AIMA

# Medical Coding Services

Case Studies

Prepared by:  Andrew Saif - Coding Manager, HIMSS APAC - EPD Committee Member

# Case Study #1

## How AIMA coding team helped a primary care physician office in Florida to increase revenue for the services

**Scenario:**

The physician does the evaluation and management and the claim was billed 99204 by considering the 3 key components of evaluation management, 1- History -Comprehensive (extended HPI- Complete-ROS, Complete PFSH,)2- Physical examination – Comprehensive and 3-Moderate MDM.

# Solution

After our review, we identified the chart was down coded. As per the 95 coding guidelines, we found the 3 key components of evaluation management A) History -Comprehensive (extended HPI- Complete-ROS, Complete PFSH B) Physical examination – Comprehensive C) MDM- high complexity (4 problem points, 4 data points and moderate risk.). Additionally, noticed the root cause was they have incorrectly calculated the amount and/or complexity of data to be reviewed, table points 3 instead of 4. As MDM satisfies 2 out of 3, the final complexity of MDM goes to High instead of moderate. Hence, the appropriate level code is 99205. Physician was educated regarding the data points calculations and claim submitted with 99205

## Higher level code 99205 got paid, resulting in higher reimbursement.

| Reason for less reimbursement | AIMA Actions |
|---|---|
| Evaluation management down coded | Applied the 95 /97 evaluation a management coding guideline to ensure the appropriate level of service coded |
| Lack of documentation | Educated the provider regarding the 97/95 documentation guidelines |

# Case Study #2

## How AIMA coding services fixed denials for California based Ambulatory Surgery Center

**Scenario:**
Previous biller was coding anesthesia wrongly, resulting in denials

Example: A 76-year-old patient admitted in a surgery center for scheduled partial colectomy due to colon CA in transverse colon. The anesthesiologist begins to prepare the patient for surgery at 9.30 am and given general anesthesia. Surgery begins at 10.00 AM and ends at 14.00 PM. The anesthesiologist releases the patient to recovery nurse at 14.30 PM. Chart coded as -C18.4, GE ,44140-00840 P3 ,9.30-14.00. In this case, provider got less reimbursement than expected.

As per our review, actual procedure performed on upper abdomen transverse colon. Hence, need to code 00790 which has (7) higher base unit than 00840 (6). Additionally, Anesthesia timing is mismatching. They have coded (9.30-14.00) 300 minutes (20 units) However anesthesiologist spend (9.30-14.30) 330 minutes (22 units). And Qualifying Circumstances Modifiers for Anesthesia is missed. Need to code 99100 1 (unit). Administration of anesthesia to a patient who is younger than age 1 or older than age 70. Here Patient age is 76, so need to code 99100.claim resubmitted as C18.4 GE 44140-00790, P3 99100 9.30-14.30

# Denial was overturned and the provider got better reimbursement

| Reason for less reimbursement/denials | AIMA actions |
|---|---|
| CO-4-The procedure code is inconsistent with the modifier used or a required modifier is missing | Applied the accurate anesthesia coding modifier guidelines. |
| Down code the anesthesia procedure code. | Assigned proper anesthesia code from OR |
| Anesthesia timing calculation. | Calculated the anesthesia timings as per anesthesia timing guidelines |
| Missed to code Qualifying Circumstances Modifier (Age) for Anesthesia. | Appended CQC Modifier as per anesthesia coding guidelines |

# Case Study #3

## How AIMA overturned denials on laboratory tests for an Independent lab from Missouri

**Scenario:**

Patient was tested for CMP, Urinalysis, toxicology screening and confirmation, Hemoglobin A1C. Free thyroxine, total thyroxine, thyroid hormone binding ratio, Claim billed the 80053,80307, G0483,81001, 84436 ,84439 ,84479 ,83036, with Primary diagnosis M17.10. E87.2. E03.9, I10; CPT 80053 was paid and CPT 81001, 84436, 84439,84479 denied as CO 97 – Claim denied as the benefit for this service is included in the payment or allowance for another service or procedure that has already been adjudicated. 83036 ,80307, G0483 as CO 50- non-covered services because this is not deemed a ‘medical necessity’ by the payer..

After review LCD Policy A57736 for CPT 80307, G0483, E87.2 is the only covered diagnosis, for CPT 83036 as per NCD 190.21 diagnosis code E11.9 covered, For CPT 81001 CMS PTP coding edits suggests modifier 59. for CPT 84436,84479- NCCI coding Manual does not permit payment of CPT codes 84436 or 84479 with CPT code 84439. The provider was educated regarding missed ICD Code, sequencing ICD 10 CM codes, and the accurate coding policy applicable to the claim and corrected claim resubmitted.

## Payer has reimbursed the denied CPT Codes 84436,84479,81001,80307, G0483,83036

| Reason for Denials | AIMA Action |
|---|---|
| CO-97 - Inclusive or bundled | Applied the principles of PTP coding edits, NCCI coding manuals, and accurate usage of modifiers resulted in the reduction in denial rates. |
| CO- 50 non-covered services as not deemed medical necessity | Applied the principles of NCD and LCD to avoid the medical necessity denials |
| C0- 151 Maximum units / frequency exceeded | Applied the principles of MUE to rectify the issue |

# Contact

www.aimabms.com
sales@aimabms.com +1 321-236-8300

FLORIDA, USA - 1990 Main Street, Suite 750, Sarasota, Florida
KERALA, INDIA - World Trade Center Kochi, Kakkanad, Kochi
LONDON, UK - Park Court, Pyrford Road, West Byfleet, Surrey
MANCHESTER, UK - Oak House, Market Place, Macclesfield, Cheshire