow is likely to recur and care should be taken to limit stress on her arm.

Outpatient Coding and Billing

- Global period 10 days
- Code 24640 - Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation

Outlier/Discount/Passthrough

Line	HCPCS	APC	Pay Stat	Pkg Flag	High Pay Flag	Bil Flag	Ter Flag	Disc Fact	Total Pay	Adj Charge	Pkg Charge	Tot Charge	Outlier
1	24640	05111	T		Y			1.0000	$207.05	$500.00	$0.00	$500.00	$0.00
2	G0463	05012	V					0.0000	$0.00	$0.00	$0.00	$0.00	$0.00
Subtotal									$207.05	$500.00	$0.00	$500.00	$0.00

Non-covered or Services Outside of OPPS

Line	HCPCS	Mod 1/2	Unit	Date	Rev Code	Pay Stat	Pricer Error	ACE Errors	ACE Disp
2	G0463		1	04/12/2020	0510	V	10 Line item reject by ACE	00021 Medical visit same day as significant procedure without modifier 25 (RTP)	04 Claim RTP

Outpatient Coding and Billing

Inpatient admission is found to be not reasonable and necessary

(CMS) will allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as an outpatient

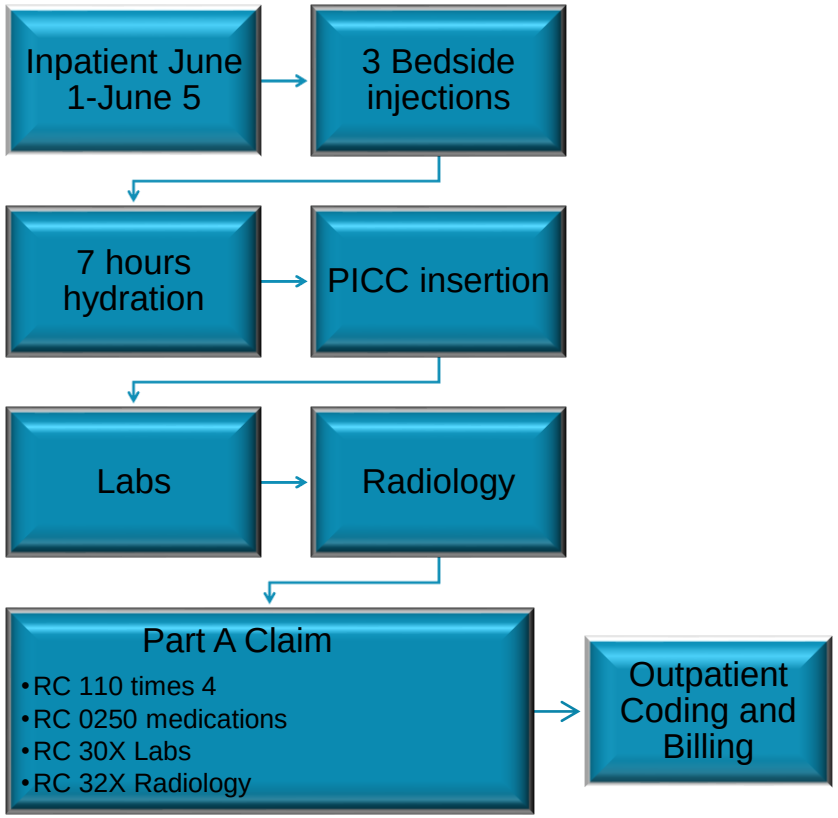
Reimbursable services on OPPS Addendum B

Reimbursable services performed by OP hospitals staff but paid under Alternate fee schedule

- PT
- OT
- SLP
- MNT
- Bedside procedures

May deny as duplicate if patient filed an appeal with Medicare

Outpatient Coding and Billing



- Inpatient denied
- Part B claim
  - RC 0260
    - 96360 X 1
    - 96361 X 6
  - RC 940
    - 96372 X 3
  - RC 0360
    - 96561
  - RC 0636 and HCPCS for drugs
  - RC 030X and CPTs for labs
  - RC 320 and CPTs for Radiology
- Do not move ED to the 12X type of bill
- Submit 2 claims if necessary, for day 1

Outpatient Coding and Billing Inpatient to Observation

- Remove room charges
- Make sure all detail medications are reported with RC 0636 and HCPCS
- Add Observation hours minus active monitored hours
- Add all bed-side procedures
- Combine ED charges and Observation on the same bill

Outpatient Coding and Billing

- MUE (Medically Unlikely Edit)
- Maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service
- Separate MUE levels for practitioners and facilities
- Most MUEs established by Medicare
- Updated quarterly
- Some established by MACs

Outpatient Coding and Billing

All MUEs established by Medicare have corresponding MAIs (MUE Adjudicator Indicator, and each MAI includes Rational

1- Line edit
Split the Units to multiple lines, each line not to exceed the MUE.

2- Policy
Charges exceeding MUE will be denied
May request reopening to correct
High level appeals give deference to MUEs

3 – Date of Service
All lines same DOS will be summed
Units exceeding MUE will be denied
Request reopening to correct
May be appeal and be overridden with supporting documentation

If MUE is exceeded, does bilateral rule apply?

Outpatient Coding and Billing

- Bilateral Service Indicator
  - 0 - Service is either unilateral or another code exists for bilateral
  - 1 – CPT is not inherently bilateral, but service may be performed bilaterally. Report modifier 50 if performed bilaterally – Bilateral procedure reduction applies
  - 2 - CPT represents bilateral service
  - 3 - CPT is not inherently bilateral, but service may be performed bilaterally. Report modifier 50 or RT, LT if performed bilaterally
    - Generally, do not report 2 units for therapeutic services performed bilaterally, if bilateral concept applies, report 1 unit with modifier 50
    - Diagnostic bilateral procedures can be reported with either one unit and modifier 50, or two units with modifiers LT, RT

Outpatient Coding and Billing

12032 - LYR CLS SCLP TRNK AXL EXTR 2.6 7.5 CM
Sum the closures together. If the size is exceeded, then choose another CPT

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
12032	1	2 Date of Service Edit: Policy	Anatomic Consideration
HCPCS/ CPT Code	Outpatient Hospital Services MUE Values	MUE Adjudication Indicator	MUE Rationale
12032	1	2 Date of Service Edit: Policy	

67110 – REPAIR DETACH RETINA
Bilateral indicator 1 – append modifier 50

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
67110	1	2 Date of Service Edit: Policy	CMS Policy
HCPCS/ CPT Code	Outpatient Hospital Services MUE Values	MUE Adjudication Indicator	MUE Rationale
67110	1	2 Date of Service Edit: Policy	CMS Policy

20200 - BIOPSY MUSCLE SUPERFICIAL

HCPCS/ CPT Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
20200	2	3 Date of Service Edit: Clinical	Clinical: Data
HCPCS/ CPT Code	Outpatient Hospital Services MUE Values	MUE Adjudication Indicator	MUE Rationale
20200	2	3 Date of Service Edit: Clinical	Clinical: Data

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE

Outpatient Coding and Billing

- Rapid Flu test – 87804
- Can be performed for Flu A or B
- Usually reported as 2 units
- Rapid Testing Methods options:
  - One sample, one analysis, and one strip, and yields one result
    - Positive or negative for Flu virus. Does not specify A or B
    - Positive Type A or B
    - Negative Flu
    - Report one unit for each of the tests if provided
  - One sample, one device, and two separate analyses and yields 2 results, either positive or negative, A or B
    - Report 2 units, one for each analysis, even if only one test kit was required. Append modifier 59 if necessary
  - One sample and one device, and yields two separate results in single analytical chamber
    - Report 2 units, because 2 separate analyses performed yielding 2 separate results
    - Append modifier 59 if necessary
- Do not use modifier 91 since the tests identify separate species or strains

Outpatient Coding and Billing

- 20600 - ARTHRO ASPIR INJ FINGERS TOES WO GUID
- MUE = 6
- Bilateral indicator = 1
- Incorrect Example
  - 20600, LT
  - 20600, RT
- Incorrect Example
  - 20600, F1
  - 20600, F6
- Correct
  - 20600, 50
  - Multiple Fingers, both hands
    - 20600, 50, F1, F6
    - 20600, 50, FA, F5

Outpatient Coding and Billing

- Outpatient Procedure Coding – Pressurized or Non-Pressurized Inhalation Treatment
- 94640 - Reported once during an episode of care regardless of the number of separate inhalation treatments that are administered
- If a patient leaves and returns to the facility for a separate episode of care, report 94640 with modifier 76
- Continuous treatment, or “back to back” continuous treatments exceeding one hour:
  - 94644 – Continuous treatment first hour
  - 94645 – each additional hour
- Do not report 94664 Demonstration and evaluation of aerosol treatment in the same encounter as 94640 unless the services took place in separate encounters

CPT	Description	OPPS
94640	Inhalation Treatment	$183.96
94644	Continuous treatment 1st Hour	$109.03
94645	Each Additional hour	$0.00
94664	Demonstrate / evaluate aerosol generator, nebulizer	$183.96

Outpatient Coding and Billing

- Review MUEs
- Identify MAI
- Correct Date of Service MAIs
- Work with coders to resolve MAI 2 or 3
- Work with Revenue Cycle to fix trends

Maternity

Outpatient Coding and Billing

- Maternity Global Period
- Professional global period includes 13 visits antepartum, delivery and uncomplicated postpartum visits
- If Ante partum care only is provided report Appropriate E/M 99201-99215 for 1-3 visits
- 59425 - Antepartum only; 4-6 visits
- 59426 - Antepartum only; 7 or more visits

Outpatient Coding and Billing

- Normal, uncomplicated maternity cases include antepartum care, delivery, and postpartum care. These services are included in the global obstetric care and are not coded separately
- Antepartum global is up to and including visits:
  - Initial and any subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation,
  - Biweekly visits to 36 weeks gestation, and
  - Weekly visits until delivery.
  - if a patient delivers prematurely and the appropriate number of antepartum visits have been scheduled, the global service is met.
  - Any other visits or services within this time period should be coded separately.
  - If the total number of antepartum visits exceeds 13 because of a high-risk condition, the additional visits may be reported using the E/M codes for each additional visit.

Outpatient Coding and Billing

- Antepartum global excludes visits for medical complications of pregnancy such as:
  - Cardiac problems
  - Diabetes
  - Hyperemesis
  - Hypertension
  - Neurological problems
  - Premature rupture of membranes
  - Pre-term labor
  - Toxemia
  - Trauma

Outpatient Coding and Billing

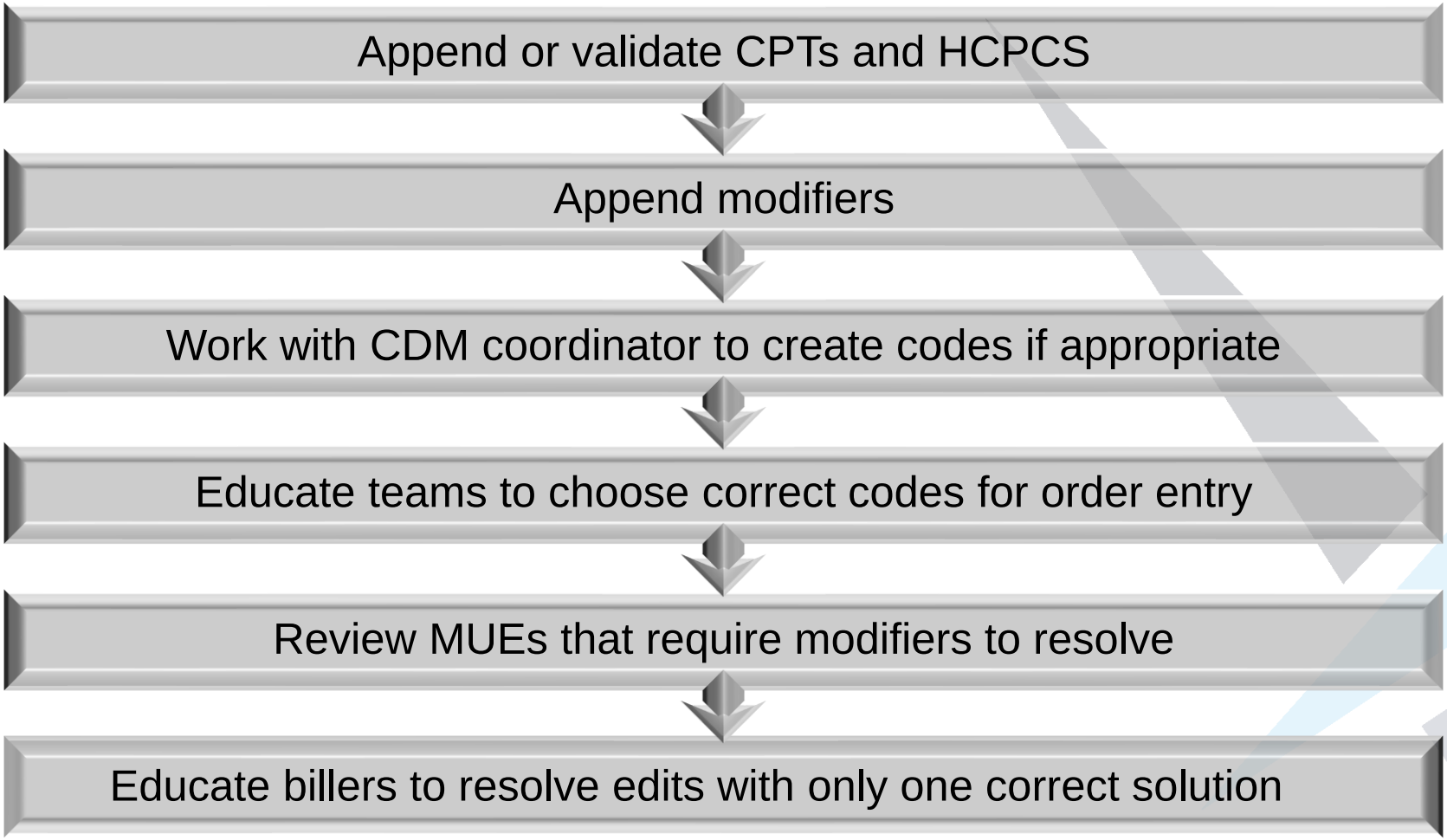
- Ante partum and intra-partum services not included in the global obstetric package and separately reported:
  - Maternal or fetal echography or fetal echocardiography procedures (CPT codes 76805-76816 and 76825-76828)
  - Fetal biophysical profile (76818)
  - Amniocentesis, any method (59000)
  - Chorionic villus sampling, any method (59015)
  - Fetal contraction stress test (59020*)
  - Fetal nonstress test (59025);
  - Hospital and observation care visits for premature labor (prior to 36 weeks of gestation)
- Note: Hospital visits within 24 hours of delivery are generally considered part of the global service.

Outpatient Coding and Billing

- Delivery services include
  - Admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery.
  - Medical problems complicating labor and delivery management that require additional resources should be reported with the Medicine and Evaluation and Management Services codes, in addition to the maternity care codes.
  - If a patient is admitted to the hospital for observation prior to delivery and stays more than 24 hours, then you should report the hospital care rendered, except the day of delivery, separately.
- Report multiple births
  - Both vaginal: 59400 for Twin A and 59409-51 for Twin B.
  - One vaginal and one cesarean: 59510 for Twin B and 59409-51 (for pro) for Twin A.
  - If both delivered via cesarean, then report only 59510 (because only one cesarean was performed).
- If the cesarean is significantly more difficult, add modifier 22. Physicians need to submit an operative note and a special report modifier 22.

Conclusion

Outpatient Coding and Billing



Questions?

Contact

Uniquely Qualified

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