# Top Reimbursement & Coding Issues Impacting GI Practices in 2019

**Presented by:**

**Kristin Vaughn, CPC, CPMA, QMGC, ICDCT-CM**

**Healthcare Consultant and Lead Auditor**

**AskMueller Consulting, LLC**

**Email: kristin@askmuellerconsulting.com**

**www.askmuellerconsulting.com**

Ask Mueller CONSULTING LLC

# Objectives

- Understanding Modifier 25 – does your documentation support a significantly separate visit from the endoscopy?
- Visit prior to screening colonoscopy – how do you document for patient's symptoms that do not alter the screening procedure?
- Documentation tips for discontinued procedures.
- Does your documentation support the level of service billed?
- ICD-10 CM Diagnosis Code Specificity – document and code to the highest degree of specificity.
- Electronic Record Documentation – how to avoid cloning, template abuse, and dictation issues.

Ask Mueller CONSULTING LLC

# Understanding Modifier 25

Modifier 25 Definition: significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service.

- A significantly separate visit is billable on the same day as a procedure as long as the documentation supports medical necessity of a separate encounter from the procedure (endoscopy).
- A quick visit “meet me in endo” is not separately billable
- Hospital follow-up visits are not billable on the same day as the procedure unless something unrelated to the procedure has been addressed
- Diagnosis order on the claim can be essential in avoiding these denials. Example: submit the symptoms for the consult and findings for the procedure whenever possible.

Ask Mueller CONSULTING LLC

# Understanding Modifier 25

- Patient is seen in consultation for rectal bleeding and pain. Provider performs a separate history, exam, and decides the patient would benefit from an in office anoscopy today to determine bleeding source. If anoscopy is unrevealing of bleeding source, will proceed with diagnostic colonoscopy to rule out polyps or masses.
  - Consultation is separately billable with modifier 25.
- Patient is seen in the hospital for initial consultation of dysphagia following a CVA. Provider performs a separate history, exam and decides the patient would benefit from a feeding tube. The patient is stable from a GI standpoint to proceed with endoscopy with PEG tube insertion.
  - Initial hospital visit is separately billable with modifier 25.
- Patient is scoped in the hospital to determine source of hematochezia. Later the same day, GI is re-consulted for evaluation of new epigastric pain.
  - Follow-up hospital visit is separately billable with modifier 24.

# Visit Prior to Screening Colonoscopy

- Most major commercial payers will be for the visit prior to screening (average risk) as long as the plan is under the Affordable Care Act.
- There is a code S0285 to bill which was specifically created for the consultation prior to screening colonoscopy. Approved dx for this code is Z12.11 (average risk screening), Z80.0 (family history of colon cancer), and Z83.71 (family history of colon polyps) only.
- If there are other symptoms addressed then you would bill a standard visit code (99201-99205) or (99212-99215) depending upon if the patient is new or established with the practice.
  - *Clinical Example:* Patient presents for consultation prior to screening colonoscopy. Upon gathering a history from the patient, there is mention of trouble with constipation. The provider completes a history and exam and instructs the patient to try Miralax and to increase water and fiber intake. The provider documented "the patient's constipation does not warrant diagnostic colonoscopy, however, patient is 50 and due for screening colonoscopy, which will be scheduled.
  - Visit is billed based upon addressing constipation and procedure is ordered and documented as a screening colonoscopy.

# Visit Prior to Screening Colonoscopy

- Medicare does not cover the visit prior to screening or surveillance colonoscopy and considers this visit part of the pre-workup associated with the procedure.
- The only time you can bill the visit to Medicare is when you addressed something completely unrelated. That problem would be billed as the primary diagnosis and the level of service should be based upon the decision making for that encounter.

**Evaluation & Management with Screening Colonoscopy by CMS:**

- The patient may be at high-risk for the screening procedure due to other conditions (i.e., COPD, medications, etc.) that affect the pre-operative instructions given to the patient or how the procedure is performed, however, the consideration given to these risk factors is inclusive in the usual “pre-operative” work associated with the procedure. Reporting an E/M service with a diagnosis code associated with one of the patient’s risk factors implies that the GI physician saw the patient in order to diagnose or manage the illness identified and that is not the case. The GI physician is seeing the patient in order to determine the suitability of the patient for the screening procedure and CMS has stated that these visits are not billable.

Ask Mueller CONSULTING LLC

# Discontinued Procedure Documentation

- Modifier 53 indicates the physician elected to terminate the procedure due to the patient's well-being.
    - CMS instructs to use the 53 modifier when the scope does not go to cecum but goes beyond the splenic flexure and the intent of the procedure is a screening or diagnostic colonoscopy
    - Set fee for colonoscopy with 53 modifier in the Medicare fee schedule. (50% of the approved colonoscopy fee) Fee not automatically set in non-Medicare fee schedule and is subject to review prior to payment.
    - Usually due to a poor prep or patient condition.
    - If unable to get past the splenic flexure, only sigmoidoscopy can be billed.
- Should also be used on an intended EGD that did not get beyond the gastric outlet and the patient will be brought back at a later time for complete examination.

# Discontinued Procedure Documentation

- Modifier 52 indicates a reduced service not a discontinued/incomplete procedure.
- Example:
  - Colonoscopy to the ascending colon with biopsy of an obstructing lesion in the ascending colon.
  - Instructions per CPT recommend that if unable to get to the cecum/terminal ileum during a therapeutic/surgical procedure, add modifier 52 to the claim to support a reduced service
  - Payment may be subject to review of the endoscopy report as most payers will tend to review either modifier 52 or modifier 53.
- Should also be used on a planned EGD when the scope does not get beyond the gastric outlet and there is no plan to repeat the procedure.

# Discontinued Procedure Documentation

**Indication:** Hematochezia

**Post-Endoscopy Findings:** Normal colonoscopy to the ascending colon. Poor prep proximal to that area. Recommend re-evaluation in 2 months.

**Procedure:** Colonoscopy with limited view proximal to the ascending colon.

**CPT Code:**

45378 Diagnostic colonoscopy to the cecum and/or small intestine/colonic anastomosis

Add modifier 53 to indicate incomplete procedure.

**Diagnosis Code:**

K92.1 Hematochezia

Z53.8 Procedure and treatment not carried out for other reasons

(utilize your comment field (box 19) of the HCFA 1500 to let the payer know where the scope ended and why)

Ask Mueller CONSULTING LLC

# Discontinued Procedure Documentation

**Indication:** Average risk colon screening

**Post-endoscopy Findings:** Poor prep. Stool in the rectal vault. Scope not advanced beyond the rectum. Screening could not be completed. Reschedule with two day prep.

**Procedure Code:**

G0104 Average risk screening sigmoidoscopy with modifier 53

Or (for those payers not accepting G0104)

45330-33-53: Diagnostic sigmoidoscopy with modifier 33 indicating this is a preventive service.

**Diagnosis Code:**

Z12.11 Encounter for screening for malignant neoplasm of colon

Z53.8 Procedure and treatment not carried out for other reasons

(utilize your comment field (box 19) of the HCFA 1500 to let the payer know where the scope ended and why)

Ask Mueller CONSULTING LLC

# Assigning Correct E&M Levels: Code Based Upon Medical Necessity

- New Patient Visit Tips:
  - The majority of new patient visits in a GI Specialty should start as level 4 (99204, new patient office visit, for example).
  - Most patients referred to GI are dealing with symptoms or conditions that require either a diagnostic endoscopic workup (EGD/Colon), prescription drug management (prescribe PPI therapy), or there is an undiagnosed new problem w/ uncertain prognosis (abnormal LFT's).
  - *Level 4 New Patient Example:*
    - New patient presents for evaluation of epigastric pain along w/ nausea and vomiting. The provider performs and documents a comprehensive history and exam then decides the patient requires a diagnostic EGD to be scheduled at the ASC.

Ask Mueller CONSULTING LLC

# Assigning Correct E&M Levels: Code Based Upon Medical Necessity

- Established Patient Visit Tips:
  - Keep in mind that medical decision making typically drops when the patient returns for a follow-up visit. You are dealing with established problems versus new problems.
  - Document any new or worsening problems that occur on a follow-up encounter with the patient.
  - Visit can be billed by time (if documented appropriately) when medical decision making doesn't support the level of service but time does.
  - *Level 3 established patient example:*
    - Patient returns to clinic for follow-up of her IBS-D and GERD. Symptoms have nearly resolved with current medications. The provider documents an appropriate history and exam then refills the patients prescriptions for IBS-D and GERD.

Ask Mueller CONSULTING LLC

# Non-Specific Diagnosis Coding Impacting GI

**R10.9: Unspecified abdominal pain – NEVER USE!**

- This should not be a choice for your providers in their "list of favorites"
- Most of the time, the documentation is very specific to the location of pain, however, your providers can't find the code
- Example: Provider should start their search with "epigastric pain" instead of "abdominal pain" which requires them to drill down to a more specific code
- Any claim with the primary diagnosis of R10.9 should be put in a que before submission so they can be reviewed by a coder to ensure the most specific code is utilized

Ask Mueller CONSULTING LLC

# Non-Specific Diagnosis Coding Impacting GI

**K50.90: Crohn's Disease, unspecified, without complications**

**K50.919: Crohn's Disease, unspecified, with unspecified complications**

**K51.90: Ulcerative Colitis, unspecified, without complications**

**K50.919: Ulcerative Colitis, unspecified, with unspecified complications**

- If the patient is known to the practice and testing has been performed, providers must document the type/location of Crohn's/UC
- Providers must be specific as to the location/type of IBD when a patient comes in for any infusion services
  - We are seeing several GI practices with denials for medical necessity of infusions when unspecified IBD codes are utilized.
- There may be times where patients are new to the practice and records are not available that may cause us to utilize a non-specific Crohn's/UC code, however, this should be limited and the type/location must be coded once known
  - If there is suspected IBD but the provider does not yet know type, choose code K52.3 for "indeterminate colitis" until final confirmation

Ask Mueller CONSULTING LLC

# Non-Specific Diagnosis Coding Impacting GI

**D64.9- Anemia, unspecified**

- Not usually on an LCD (Local Coverage Determination) for EGD or colonoscopy
- When assigning the anemia codes, be sure there is supporting lab studies in your medical record.
- Could be appropriate for clinic visits when the type of anemia is unknown and further studies need to be obtained.
- We tend to see anemia incorrectly assigned on hospital visits. Be sure you document the specific type of anemia (if known) and choose the correct corresponding ICD-10 code.

Ask Mueller CONSULTING LLC

# Avoiding Pitfalls of the Electronic Health Record: Creating List of Favorites

- Since most EHR programs have two files for diagnosis codes: one file with all diagnosis codes listed as per ICD book description which can't be altered in code and description and the other file that can't be altered in code but can be altered and customized to individual/group provider familiar description(s).
- Work with providers to customize the software to facilitate ease of diagnosis look-up.

Ask Mueller CONSULTING LLC

# Avoiding Pitfalls of the Electronic Health Record: Creating List of Favorites

Electronic Record: Angiodysplasia of stomach and duodenum without bleeding

Provider list of favorites:

| | |
|---|---|
| K31.819 | Gastric AVM without bleeding |
| K31.819 | Watermelon stomach |
| K31.819 | Angiodysplasia without bleeding |
| K31.819 | GAVE |
| K31.819 | Angioectasia without bleeding |

Ask Mueller CONSULTING LLC

# Avoiding Pitfalls of the Electronic Health Record: Creating List of Favorites

Abnormal LFT's – providers must be specific as to which LFT's are elevated.

Electronic Record: If the provider searches "elevated LFT's" in the system, it will most likely choose R94.5 which is incorrect. What your provider is looking at is abnormal blood/enzyme values and not an abnormal liver function study.

Provider list of favorites:

- R74.0: Elevated transaminase (includes AST, ALT)
- R74.8: Other abnormal liver enzymes (includes acid phosphatase, alkaline phosphatase, amylase, and lipase)
- R79.89: Elevated bilirubin

Ask Mueller CONSULTING LLC

# Avoiding Pitfalls of the Electronic Health Record: Creating List of Favorites

Abnormal CT scan of GI tract

Electronic Record: when provider searches “abnormal CT” in the system, it will most likely choose R93.5 for abnormal imaging of other parts abdominal regions when the abnormality is really in either the GI tract OR biliary tract

Provider list of favorites:

- R93.2 abnormal imaging of liver and biliary tract
- R93.3 abnormal imaging of other parts of digestive tract

Ask Mueller CONSULTING LLC

# Avoiding Pitfalls of the Electronic Record: Creating List of Favorites

**Abdominal Pain**

- Electronic Record: the provider most likely searches for “abdominal pain” and the first code to come up is R10.9 for non-specific abdominal pain. Then they may have a drop-down list with all the specific quadrants, etc.
- Provider list of favorites:
  - R10.11 RUQ pain
  - R10.13 Epigastric pain
  - R10.84 Generalized pain
  - R10.31 RLQ pain
  - There are also codes for upper abdominal pain (R10.10) and lower abdominal pain (R10.30)

Ask Mueller CONSULTING LLC

# Avoiding Pitfalls of the electronic record: Creating list of favorites

**Hemorrhoids**

- Electronic Record: when the provider searches “hemorrhoid” in the system, it will most likely choose K64.8 for “other hemorrhoid” (without mention of degree). If the provider is treating the hemorrhoid with a banding procedure for example, they should document the grade/stage of hemorrhoid. If this is done, they need to search by degree in order to assign the correct code.

## Provider list of favorites:

- K64.0 First degree hemorrhoid
- K64.1 Second degree hemorrhoid
- K64.2 Third degree hemorrhoid

Ask Mueller CONSULTING LLC

# Clinical Example: Specificity is Key

Patient with history of Crohn's large intestine presents with rectal bleeding, LLQ abdominal pain, and diarrhea.

- K50.111 Crohn's Disease large intestine with rectal bleeding
- K50.118 Crohn's Disease large intestine with other complications
  - R10.32 LLQ Abdominal Pain
  - R19.7 Diarrhea

Per ICD-10 CM instructions: When the combination code lacks necessary specificity in describing the manifestation or complication, an additional code should be used as the secondary code.

Ask Mueller CONSULTING LLC

# Popular Z codes to utilize for Gastroenterology

- Z16.11 Resistance to penicillins
- Z16.21 Resistance to vancomycin
- Z16.22 Resistance to vancomycin related antibiotics
- Z16.33 Resistance to antiviral drugs
- Z21 Asymptomatic HIV status
- Z48.23 Encounter for aftercare following liver transplant
- Z53.8 Procedure not carried out because of contraindication
- Z66 Do not resuscitate / DNR status
- Z71.1 Problem in normal state / Feared complaint not found
- Z71.3 Dietary counselling and surveillance
- Z99.81 Dependence on supplemental oxygen

Ask Mueller CONSULTING LLC

# Popular Z codes to utilize for Gastroenterology

Patient with morbid obesity with a current BMI of 42 counseled on diet and exercise.

- Z71.3: Dietary counseling/surveillance
- E66.01: Morbid obesity due to excess calories
- Z68.41: BMI 40.0-44.9, adult

- Be sure your practice is assigning the patient's BMI level on the claim when overweight or obesity issues are addressed during the encounter.

Ask Mueller CONSULTING LLC

# Popular Z codes to utilize for Gastroenterology

- Z79 Long term current drug therapy category
- Z79.01 Anticoagulants
- Z79.02 Antithrombotics / antiplatelets
- Z79.1 Non-steroidal anti-inflammatories (NSAID)
- Z79.2 Antibiotics
- Z79.4 Insulin
- Z79.51 Inhaled steroids
- Z79.52 Systemic steroids
- Z79.82 Aspirin
- Z79.84 Oral hypoglycemic/antidiabetic drugs
- Z79.891 Opiate analgesic
- Z79.899 Other long term current drug therapy

Ask Mueller CONSULTING LLC

# Popular Z codes to utilize for Gastroenterology

- Patient presents for screening colonoscopy. She is on Coumadin and has been for years due to chronic atrial fibrillation.
    - Z12.11: Screening colonoscopy
    - Z79.01: Long term (current) use of anticoagulants
    - I48.2: Chronic atrial fibrillation

# Popular Z codes to utilize for Gastroenterology

Noncompliance

- Z91.11 Patient's noncompliance with dietary regimen
- Z91.120 Intentional underdosing of medication due to financial hardship

*Code first underdosing of medication (T36-T50)*

- Z91.128 Intentional underdosing of medication for other reason
- Z91.130 Unintentional underdosing due to age-related debility
- Z91.138 Unintentional underdosing for other reason
- Z91.14 Other noncompliance with medication regimen
- Z91.19 Noncompliance with other medical treatment and regimen
- Z91.5 Personal history of self-harm

Failed Sedation

- Z92.83 Personal history of failed moderate sedation

Ask Mueller CONSULTING LLC

# Popular Z codes to utilize for Gastroenterology

- Patient presents to clinic for evaluation of break-through heartburn symptoms who has a long history of severe GERD. Upon gathering a history from the patient, she admits that she doesn't take her Nexium as prescribed. She states that she often misses doses due to her financial situation and is unable to pay for refills.

  - R12: Heartburn
  - K21.9: GERD
  - Z91.120: Intentional underdosing of medication due to financial hardship

Ask Mueller CONSULTING LLC

# Detailed documentation is key

Improving documentation will support medical necessity

- Documentation is often requested by payers to ensure medical necessity is met

- Improving the quality of your documentation will lead to a more accurate medical record
  - Decrease in claim denials
- Improved documentation and accurate medical records translate into good patient care
- Documentation is not just a billing tool but a medical legal document.  Accuracy is a must.
- Research denials
  - Create a process for working denials
  - Often times payers want further information to process the claim (signatures, place of service correction, medical records)

Ask Mueller CONSULTING LLC

# Safe Use of Templates

- Medical necessity should be the driving factor for templates – every note shouldn't look identical and must be specific to the patient's chief complaint
- Templates should be used as a guide to gather the appropriate history and exam elements that are performed during each patient encounter. History and exam components should not be selected if they were not done during that encounter.
- Avoid contradictions within the medical record. This typically occurs when you have ancillary staff entering the chief complaint or history elements. Information should be updated by the provider (prior to signature) if there are mistakes/blanks/contradictions.
- Use the basic SOAP note format for follow-up notes in both office and hospital and keep it pertinent to the current encounter for follow-up care.

Ask Mueller CONSULTING LLC

# Avoid the Copy/Paste Option

- Cloned documentation continues to be a significant problem that creates unnecessary redundancy and at times inaccurate information in the medical record
- Most electronic health records have the ability to copy one document to another which causes an explosive amount of data and information that has nothing to do with the current status of the patient
- Practices must develop policies designed to address inappropriate use of cloning to minimize non-compliance

Ask Mueller CONSULTING LLC

# Avoid the Copy/Paste Option

- Providers must recognize that every patient encounter should be unique and must ensure that the health service provided is documented distinctly from all others.
- Auditors are now trained on the quality and not the quantity of the medical record
- Consecutive visits can be requested for one patient to ensure quality of the record.  Auditors can completely disallow visits that are cloned from previous encounters.

Ask Mueller CONSULTING LLC

# Dictation & Voice Recognition Systems

- Voice recognition systems (i.e.: Dragon) are becoming popular documentation programs.  Be sure to “train your dragon” to ensure documentation makes sense!
- If there are blanks that are returned on your dictation notes, be sure and complete the missing information before finalizing
- Remember what you sign is a medical legal document and your name is on the claim!

Ask Mueller CONSULTING LLC