Medical coding mistakes that could cost you

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Government and private insurers' audits have revealed unfortunate cases of fraudulent or abusive medical billing practices. You deserve to be paid for the medical care you provide, but it is essential that you avoid improper billing practices to steer clear of trouble and maintain a flourishing practice.

When it comes to medical coding errors, they fall into the broad categories of "**fraud**" and "abuse."

The former involves **intentional** misrepresentation. The latter means "the falsification was an innocent mistake, but nonetheless representative," according to the AMA's *Principles of CPT® Coding*, ninth edition. An example of abuse could involve coding "for a more complex service than was performed due to a misunderstanding of the coding system," the text notes.

The AMA has several resources to help you accurately bill procedures and services with the Current Procedural Terminology (CPT) code set and Healthcare Common Procedure Coding System (HCPCS) codes.

Visit the AMA on Amazon for coding resources from the authoritative source on the CPT code set. At the AMA Store, you'll find print and digital versions of the codebook, online coding subscriptions, data products (including the Advanced Coding Pack) and the CPT Network.

The CPT code set is expanding, and you can start preparing for next year with the Outpatient CDI Workshop and the CPT and RBRVS 2026 Annual Symposium, which are being held virtually Nov. 19–21.

The Outpatient CDI Workshop will enhance your understanding of outpatient documentation requirements. Choose from two programming tracks according to your clinical documentation improvement (CDI) goals.

CPT and RBRVS 2026 Annual Symposium is the world's only medical coding conference presented by the experts who develop the CPT code set. Each year, hundreds of CPT codes are updated to reflect the very latest in medical care provided to patients. For over 30 years, the AMA has hosted this authoritative educational event to equip health care professionals with primary source information and expert insights on how to use the most current CPT codes to maintain high claims accuracy and timely

reimbursement.

Don't miss out on the opportunity to join members of the AMA-convened CPT Editorial Panel, CPT Advisory Committee, AMA/Specialty Society Relative Value Scale (RBRVS) Update Committee (RUC) and more than a thousand of your peers for three days of premier education on the CPT 2026 code set and RBRVS updates. Complete this form to stay updated about these upcoming events.

Here are some of the most common mix-ups to avoid in medical coding.

Unbundling codes. When there is a single code available that captures payment for the component parts of a procedure, that is what should be used. Unbundling refers to using multiple CPT codes for the individual parts of the procedure, either due to misunderstanding or in an effort to increase payment.

Upcoding. Example: You are a physician in a specialty, such as oncology, that often has highly complex patients. Due to this, you always report the highest-level evaluation-and-management (E/M) service regardless of the actual condition your patient presents with. While this isn't always upcoding, you should accurately report the level of E/M code based on the patient's condition and not just based on your specialty.

And of course, there are examples of outright fraud in terms of upcoding. Take this case as a warning. One psychiatrist was fined $400,000 and permanently excluded from taking part in Medicare and Medicaid in part due to upcoding. He billed for 30- or 60-minute face-to-face sessions with patients when, in reality, he was only meeting with patients for 15 minutes each to do medication checks.

Failing to check National Correct Coding Initiative (NCCI) edits when reporting multiple codes. The Centers for Medicare & Medicaid Services developed the NCCI to help ensure correct coding methods were followed and avoid inappropriate payments for Medicare Part B claims.

These are automated prepayment edits that are "reached by analyzing every pair of codes billed for the same patient on the same service date by the same provider to see if an edit exists in the NCCI," the AMA's text notes. "If there is an NCCI edit, one of the codes is denied." NCCI edits will also typically provide a list of CPT modifiers available that may be used to override the denial. In certain cases, clear direction is stated that no modifier may be used to override the denial.

Example: You bill for a lesion excision and skin repair on a single service date. But CPT coding guidelines say simple repairs are included in the excision codes, so separately coding the repair would be wrong and generate an NCCI edit. But if the repair was performed on a different site from where the lesion was removed, it is appropriate to bill for both and append a modifier to let the payer know the procedure was indeed separate from the excision.

Failing to append the appropriate modifiers or appending inappropriate modifiers. Related to the case outlined above, this could involve reporting modifier 50, *Bilateral Procedure*, to a procedure code that already includes bilateral service.

Overusing modifier 22, *Increased Procedural Services*. You must include proper documentation to explain why the procedure requires more work than usual.

Example: You excise a lesion located in the crease of the neck of a very obese patient. The obesity makes the excision more difficult. In such a case, appending the modifier 22 to the code used to report the removal can indicate the increased complexity of the service.

Improper reporting of the infusion and hydration codes, which are time-based. Good documentation of the start and stop times are essential for medical coders to properly bill for these services. And then there are wrinkles involving services that are provided over two days of service.

Example: A continuous intravenous hydration is given from 11 p.m. to 2 a.m. In that case, instead of continuous infusion, the two administrations should be reported separately as initial (96374) and sequential (96376).

Reporting unlisted codes without documentation. If you must use an unlisted code to properly bill for a service, you must properly document it.

Subscribe to the AMA's *CPT News* email newsletter and to *CPT Assistant Online*, which provides information on the latest codes and trends in the medicine, clinical scenarios that demystify codes, information for training staff, appealing insurance denials and validating coding to auditors, and answering day-to-day coding questions.

Learn more about implementing CPT evaluation and management (E/M) revisions.