Gastroenterology Coding Alert

Denials: One MAC Released Its Top Denial Reasons for 2018 — Is Your GI Practice at Risk?

Hint: Nail down your documentation so you don't commit these infractions.

If denials at your GI practice are piling up and you can't figure out why, perhaps it's time to look into a few potential culprits.

Part B payer Palmetto GBA recently released several articles profiling the most common reasons for claim denials. We've gone through the issues that the MAC has highlighted as being problematic in 2018 and matched them to services that gastroenterology practices frequently perform. Read on to see which issues are on auditors' radar screens, and how you can avoid them.

1. Procedure Code Was Invalid on the Date of Service. Naturally, every coder is eager to use new CPT® and ICD-10 codes as soon as the word is out that they're valid - but that doesn't mean you can. New ICD-10 codes go into effect on Oct. 1 of each year, while new CPT® codes kick in on Jan. 1.

Of course, this problem exists in reverse as well - many coders fail to take note of new, deleted, or revised codes, and keep on reporting services the same way they always have, even after changes have gone into effect. Your best bet is to go through the CPT® and ICD-10 changes every Jan. 1 and Oct. 1, respectively, and update your systems accordingly so you're always reporting valid codes.

2. Similar E/M Services Performed by Multiple Providers in Same Group. This most often happens when patients report with an acute condition in the morning, see one physician, and then present again later in the day with an exacerbation of that condition and see a different gastroenterologist. Although it doesn't happen every day at most gastroenterology practices, it occurs enough for Palmetto to flag it as a common denial reason.

"Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician," Palmetto reminds coders. Therefore, if Gastro A sees a patient in the morning and Gastro B sees the same patient in the afternoon, you'll combine their E/M notes to pinpoint the most accurate E/M code for the two combined visits.

"A common related problem in larger groups is billing for a new patient evaluation when the individual was seen for a screening colonoscopy (or other service) by another physician within the same practice but from a different office within three years," said **Glenn D. Littenberg, MD, MACP, FASGE, AGAF,** a gastroenterologist and former CPT® Editorial Panel member in Pasadena, California. "Staff setting up the appointment may consider the patient new but CPT® defines patient as established. Schedulers and billers need to stay alert to this situation."

Caveat: If, however, one of the gastroenterologists has a subspecialty, both can report separate E/M codes. "On electronic claims, the documentation record could be used to specify the subspecialty of the provider when more than one services has been billed by multiple providers in the same group," Palmetto said.

3. Reporting A Service Without First Billing Its Prerequisite. Not all CPT® codes can be billed on their own - some aren't payable unless you first report a qualify service or procedure.

For instance, suppose the gastroenterologist is performing three laparoscopic small intestine resections and reports three units of +44203 (...each additional small intestine resection and anastomosis [List separately in addition to code for primary procedure]). This would not be payable, because add-on codes like +44203 cannot be reported without their "parent" code.

In this case, you'd report one unit of 44202 (Laparoscopy, surgical; enterectomy, resection of small intestine, single resection and anastomosis) followed by two units of +44203.