10 KEYS TO IMPROVE CODING FOR ORTHOPAEDIC, SPINE, AND PAIN IN ASCs

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10 Keys To Improving Coding Efficiency:

- Knowledge of Multi-specialty procedures and coding guidelines
- Continuing Education
- Utilization of Credible and Current Resources
- Knowledge of AMA vs CMS
- Knowledge of Commercial vs Medicare reimbursement and reporting guidelines
- Understanding of Medicare Edits (NCCI)
- Workload
- Work Environment (Logistics)
- Detailed Documentation
- Compliance Audits
Knowledge of Multi-specialty procedures and coding guidelines

- Simply because an ASC employs a **certified** coder, does not denote the coder automatically has a good working knowledge of the facility’s various specialties.

- The coder should have experience in ASC coding.

- The coder should have experience in coding the varying specialties performed in his facility.

Primary Coding Sources

- American Hospital Association (AHA)
- American Medical Association (AMA)
- Specialty Society- Orthopedics, Podiatry Gynecology, Anesthesia etc.
- Center for Medicare Services (CMS)
- Medicare Carrier (LCD)
- Individual Insurance Carrier Written Directives

Resource Tip!

**Use Local Coverage Determination (LCD)**

- LCDs list directives for many Procedures as well as medically necessary diagnoses
- Not the same for all states!
- Sequencing according to these is sometimes indicated to alleviate many denials and delays in payment
- **CAUTION: DO NOT MAKE UP A DIAGNOSIS!**
Coding Resources

- CPT Manual for CURRENT year
- ICD-9-CM Manual for CURRENT year
- HCPCS Manual for CURRENT year
- Medical Dictionary
- Medicare Edits
- CPT Assistant
- Part B News
- Coder’s Desk Reference CPT and/or ICD-9-CM
- Coding Companions appropriate for specialties
- UB-92 Editor

Other Coding Sources

- Trade or Industry Publication: these should reference where any coding guidance or directives are derived from.

- Beware of vendor supplied codes!

- Are they familiar with your State carriers, site of service?

General Coding: MCR vs AMA

Question:

Should we code by Medicare edits or AMA guidelines?
General Coding Answer:

- Your facility or corporation should set a standard/protocol that is nothing less than consistent across the board and based on credible and documented coding guidelines.

- Medicare accounts should follow MCR guidelines/edits.

- Commercial accounts in which commercial carriers follow MCR reimbursement guidelines should follow MCR edits.

- Some Commercial accounts may reimburse by AMA guidelines or specialty guidelines allowing for a more aggressive approach to coding.

- Don’t forget individual MAC/FI and/or carrier guidelines!

The facility or corporation should not alternate one day from the next based on which directive will reimburse better!! NO NO NO!

Commercial versus Medicare Reporting Policies

- Do you know where your contracts are located?

- Does your business office team have access to the insurance contracts?

- Does your business office team know which contracts follow Medicare reimbursement and reporting policies and which do not?

Managed Care Contracting Develop a Contract Matrix

- Type of Contract
- Plan
- Key Dates
- Termination Language
- Rates
- Exclusions
- Carve Outs
Coding Directives

- Any Insurance Carrier, Medicare Carrier or other entity giving coding “advice” or directives, should provide this to provider in writing.

- Any addendums, clarification to the clinical/operative report should be provided in writing.

Tools for Successful Reimbursement

- Updated copies of each payer’s guidelines including any letters or memos sent from the payer affecting coding, billing and reimbursement.

- Updated copy of the facility’s contract

Facility Checklist - Coders

- Ensure your coder is up-to-date with and understands coding guidelines and rules for new procedures.

- Communicate with your coder/biller/payment posters/denials team regarding any new changes.
Documentation

“Services billed to Medicare must be substantiated by complete documentation. The documentation should be legible and clearly show the services being rendered, the extent to which it was rendered, and the medical necessity of the service.”

Medicare News, Jan96

If it’s not documented, it never happened

Joint Commission

The operative report must be written or dictated immediately after an operative or other high risk procedure. An organization’s policy, based on state law, would define the timeframe for dictation and placement in the medical record. The most important issue is that there needs to be enough information in the record immediately after surgery in order to manage the patient throughout the postoperative period. This information could be entered as the operative report or as a hand-written operative progress note when there is a transcription/filing delay. This operative progress note should contain at least comparable operative report information. These elements include:

- the name of the primary surgeon/assistants
- procedures performed and complete description of each procedure and findings
- estimated blood loss
- specimens removed
- post operative diagnosis
Poor Documentation: The Consequences

- Accurate Statistical Databases and Reporting is compromised.
- Safe patient care is compromised due to a nurse's incomplete/inaccurate clinical chart
- Reimbursement/gross revenue is decreased
- Findings of fraud and abuse will lead to federal prosecution

Coding Documentation Challenges

- Contradictory information
- Errors dictated in the operative report
- Op notes that result in more questions than answers
- Missing or incomplete information in operative report
- Coding from “procedures performed” list and not the “description of the procedure” – missed coding opportunities
- Difficult coding cases

Basic Documentation Rule DON’Ts:

- Don’t Assume You Know What the Doctor is TRYING TO SAY!
- Don’t report a CPT code just because the doctor says so...needs to be documented.
- Don’t code from the title of the op note......needs to be detailed in the description.

READ THE ENTIRE OP NOTE!
Why Detailed Documentation?

- Allows practice to receive maximum appropriate reimbursement for services rendered when accurate code selection based on most specific clinical documentation.
- Allows practice to maintain reimbursement in an audit situation
**Reimbursement Impact:**

- CPT Code 11403 - exc benign lesion
  ...2.1 to 3.0 cm = 90.89 MCR 2009

- CPT Code 11404 – exc benign lesion
  ...3.1 to 4.0 CM = 483.18 MCR 2009

**Reimbursement Impact:**

- CPT Code 23410 – Repair of ruptured musculotendinous cuff open; acute = 1264.85 MCR (approx. 2009)

- CPT Code 23412 – Repair of ruptured musculotendinous cuff open; chronic = 1400.99 MCR (approx. 2009)
Who should be involved in Coding Compliance?

- Physicians/Clinical staff-documentation standards are met for services provided
- Billing and Coding staff- accurately abstract and report procedures and diagnosis
- Quality Assurance, Practice Management and Compliance committee

Coding Compliance Plan

Monitoring Coding Performance- (Audits)

STANDARDS OF CONDUCT

- Standards must include measurable performance standards to include code assignment accuracy.
- Measure code accuracy to establish baseline indicator of coding accuracy.
- By monitoring actual performance against the established baselines, variations in coding practices can be determined. Medicare Desk Reference 2008

Your Coding Compliance Plan

CHANGES IN CODING GUIDELINES

- Have a central source for managing official information on coding guidelines and other coding related compliance issues.
- Old guidelines need to be kept on file in event of facility or auditor needs access to the rules available at the time the original claim was coded. Medicare Desk Reference 2008
Coded Directives

- Any insurance carrier, Medicare carrier, or other entity giving coding "advice" or directives, should provide this to you in writing.
- Faxing a restatement of the information provided and getting a signature is often the quickest and most painless way to get this information in writing.

Common Audit Pitfall

**NOT making use of information provided in the audit results.**

- Accuracy rate doesn’t improve. Why?
- Coder never sees audit results. (repetitive mistakes)
- Facility/Coder doesn’t question results.

What Prompted the Error? ....Resolve!

- Determine the problem areas and who or what is accountable.
- Is it poor documentation, or is it the coding, billing, or payer reimbursement practices?
General Audit Trends

- Insufficient Clinical Documentation
- Coding only from the operative "Title"
- Coding "close-enough" vs unlisted
- Reporting invalid ICD-9-CM and CPT codes (code books and computer systems haven’t been updated)
- Incorrect Use of Modifier -59
- Incorrect Sequencing

ORTHOPAEDIC AUDIT TRENDS

- SLAP Repairs & Capsulorrhaphy Px - Shoulders
- Limited VS Extensive Debridement - Shoulders
- Abrasion Arthroplasties vs Chondroplasties - Knees

PAIN MANAGEMENT AUDIT TRENDS

- under- or over-reporting additional levels
- not billing fluoroscopy use appropriately
- reporting multiple injections for the same level.
Coding Compliance Plan – Continuing Education

TRAINING PROGRAM AND AUDITS

- Coding Staff needs to be educated annually regarding the compliance plan.
- Coding staff has potential of putting facility at risk….additional education should be provided regularly.
- Education programs should include coding conventions, guidelines, documentations etc.
- Keep records of staff education programs and attendees.
- Formal Coding audit protocol should define purpose of audit, frequency of review, sample size. Medicare Desk Reference 2008

Medicare Edits vs Payment Indicators

Points To Remember:

- Medicare Edits drive reimbursement
- Payment Indicators may allow for reimbursement if service/procedure doesn’t bundle into a comprehensive procedure.
- Coders will continue to code by edits for MCR patients and those carriers following MCR.
- Coders/Billers/Payment Posters should utilize payment indicators to determine whether payment should be expected and “how” paid.

Medicare Edits (NCCI)

- In addition to understanding Medicare guidelines, the coder should be quite knowledgeable in regards to modifier usage when reviewing Medicare Edits.
- Coders tend to err on the side of caution when reviewing the edits or they don’t understand “when” modifiers should be appended to the CPT code to indicate a “separate” and “distinct” procedure that would otherwise be considered bundled.
- Medicare edits may allow a modifier to be utilized when a normally integral procedure is separate and distinct; however, this doesn’t imply to automatic utilization of a modifier for all scenarios! (Don’t take it and run!!!)
- In this instance, the coder’s knowledge of the procedure(s) will assist in determining whether a modifier is applicable.
Medicare Edits (NCCI)

- 29824 and 29823?
- If 29823 bundles into 29824 under normal circumstances, does the Medicare edits allow for a modifier?
- If Medicare edits allow a modifier, is the service separate and distinct from the primary procedure in this instance and clinical/op documentation describes add’l px in detail?

Workload

- Facility volume – how many cases are being performed daily/monthly?
- Job responsibilities – what are the coder’s responsibilities on a daily basis? On a monthly basis?

Business Office Logistics

- Location of your business office team may need to be revisited. Placing your coder in a high traffic area may hamper the coding process not to mention result in errors.
- Where are your coder(s) workstations located in relation to the rest of your team?

  Ensure your coder is not distracted or constantly interrupted while coding operative cases.

  Covering the patient registration/front desk while attempting to code procedures is not acceptable and will result in errors.
THANK YOU!

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