Correct Coding to Maximize Reimbursements: Common Urological Coding and Billing Errors

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Objectives:
• Determine accurate from inaccurate urological coding
• Recognize common urological coding errors and avoid loss of entitled payments
• Maintain coding rules compliance
6th Annual Excellence in Urology Seminar
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Common Urological Coding and Billing Errors

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Editor: “Urology Coding Alert”, Naples, Fla.
Common Coding Errors in Urology

• Use of modifier-25
• Use of modifier -59
• Treatment of bladder neck contracture
• Complicated catheterization
• Bladder biopsy vs TURB
• Removal and closure of skin lesions
Modifier Confusion
Modifier Errors in Urology
E/M + Modifier -25 + Cystoscopy

• **Modifier - 25** Significant, separately, identifiable E/M service by the same... *urologist*... on the Same Day of the procedure or other services... The E/M services may be prompted by the symptom for which the procedure or service was provided.
• Can only be used on the day of a minor procedure
• Attached to an E/M code
• Do not report an E/M service that resulted in a decision to perform...minor...surgery
• OIG: Incorrectly used on 35% of claims
• CMS: > $538 million in improper payments

2013 CPT, current procedural terminology, Appendix A page 595
Modifier Errors in Urology

* Modifier -25*

• Use with 0 or 10 day global procedures
• Examples of correct use:
  – Two **co-existing unrelated** problems (with separate diagnoses)
  – Problem **prompts** E/M service **and** a procedure (may use the same diagnosis)
  – Same day **counseling** after surgery
• No effect on payment

Coding Tips
Modifier-25 Errors

• Do not bill an E/M service: “The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure, and an examination that includes the decision to do minor surgery should not be reported as an E/M service.”

• Bill an E/M service...“if a...urologist...performs a medically reasonable and necessary full...urological...examination” at the same encounter when performing a minor surgical procedure.

2013 NCCI Manual: Chapter 1
Coding Tips
Modifier 25 for Medicare

Per Medicare Claims Processing Manual (100-04) Section 40.1

(C) Minor Surgeries and Endoscopies: Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. For example, a visit on the same day could be properly billed in addition to suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Billing for a visit would not be appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status.
Coding Tips for Urology
Modifier 25 for Medicare

Per Medicare Claims Processing Manual (100-04) Section 40.1

(C) Minor Surgeries and Endoscopies: Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. *For example, a visit on the same day could be properly billed in addition to cystoscopy if a full urological examination is made for a patient with hematuria.* Billing for a visit would not be appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status.
Office Urology Coding Update

Office E/M and Cystoscopy EOB

• Diagnosis: Gross Hematuria (599.71) (R31.0)
• E/M office visit with modifier-25
• Urinalysis without microscopic examination
• Cystoscopy
Coding Tips
Modifier -25

• Do not use for a chief complaint:
  “patient here for cystoscopy...” or
  “patient here for a urodynamic study...”

• With these chief complaints an auditor will never allow payments for an additional E/M service

• Bill an E/M service if it is not related to the decision for surgery

• Bill an E/M service if a visit is medically reasonable and necessary in the further care of the patient irrespective of the minor surgery performed

2013 NCCI Manual: Chapter 1
Modifier -25 in Urology

• Modifier – 25 and E/M denials

In 2014 there will be more and more carriers (Medicare, Geisinger, First Priority Health, Elderplan, Aetna, Avmed...) who will not reimburse for any E/M service on the same day as a procedure even with modifier -25 and separate diagnoses. All appeals will be unsuccessful...try modifier-57
Errors in use of Modifier -59
Unbundling a CCI Edit

- Distinct Procedural Service
  - Used to report for payment a *bundled procedure performed* on the same day as a primary procedure:
  - **Criteria to be met:**
    - ✓ Different session
    - ✓ Different patient encounter
    - ✓ Different procedure
    - ✓ Different surgical incisions
    - ✓ Different sites, separate organs
    - ✓ *Separate sites in a single organ*
    - ✓ Different organ system
2013/2014 Modifier-59

• “Medicare has stated that modifier 59 is ‘...appropriate...on a bundled procedure for payment... if procedures are performed for lesions anatomically separate from one another’.. in the same organ”

• Findings: *Stone in renal pelvis and upper pole calyx of the same kidney*

<table>
<thead>
<tr>
<th>CPT</th>
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<tr>
<td>52353</td>
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</tbody>
</table>

Ray Painter, MD & Mark Painter, PRS CEO, Urology Times, January 2013
Modifiers in Urology
Modifier -76

• Modifier -76

“Repeat procedure” or services by the same surgeon...(during the same day... or same time as an initial procedure)
2014 Modifier 59

• Findings: *left renal pelvic calculus and left ureteral calculus*

Procedure: *ESWL for both calculi*

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>50590</td>
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</tr>
<tr>
<td>50590 59 76</td>
<td>592.0</td>
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</table>
2013/2014 Modifier 59

- Findings: *left renal pelvic tumor and left ureteral tumor*

  Procedure: Ureteroscopic biopsy of both tumors

<table>
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<tr>
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<tr>
<td>52354 59 76</td>
<td>189.2</td>
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United HealthCare EOB

<table>
<thead>
<tr>
<th>Dates of Service</th>
<th>Procedure</th>
<th>Mods</th>
<th>Description</th>
<th>Diag1</th>
<th>Description</th>
<th>TOS</th>
<th>Units</th>
<th>Fee Amt</th>
<th>Pmts/Adjls</th>
<th>Amt Due</th>
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<th>Allowed</th>
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<th>Deductible Reimb Comment</th>
<th>Co-Pay</th>
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Payment is made for both procedures performed in one kidney
52353 and 52353-59-76
Reimbursement Controversy

• AUA does not sanction this coding

• Many carriers (Medicare, commercial, and private) do not reimburse for the second or third procedures billed

• NCCI consider this “inappropriate coding”

• Many carriers do pay!
Medicare* now wants you to use modifier 76 alone for repeat exact duplicate services on the same day

“As of **July 1, 2013**... modifier 59 (for a distinct service) is no longer considered a valid repeat modifier. Procedures billed with modifier 59 will be denied as **exact duplicates**. To avoid these denials on repeat...**same exact**... procedures, you may bill using only a 76 modifier (repeat service)...”

Claim Example:

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<tr>
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<td>52353 -76</td>
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*NSG announcement: [http://tinyurl.com/njtdvwl](http://tinyurl.com/njtdvwl)
For Medicare
Use Modifier-76 in place of Modifier-59

• Findings: *Stone in renal pelvis and upper pole calyx of the same kidney*

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*Diagnoses are never used to determine appropriateness of CPT codes or CPT compliance*
Use Modifier 59 and 76

Different procedures in the same organ

- Findings: left renal pelvic calculus and left ureteral calculus

Procedure: ESWL of pelvic calculus and

*Ureteroscopic fragmentation of ureteral calculus*

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*Diagnoses are never used to determine appropriateness of CPT codes or compliance*
Summary: Use of -59 and -76
Coding for Multiple Procedures in One Organ

• **Medicare**
  - Modifier on 2\textsuperscript{nd} codes
  - Duplicate exact CPT codes -76
  - Different CPT codes -59 and -76

• **Non-Medicare**
  - Duplicate exact CPT codes -59 and -76
  - Different CPT codes -59 and -76

(Check: whether Non-Medicare carriers follow Medicare rules)
Coding Errors for Treatment of “Bladder Neck Contracture”

Correct Coding is Based on Etiology in the Male

• Congenital: ICD-9 753.6, [Q64.31]
  – Cystoscopic Incision – 52400

• Benign Hypertrophy (BPH): ICD-9 596.0 [N32.0]
  – TUIP – 52450
  – TUIBN – 52450 -52
  – TURBN – 52500
Coding Errors for Treatment of “Bladder Neck Contracture”

Correct Coding is Based on Etiology in the Male

• Postoperative Bladder Neck Contracture:
  – TURBN – 52640
  – TUIBN – 52640 -52
    52276 (post radical prostatectomy))
    (ICD-9 598.2) [N99.111]

• Laser ablation of bladder neck contracture- 52214
Catheterization Coding Errors

Complicated Catheterization - 51703

• Use Complicated Catheterization for:
  – Catheter passed over a guide wire
  – Catheter guide
  – Council tipped catheter
  – Coude catheter
  – Several catheters tried
  – Instillation of lubricant into the urethra
  – Difficult catheter removal (and replacement)

• Diagnoses: 598.9, N 599.4, 596.0, 996.31, V53.6
  N35.9,N36.5, N32.0, T83.018A
<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>52204 vs 52224</th>
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</thead>
<tbody>
<tr>
<td>Biopsy of lesion</td>
<td>Removal of lesion</td>
</tr>
<tr>
<td>Any size, normal mucosa</td>
<td>0.5cm. or less</td>
</tr>
<tr>
<td>Fulgurate bleeder from biopsy site</td>
<td>Fulgurate the complete lesion or residual of the lesion/base</td>
</tr>
<tr>
<td>Not a treatment</td>
<td>Treatment of lesion</td>
</tr>
<tr>
<td>$349.91/$142.13*</td>
<td>$644.82/$205.98*</td>
</tr>
</tbody>
</table>

*2014 Utah Medicare fee schedule
52204 and 52224
Cystoscopy/Biopsy vs TUR of Bladder Tumor

• Cannot be billed together (always bundled)
  – Cystoscopy and biopsy alone...52204
  or
  – Cystoscopy, biopsy, and treatment of a bladder lesion, < 0.5 cm....52224
Correct Measuring for Lesion Removal

What to Measure for Skin Excisions

```
11421 ($150.42/$109.27) → 11426 ($342.97/$273.28)
```

**Diagram:***
- 1.0 cm. lesion
- Excised diameter = (lesion + 2x smallest margin):
  - 1.0 cm + 4.0 cm = 5.0 cm margin (2.0 cm)

Measurement of lesion plus margins should be made prior to excision
Includes a simple (one-layered closure) when performed
also includes administration of local anesthesia
Skin Closures

- **Intermediate Closure:** requires layered closure, deeper layers of SC and non-muscle fascia as well as skin closure 12041 to 12047

- **Complex Closure:** more than a layered closure with scar revision, debridement, extensive undermining, or retention sutures 13131 to 13133

- *Remember to code for both excision of the lesion and an intermediate or complex closure when performed; check: some bundling of lesion excision and repair codes will require modifier-59*
Skin Lesion Excision and Skin Closure

• **14040** adjacent tissue transfer or re-arrangement...genitalia; defect 10 sq cm or less includes excision of lesions
Adjacent Tissue Repairs
14040

Repair of primary and secondary defects requires assignment of a code based upon the location and the approximate description (as demonstrated below) of the area required.

A. Advancement Flap

![Diagram of advancement flap]

Area 1: 1.0 cm x 1.0 cm = 1.0 sq cm
Area 2: 1.0 cm x 2.0 cm = 2.0 sq cm
(Area 1) + (Area 2) = 1.0 sq cm + 2.0 sq cm = 3.0 sq cm
B. Rotation Flap

Primary defect (Area 1)
1.0 cm

Secondary defect (Area 2)
2.5 cm

1.2 cm

Area 1: 1.0 cm x 1.0 cm = 1.0 sq cm
Area 2: 2.5 cm x 1.2 cm = 3.0 sq cm
(Area 1) + (Area 2) = 1.0 sq cm + 3.0 sq cm = 4.0 sq cm
Coding Questions now??
Or Call Me Later - I’d be Happy to Help!

- Private  516 741 0118
- Cellular  516 721 8149
- Office    516 746 5550
- Fax       516 294 4736
- E mail    Liqgold2@aol.com