

# Top Missed Coding Concepts

# Open vs Closed Fracture Care

- ▶ Open fracture care is reported when the provider **creates** an opening to expose the bone to treat a fracture.
  - ▶ Not performed in the ED
  - ▶ Patient is taken to an operating room
  - ▶ The patient may present with an open fracture (bone pierces the skin) that is treated with closed fracture care.
- ▶ For example:
  - ▶ Bone is manipulated back in place, the wound is repaired, and a cast is applied. The treatment performed dictates the type of fracture care reported, not the patient's diagnosis.

# Requiring anesthesia versus without anesthesia

- ▶ Some procedures in CPT have a selection “with anesthesia” and “without anesthesia”. To select codes that require anesthesia, general, regional, or monitored anesthesia care are required.
  - ▶ Moderate/conscious sedation is not considered anesthesia
  - ▶ When moderate/conscious sedation is performed, select CPT code option “without anesthesia”

## For example:

- ▶ A closed treatment of a shoulder dislocation on a 13-year-old, performed with 30 minute of moderate/conscious sedation by the treating physician with a trained observer, is reported with:
  - ▶ **23650**, Closed treatment of shoulder dislocation, with manipulation, without anesthesia
  - ▶ **99144**, Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; age 5 years or older, first 30 minutes intra-service time

# Moderate/Conscious Sedation

- ▶ Choose 99143 – 99145 when the provider performing the MCS is also performing the therapeutic or diagnostic procedure
  - ▶ A trained independent observer is required
- ▶ Report 99148 – 99150 when the provider performing the MCS is different from the provider performing the therapeutic or diagnostic procedure
- ▶ MCS is time based – A minimum of 16 minutes is required to report 99142, 99144, 99148, or 99149
- ▶ To report the base codes with the add-on codes (99145, 99150) a minimum of 38 minutes must be performed and documented
- ▶ The patient's age is also required to select the correct code

# Proper ICD-10-CM code selection for suspected or probable

- ▶ Conditions documented as suspected, rule out, or probable are not coded. This information is pertinent in the documentation, but not coded as an ICD-10-CM code
- ▶ Instead, code the sign or symptom
- ▶ If the patient comes in because he or she thinks he or she may have a condition, and nothing is found, report a code from subcategory Z04.8 (Observation and evaluation for other specified suspected conditions)

# Proper ICD-10-CM code selection for adverse reactions

- ▶ When coding adverse reactions to a correct substance properly administered you will first report any manifestation(s) caused by the drug and then you report a code from the Adverse Effects column in the Table of Drugs and Chemicals. An adverse effect is not considered a poisoning; do not report a poison code from the Poisoning column in the Table of Drugs.
- ▶ For example:
  - ▶ A patient is prescribed with an antibiotic to treat an UTI. She takes the medication as directed and becomes nauseous and can't stop vomiting.
    - ▶ R11.2, Nausea with vomiting, unspecified
    - ▶ T36.95XA, Adverse effect of unspecified systemic antibiotic, initial encounter

# Proper ICD-10-CM code selection for injuries

- ▶ Select a code for each injury when the patient presents with multiple injuries
- ▶ Select the diagnosis code for the most severe injury when the patient has multiple injuries in the same anatomic area
- ▶ For example:
  - ▶ A patient presents with a fracture and abrasion on the right elbow.
    - ▶ Only select the diagnosis code for the fracture because it is the most severe injury

# Understand the 1995 and 1997 Documentation Guidelines

- ▶ When determining the element of exam, understand the 1995 and 1997 Documentation Guidelines. When determining the level of exam under the 1995 Guidelines, make sure to read the information documented instead of relying on the heading of documentation.
- ▶ For example:
- ▶ “Extremities: no edema, positive pedal pulses” – CV not MS
- ▶ “Constitutional: Vitals 120/80, patient appears well. AOX3”

# Proper ICD-10-CM code selection for NOS versus NEC

- ▶ Not Otherwise Specified (NOS) is selected when there is not enough documentation to select a more specific code
- ▶ Not Elsewhere Classified (NEC) is selected when there isn't an ICD-10-CM code that succinctly describes the specific information documented for the diagnosis

# Proper ICD-10-CM code selection for benign prostatic hypertrophy (BPH)

- ▶ Select the ICD-10-CM code for BPH based on whether the patient has lower urinary tract symptoms. If the patient has lower urinary tract symptoms (e.g. urinary frequency, urinary urgency) report:
- ▶ N40.1 Enlarged prostate with lower urinary tract symptoms with additional code(s)\*
  - ▶ \*Use additional codes for associated symptoms, when specified

# Proper ICD-10-CM code selection for postoperative pain

- ▶ Postoperative pain is reported with G89.18 for acute pain or G89.28 for chronic pain
- ▶ What if the provider does not indicate acute or chronic?
  - ▶ Section I.C6.b.1 states “If the pain is not specified as acute or chronic, post thoracotomy, post procedural, or neoplasm related, do not assign codes from category G89”
  - ▶ If the postoperative pain is due to a complication report with T81.89X

# Proper ICD-10-CM code selection for Diabetes Manifestation

- ▶ When a patient is seen for a diabetic manifestation, you will use a combination code for the diabetes and the manifestation from category E09 through E13
- ▶ For example:
  - ▶ A patient being treated for Type 2 diabetic retinopathy moderate is coded as
  - ▶ E11.339, Type 2 diabetes mellitus with moderate nonproliferative diabetic retinopathy without macular edema

# Incision and Drainage (I&D)

- ▶ I&D codes for abscesses are selected based on whether the procedure is simple or complicated. (CPT 10060 & 10061)
- ▶ A complicated I&D is reported when: performed on multiple abscesses, drains are inserted, packing with gauze, or there is a large amount of fluid expressed

# Multiple Lesion Excisions

- ▶ When multiple lesions are excised from the same anatomic site, append a modifier to report the procedure was performed on different lesions.
- ▶ For example:
  - ▶ The provider excises a 2.8 cm malignant lesion and a 2.1 cm malignant lesion on the patient's back.
    - ▶ The correct codes are 11603, 11603-XS

# Colonoscopy with polyp removal

- ▶ Codes for polyps removal are selected based on the technique used to remove the polyp(s)
- ▶ If more than one polyp is removed using the same technique, report only one CPT code
- ▶ If multiple polyps are removed using different techniques, report a CPT for each technique

# Read the entire operative note

- ▶ Do not rely on the headers of the operative report. Sometimes additional procedures are performed that are not listed in the header or the provider does not perform the procedure listed in the header.
- ▶ For example:
  - ▶ The provider may indicate a radical nephrectomy is performed. Review the operative report to make sure that the regional lymphadenectomy and vena caval thrombectomy is performed.

# Repairs

- ▶ Codes for wound closures are selected based on type of repair (simple, intermediate, complex), anatomic site, and length.
- ▶ Intermediate repair is a layered closure or heavily contaminated single layer closure.
- ▶ Complex repairs require extensive undermining, creation of defect, or debridement.

# Circumcision

- ▶ Report 54150 when a clamp or other device is used to perform a circumcision. The procedure includes a dorsal penile or ring block. If a block is not performed, report 54150-52.
- ▶ Report 54160 or 54161 based on the patient's age when a device is not used to perform a circumcision.

# Critical Care

- ▶ Critical care codes are based on time
- ▶ The time spent performing billable services (e.g., CPR, central line placement) is not included in the billable critical care time
- ▶ Time spent performing bundled services (e.g., EKGs, chest X-ray interpretations) is included in the billable critical care time
  - ▶ Review the bundled services listed in the coding guidelines preceding codes 99291 and 99292
- ▶ It is inappropriate to report the bundled services in addition to the critical care codes

# Grafts with skin substitutes

- ▶ Codes for skin substitute grafts are reported based on total wound surface area and anatomic site.
- ▶ For example:
  - ▶ A skin substitute graft for a wound measuring 10 cm x 20 cm on the patient's leg, the total wound surface area is 200 sq. cm.
    - ▶ Report 15273 for the first 100 sq. cm and
    - ▶ Report +15274 for the additional 100 sq. cm

# Nonunion and malunion repairs

- ▶ If the patient has a nonunion or malunion fracture, select the procedure code specific for treatment for the nonunion or malunion
- ▶ Do not report fracture care codes if a specific code for the treatment for a malunion or nonunion is available
- ▶ If there is no option for a specific code to treat nonunion or malunion, report a fracture care code if it is performed

# Osteotomy

- ▶ An osteotomy is a procedure in which the provider removes a wedge of bone from the effected joint. The codes are based on the anatomic site of the surgery
- ▶ Do not confuse osteotomy with arthrodesis, which is a fusion of the joint

# Cardiology - Stents

- ▶ Codes for stent placement are reported per vessel, not per stent
- ▶ If two stents are deployed in the same vessel, report the procedure only once
- ▶ Catheter placement to access the vessel to deploy the stent is included in the stent code. Do not report catheter placement separately

# Cardiology - Angioplasty

- ▶ Codes for angioplasty are reported per vessel, not per angioplasty
- ▶ If angioplasty is performed on two separate sites of the same vessel, only report the procedure once
- ▶ Catheter placement to access the vessel to perform angioplasty is included in the angioplasty code. Do not report catheter placement separately
- ▶ Angioplasty is included when other interventions are performed in the same vessel (e.g. stent placement, atherectomy)

# Cardiology – Angioplasty and stent in renal artery

- ▶ Stents deployed into the renal artery are reported with 37236 for the initial artery and + 37237 for each additional artery
- ▶ Radiologic supervision and interpretation is included in these codes