Common mistakes: Navigating the complexities

Improper coding can lead to missed reimbursement opportunities and, in more severe cases, result in payer audits, fines or penalties if fraudulent or inappropriate billing practices are detected. By correcting such coding errors, healthcare providers can prevent claim denials and ensure appropriate reimbursement.

Additionally, preventing such mistakes reduces the risk of scrutiny from payers. To ensure practice compliance, OMSs must prioritize accurate and ethical billing, adhere to guidelines and avoid any practices that may be construed as inappropriate.

The following are common challenges in OMS medical and dental coding:

- **Unbundling** refers to reporting two procedures that can be described by a single comprehensive code during the same encounter, either due to a misunderstanding of the intent of the codes and/or coding edits or intentionally in an effort to increase payment. Checking National Correct Coding Initiative (NCCI) edits and reading code descriptors are crucial when reporting multiple CPT* codes. NCCI edits identify code pairs that, when billed together, may represent an unbundling of services that may be billable with one code.

Example: When performing an arthroplasty (21240), condylectomy (21050) and meniscectomy (21060) during the same surgical session, coders sometimes report each individual code to account for all three services. Reporting two or all three of these codes together may be considered unbundling since the code descriptors for both 21050 and 21060 include "separate procedure," which indicates these codes may be carried out as a part of a larger, more global service. CPT codes designated as a "separate procedure" are considered incidental and bundled with any related comprehensive/major procedure when performed during the same session, through the same incision and/or at the same anatomic site. A separate procedure may be reported only if:

1. *It is the only procedure performed, or*
2. *It is unrelated to or distinct from other procedures performed during the same operative session.*

If deemed appropriate, modifiers are available to allow specific code pairs to override a NCCI edit and report the service separately if the parameters above are followed.

- **Appending inappropriate modifiers** may lead to claim denials, delayed payments and may result in an inaccurate representation of the services provided. Modifier usage in medical coding is essential for accurately reflecting the specific circumstances of a medical service or procedure. Modifiers are alphanumeric codes that provide additional information to explain variations or special circumstances that may affect the way a service is reported. Using modifiers can help distinguish between similar procedures, indicate multiple procedures performed during the same session and/or identify unique situations that affect coding and payer adjudication.

Example: When reporting CPT codes 21470 and 21453 for a bilateral fracture when only one set of arch bars is applied, appending modifier –52 (Reduced Services) to CPT code 21453 may be required, given that both codes include internal and/or interdental fixation in their code descriptors. In addition, CPT code 21470 is a more extensive procedure that may include the services described by 21453; therefore, a NCCI edit prevents the two codes from being reported together. In this case, a modifier would be required to indicate to the payer these services were two separately identifiable, distinct and medically necessary procedures.

# of billing and coding for an OMS practice

When reporting these two codes during the same encounter, appending modifier –59 (Distinct Procedural Service) to CPT code 21453 may be necessary to bypass the NCCI edit and allow both services to be considered for payment, providing the documentation is supported by medical necessity. In cases where both modifiers are reported, modifier –59 should be appended in the first position so as to potentially override or bypass the NCCI edit and allow for claims adjudication. Modifier –52 would be appended second to indicate interdental fixation was only performed once.

■ **Upcoding** refers to the practice of assigning a diagnostic or procedural code that reflects a more severe or complex condition or service than what was actually performed or documented. Upcoding may be considered a violation of the False Claims Act and lead to exclusions from federal healthcare programs and increase the potential for commercial plan audits. It is important for healthcare providers to accurately document and code for the services they provide to ensure proper billing and reimbursement.

Example: When selecting dental extraction codes, it is important to read the code nomenclature and descriptor carefully. Each CDT^ extraction code provides a description of the technique used to remove the tooth. Reporting D7210 instead of D7140 may be considered upcoding if documentation does not mention removal of bone and/or sectioning of the tooth. Keep in mind that not all tooth extractions should be considered surgical. Code selection should be based on the clinical discretion and professional judgment of the provider as well as capturing the services rendered to the patient as accurately as possible.

■ **Improper crosswalking** in medical/dental coding refers to the incorrect or inappropriate translation of codes between different coding systems. This error occurs when procedure codes are translated or crosswalked between coding systems in a way that does not accurately reflect the equivalent procedure or service. "Crosswalking" is the mapping of equivalent information across two or more distinct data sets. Oral and maxillofacial surgery is unique in that OMSs routinely provide services that are both dental and medical in nature. However, there is not always an appropriate crosswalk between CDT and CPT coding. This makes coding when working with two different code sets especially challenging.

From a coding perspective, if an equivalency (or crosswalk) does not exist, it may be more appropriate to report the CDT code to the medical carrier. Furthermore, code selection should be based on the clinical discretion of the OMS in conjunction with fulfilling the parameters set in the nomenclature and/or code descriptor, rather than by the patient's coverage (or lack of) for a given procedure.

Example: When reporting bone grafts, it is not appropriate to crosswalk CDT code D7950 (which describes ridge augmentation or reconstruction to increase height, width and/or volume of residual alveolar ridge) or D7953 (for ridge preservation) to CPT codes 21210 and 21215. These codes are commonly performed in concert with autogenous bone harvest from the anterior or posterior iliac crest and should not be utilized to report socket preservation or simple bone grafts, as these procedures are based on the intensity of the procedure and degree of reconstruction and are more extensive in nature. In such cases, the CDT code itself would be more appropriate to report to both dental and medical carriers. Additionally, CPT codes 21210 and 21215 would be more appropriate crosswalks for CDT D7955, as these codes would be reported for instances involving reconstruction of the jaws due to trauma or surgical correction of the congenital defects rather than in the case of prosthetic restoration. ■