

Coding Inaccuracies That May Put an ASC or Practice at Risk With the OIG and RACs

Cristina Bentin, CPC-H, CCS-P, CMA
President
cristina@ccmpro.com
225.752.8390

OBJECTIVES:

- Medicare Edits- Improper Usage
- Pain Management – Medical Necessity
- Shoulders – Under/Over-reporting
- Knees – Under/Over-reporting
- Spines- Common Errors Seen on an Audit
- RACS – What We Are Seeing

Medicare Edits (NCCI)

- Incorrect utilization of Medicare Edits

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.

NCCI Edits – If MCR Edits Allows use of a Modifier

- NCCI edits define when two procedure HCPCS/CPT codes may not be reported together except under special circumstances.
- If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together if the two procedures are performed at different anatomic sites or different patient encounters.
- Carrier processing systems utilize NCCI-associated modifiers to allow payment of both codes of an edit. Modifier -59 and other NCCI associated modifiers should NOT be used to bypass an NCCI edit unless the proper criteria for use of the modifier is met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used. <http://www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf>

Coding with a "Quick Fix" Mentality

- Don't code with blinders on. A tendency of NCCI edits users is to interpret the codes found in column 2 to be bundled at all times with codes found in column 1 thereby disregarding the CCM indicators.
- An understanding of the rationale behind the edits will ensure that correct coding becomes second nature.

Over-use of modifier -59

- The application of the -59 modifier is applicable **only** in certain circumstances.
- The over-use of the -59 is a red flag to Medicare and the OIG.

Applying a Modifier to the Wrong Code

- The modifier should be applied to the code found in column 2 since it is the code that is deemed integral to the procedure under normal circumstances.

TOP CODING PITFALLS AS IT PERTAINS TO ASC PAIN MGT CODING

Cristina Bentin, CPC-H, CCS-P, CMA
President
www.ccmpro.com
225.752.8390



Medical Necessity Challenges

- Case gets scheduled with one diagnosis that gets patient in the door.
- Once the procedure is performed, the operative documentation and H& P reflect a non-covered diagnosis or condition.

Educate Your Team

- Educate your scheduler
- Educate your insurance verifier
- Educate your physician - don't lead but educate!

Education: Local Coverage Determinations

- 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
- http://www.cms.hhs.gov/mcd/index_lmrp_bystate.asp
- *Caution:* do *not* make up a diagnosis!

Education: Local Coverage Determinations Incorrect Utilization of LCDs

- Facilities selecting diagnoses covered on LCD policy simply for reimbursement with no documentation to support diagnosis code selection.

Facet Joint and Medial Branch Block

- The approach for the paravertebral facet and the medial branch block are different, but captured with the same CPT code series **64490-64495**.
- These are unilateral codes.
- Review carrier requirements for submission of bilateral services.

Nervous System: Paravertebral Facet Joint Injections and Medial Branch Nerve Blocks

- **64490** - Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with guidance (fluoroscopy or CT), cervical or thoracic; single level. (MCR 2011 \$294.00)
- **+64491** - second level (MCR 2011 \$103.38)
- **+64492** - third and any additional level(s) (MCR 2011 \$103.38)
- **64493** - Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with imaging guidance (fluoroscopy or CT), lumbar or sacral; single level. (MCR 2011 \$294.00)
- **+64494** - second level (MCR 2011 \$103.38)
- **+64495** - third and any additional level(s) (MCR 2011 \$103.38)

Medial Branch Nerve Block Reporting

- Audits show Medial branch nerve block reporting errors
- Reporting per nerve is incorrect for a medial branch nerve block
- Reporting is *per joint* the nerve(s) innervate and not per nerve.
- Reference: AMA CPT ASSISTANT Aug 2010
AMA CPT ASSISTANT [September 2004](#)

Medial Branch Nerve Block: Question

- *Question to the AMA:* "A physician performs medial branch blocks at C4,C5,C6. For Left C4 Medial branch block he describes. . . a 22 gauge 3.5 inch needle inserted down to the waist of the pillar view of the left side of the C4 lateral mass using a lateral to medial and caudal to cephalad approach. After needle placement a 0.5cc volume of 0.5% Bupivacaine without epi was injected performing a medial branch block. For Left C5 and Left 6, the same description as the C4 injection was indicated but for the C5 and C6.

How is this coded please - specific codes and how many (3 CPT codes?)
64490; 64491; 64492? Or . . . just 64490; 64491?"

- *Answer from the AMA:* CPT codes 64490 and 64491 should be used. June 7 2010 #4742



Facet Joint and Medial Branch Nerve Block Injections

- A facet injection *and* a medial branch block can be performed on the same side same level.
- Only *one* (1) CPT code is assigned for both of these services.

Facet Joint Injections

- Imaging guidance (fluoroscopy, CT, ultrasound), while inclusive to the facet injection(s), must be clinically documented when utilized.
- CPT guidelines direct users to report tendon/trigger point injection code series **20550–20553 (MCR 2011 reimbursement range \$27.86–\$31.26)** in the absence of imaging, further decreasing the reimbursement.
- Facet injections with fluoroscopic guidance are coded toward the **64490–64495** code series.

Facet Joint Injection Add-on Codes

- Add-on codes **+64492** and **+64495** should *not* be reported more than *once* per day.
- Reimbursement for facet joint injection(s) is capped at no more than three (3) levels despite work performed at additional levels.

Post-op Pain Reporting -

- Inappropriate reporting of post-op pain blocks to Medicare.

Post-op Pain Management - AMA

- It is appropriate to report pain management procedures, including the insertion of an epidural catheter or the performance of a nerve block, for postoperative analgesia *separately* from the administration of a general anesthetic.
- When general anesthesia is administered and these injections are performed to provide postoperative analgesia, they are separate and distinct services and are reported in addition to the anesthesia code. Whether the block procedure (insertion of catheter; injection of narcotic or local anesthetic agent) occurs preoperatively, postoperatively, or during the procedure is immaterial.
- If, on the other hand, the block procedure is used primarily for the anesthesia itself, the service should be reported using the anesthesia code alone. In a combined epidural/general anesthetic, the block cannot be reported separately. AMA CPT ASSIST OCT p 9 01
- Separate detailed documentation is warranted. The facility can't assume.

Post-op Pain Management - CMS

- Per CMS, *not allowed* if post-op pain injection/block is performed by *same* physician performing the surgery . . .
- Check edits as commonly the injections are considered bundled unless there is an expressed documented reason (so complex it is outside the scope of the surgeon)
- Verify carrier policies and reporting requirements.
- *Local Coverage Determinations (LCDs) must be reviewed.*



CMS NCCI POLICY MANUAL Chapter II Anesthesia Services CPT Codes 00000 - 09999

- "Postoperative pain management services are generally provided by the surgeon who is reimbursed under a global payment policy related to the procedure and shall not be reported by the anesthesia practitioner unless separate, medically necessary services are required that cannot be rendered by the surgeon . . .
- Certain procedural services such as insertion of a Swan-Ganz catheter, insertion of a central venous pressure line, emergency intubation (outside of the operating suite), etc. are separately payable to anesthesiologists as well as non-medically directed CRNAs if these procedures are furnished within the parameters of state licensing laws.
- The surgeon is responsible to document in the medical record the reason care is being referred to the anesthesia practitioner." There still must be medical necessity!!!!

CMS NCCI POLICY MANUAL Chapter II Eye, Nervous Services etc.

- “Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62318-62319, 64415-64417, 64450, 64470, 64475, and 90760-90775 describe some services that may be utilized for postoperative pain management.
- The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.” Version 14.3.1 VIII-11



TOP CODING PITFALLS AS IT PERTAINS TO SHOULDER SCOPES



Coding Compliance Management, LLC
Our Experience Is Your Resource

Shoulder Scopes- Missed Opportunity

- Not capturing both the arthroscopic capsulorrhaphy and arthroscopic SLAP repair when separate and distinct.

Arthroscopic Surgical Capsulorrhaphy

29806: Arthroscopic surgical shoulder; capsulorrhaphy

- Use this code for capsular repairs (eg Bankart, Putti-Platt, etc. when arthroscopic).
- Do *not* report this code for arthroscopic *thermal* capsulorrhaphy.

Arthroscopic SLAP Repair

29807: Arthroscopic surgical shoulder; repair of SLAP Lesion

- Potential to report both *29807* and *29806* per AAOS and AMA if SLAP Type II or Type IV SLAP is performed in addition to capsulorrhaphy.
- Must have two (2) separate problems:
 - Capsular Defect – not caused by SLAP
 - SLAP Tear

CMS bundles but allows a modifier when separate and distinct procedure is performed. Verify carrier guidelines!

Shoulder Scopes- Overstatement

- Incorrect unbundling:
On the flip side, incorrect reporting of both the arthroscopic capsulorrhaphy and arthroscopic SLAP repair when NOT separate/distinct.

Labrum Debridement

- If the only work on the labrum is a “*debridement*” we would *not* report a “SLAP repair,” *29807*.
- We would report *29822*, limited, pending other work being performed during that operative session.
- If other debridement work is being performed, the CPT code may change to extensive code *29823*.

Arthroscopic Shoulder: Incorrect Reporting of Extensive Debridements

- Incorrect reporting/up coding of CPT 29823 instead of CPT 29822 when the debridement(s) is part of another procedure being performed and reported.

Arthroscopic Shoulder: Limited Debridement

Code 29822 covers limited debridement of soft or hard tissue and should be used for limited labral debridement, cuff debridement or the removal of degenerative cartilage and osteophytes when not part of a more extensive procedure. AAOS MAR 09; AAOS APR 06; AMA May 01

29822: Arthroscopy, shoulder limited debridement may involve . .

- Minor synovial resection
- Articular shaving and/or chondroplasty synovectomy
- Labrum debridement
- Removal osteophyte humerus/glenoid

2011 approx reimbursement – \$1161.03

Arthroscopic Shoulder: Limited Debridement

Code 29822 covers limited debridement of soft or hard tissue and should be used for limited labral debridement, cuff debridement or the removal of degenerative cartilage and osteophytes when not part of a more extensive procedure. AAOS MAR 09; AAOS APR 06; AMA May 01

Example: Arthroscopic rotator cuff debridement is performed and an arthroscopic rotator cuff repair is performed on the subscapularis tendon. We code 29827 only. We don't consider the 29822 at all since the work of debriding was performed on the tendon he repaired.

Arthroscopic Shoulder: Extensive Debridement

Code 29823 should be used *only for extensive* debridement of soft or hard tissue. It includes a chondroplasty of the humeral head or glenoid and associated osteophytes or multiple soft tissue structures that are debrided such as labrum, subscapularis and supraspinatus when not part of a more extensive procedure. References: AAOS MAR 09; AAOS APR 06; AMA May 01

29823: Arthroscopy, shoulder extensive debridement may involve . . .

- Articular shaving
- Synovectomy
- Limited debridement
- Labrum debridement
- Removal osteophyte humerus/glenoid
- Biceps tendon and rotator cuff debridement
- Abrasion arthroplasty
- Removal osteochondral/bodies
- Sufficient, detailed, operative documentation is indicated.

Arthroscopic Shoulder: Extensive Debridement

Code 29823 should be used *only for extensive* debridement of soft or hard tissue. It includes a chondroplasty of the humeral head or glenoid and associated osteophytes or multiple soft tissue structures that are debrided such as labrum, subscapularis and supraspinatus when not part of a more extensive procedure. References: AAOS MAR 09; AAOS APR 06; AMA May 01

Example: The labrum, rotator cuff, biceps tendon, and the acromion are debrided. A SLAP repair, rotator cuff repair, and acromioplasty are also performed of the labrum, rotator, and acromial areas previously debrided. Do we report 29823 or 29822 or neither?

Answer: 29822 – for biceps tendon with -59 if warranted

TOP CODING PITFALLS AS IT PERTAINS TO KNEE SCOPES

Knee Arthroscopy: Synovectomies

Incorrect reporting of two compartmental synovectomies when other procedures were performed in the same compartment in which the synovectomy bundles.

Knee Arthroscopies

- **29875** - Arthroscopy, knee, surgical; synovectomy, limited (plica resection)
- **29876** - Arthroscopy, knee, surgical; synovectomy, major, two or more compartments

Report 29875 vs. 29876

Let's say *the physician performs an arthroscopic lateral meniscectomy and an arthroscopic two compartmental synovectomy of the medial and lateral compartments of the right knee.*

- It is *incorrect* to report an arthroscopic two-compartment synovectomy, CPT code *29876* in this case.
- The lateral synovectomy, *CPT 29875*, is inclusive in the lateral meniscectomy procedure reported with *CPT 29881*.
- Only the medial compartment will have a final synovectomy reporting of *CPT 29875*.

Report 29875 or 29876

Example:

P = Patella - n/a

M = Medial - *29875*

L = Lateral - *29875* + *29881* = *29881* (*29875* bundles into *29881*)

Answer:

29881RT + 29875-59-RT

Report 29875 vs. 29876

Let's say *the physician performs an arthroscopic lateral meniscectomy and an arthroscopic two compartmental synovectomy of the medial and patellofemoral compartments of the right knee.*

Because the medial and patellofemoral synovectomies are distinct from the lateral location, an arthroscopic two-compartment synovectomy, CPT code *29876* is supported.

Medial = 29875

Lateral = 29881

Patellofemoral = 29875

Answer: *29881-RT; 29876-RT*

Knee Arthroscopy: Incorrect Reporting of 29877 to Medicare

- Incorrect reporting of 29877 to MCR when performed secondary to the primary procedure in a different compartment .
- Correct code: G0289 (N1 indicator) packaged

Arthroscopic Procedures - 29877

29877 - Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty).

- Report only *once* despite px performed in 1, 2 or 3 compartments and no other px performed that it may bundle into - watch for other procedures performed in same compartment – **29877** may bundle)
- Commercial patients – report **29877** when performed in a separate compartment and not inclusive of other px performed in that compartment if any. (AMA)

Arthroscopic Procedures - 29877

When a meniscectomy is performed in a separate compartment from the chondroplasty it can be a challenge of when to report.

- CPT code **29877** versus
- HCPCS Level II Code **G0289**, Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of another surgical knee arthroscopy in a different compartment of the same knee

Arthroscopic Procedures - 29877

29877 - Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty).

- Medicare patients – report **29877** if chondroplasty is only px performed during operative session . . . Or . . .
- Medicare patients - report **G0289** if chondroplasty is secondary px performed in separate compartment from primary px.
- (CMS) - (ASC status indicator is N1) - packaged/incidental . . . follow billing policies of carriers.

Arthroscopic Procedures - 29877

- Let's look at an example: *an arthroscopic medial meniscectomy is performed with an arthroscopic lateral chondroplasty of the knee.*
- Prior to code determination, the facility must be knowledgeable of the *type of carrier* (commercial vs. Medicare) for the account being reported.

Arthroscopic Procedures - 29877

- If the account is a commercial account that follows AMA guidelines, we would report CPT codes **29881; 29877-59**. AMA CPT ASSIST [April 2005](#) page 14
- Keep in mind, some carriers may differ from AMA guidelines allowing reporting/reimbursement for only CPT code **29881**.
- If the account is a Medicare account, we would initially consider CPT codes **29881; G0289**. However, **G0289**, while on the Medicare ASC list of approved procedures, is listed with an N1 payment indicator. N1 indicates the reimbursement for **G0289** is packaged into the reimbursement for the main procedure performed (meniscectomy) during the operative session.

Arthroscopic Procedures - 29877

- The Medicare Claims Processing Manual states “ASCs should not report separate line-item HCPCS codes or charges for items that are packaged into payment for covered surgical procedures and therefore, are not paid separately.”
- Facilities should follow billing guidelines for HCPCS listed as N1, since individual state ASC billing policies may differ in regards to dropping these HCPCS to a claim.
- CMS does not allow substitution of *G0289* with *CPT 29877* simply to receive additional reimbursement.

Arthroscopic Procedures – 29879

Yet another challenge for coders occurs with the determination of reporting either:

- *CPT 29877*, arthroscopy knee, surgical; debridement/shaving of articular cartilage (chondroplasty) versus
- *CPT 29879*, arthroscopy knee, surgical; abrasion arthroplasty (includes chondroplasty where necessary) or multiple drilling or microfracture.

Arthroscopic Procedures – 29879

29879 - Arthroscopy, knee, surgical; abrasion arthroplasty.

- Documentation should support reporting. It should detail drilling, microfracturing, and/or debriding to bleeding bone etc. American Academy of Orthopaedic Surgeons
- If operative report only states, “I did an arthroplasty” a query is needed as this could also be a simple chondroplasty (*29877*).
- *29879* may be reported in addition to *CPT 29877* if performed in a *separate* compartment than *29877* pending clinical documentation and carrier guidelines.
- *29879* may be reported x3 if performed in all 3 compartments.

Arthroscopic Procedures – 29879

Poor documentation:

"Next, I performed an abrasion chondroplasty in the lateral compartment. Attention was then turned to the medial compartment, where again, another abrasion arthroplasty was performed."

Arthroscopic Procedures – 29879

Better documentation:

"In the lateral compartment, an Abrasion arthroplasty was performed with debriding down to bleeding bone. Attention was then turned to the medial compartment, where again, an abrasion arthroplasty was performed with debridement down to bleeding bone."

Code selection for the description above would be **CPT 29879** x 2 rather than **CPT 29877** x 1.

SPINAL CODING



Coding Compliance Management, LLC
Our Experience Is Your Resource

Cage Reporting Once or Twice?

- Incorrect reporting of Cages inserted at the same level.

CPT CHANGES: Neurosurgery - Spine

- + ▲ **22851** - Application of intervertebral biomechanical device(s) (e.g., synthetic cage(s), ~~threaded bone dowel(s)~~, methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure.) (**Not on MCR ASC List**)
- Threaded bone dowel rarely used so phrase was omitted.
- Clarifies that any structural biomechanical device is reported with this code.
- Report bone graft codes **20930-20938** for the application of an intervertebral bone device and graft procedure.

22851 Reporting Once or Twice?

- These cage(s) are used for an interbody arthrodesis because they are placed within the disc space and reported once per level regardless of the number of cages at one level.
- Two cages at L3-L4 is reported with **CPT 22851** x 1
- One cage at L3-L4 and One at L4-L5 is reported with **CPT 22851x2**.

Cage and Instrumentation

- If a metal cage is placed via anterior approach and pedicle screws are placed through a posterior approach, can we code *both*?
- *Yes*. It is appropriate to report both codes +22851 and one of the codes from the posterior instrumentation series, +22840, +22842-+22844 pending documentation.
- Do *not* report both an anterior instrumentation code, for example, and +22851 if only a cage is inserted. AMA CPT Sep 97

Spinal Instrumentation Removal

- 22852:** Removal Posterior segmental instrumentation
- *Question:* Is it appropriate to report code 22852, Removal of posterior segmental instrumentation, per level when multiple levels are involved?
 - *AMA Comment* [May 2006 page 16](#)
 - From a CPT coding perspective, code 22852 should not be reported per level. Code 22852 should be reported one time whether single or multiple levels are involved.

Bone Graft Reporting

- Each *type* of bone graft code for spinal surgery (20930-20938) may be reported one time for a spinal procedure regardless of the number of vertebral levels being surgically fused. CPT ASSIST Jan 04
 - *Example:* 20930 for an allograft for spine surgery, morselized may not be reported multiple times for each spinal level in which an allograft is used)
- Check edits for bundling of bone graft codes and whether the edits allow a modifier when applicable to the service.

63030 versus 63047

- **63030:** Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of **herniated intervertebral disk**; one interspace, lumbar (including open or endoscopically-assisted approach)
- **63047:** Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s) (e.g. **spinal or recess stenosis**), single vertebral segment, lumbar

63030 vs 63047 (Can Both be Reported?)

- Let's say a laminectomy, decompression of the spine, facetectomy of the L2 vertebra for spinal stenosis, and laminotomy with excision of the intervertebral disk at L1 for HNP is performed.
- If both a laminectomy and a laminotomy are performed on different levels of the spine, both CPT code **63030** and **63047** may be reported with the appropriate modifier.
 - L1 = **63030**
 - L2 = **63047**
 - Sequence and append appropriate modifier to indicate separate and distinct level (i.e. -59)

MILD: Minimally Invasive Lumbar Spinal Decompression (MILD) Procedure

Question: May either CPT code **63030** or **63047** be reported for a minimally invasive lumbar decompression described as follows: *"Through a small incision and using the fluoroscopic guidance, the surgeon performs an epidurogram to identify the specific lumbar stenosis location, followed by a small laminotomy and decompression resection of the ligamentum flavum to treat the patient's central canal spinal stenosis."*

MILD: Minimally Invasive Lumbar Spinal Decompression (MILD) Procedure

- **Answer:** No. Procedures using MILD devices should be reported using unlisted spine code, **22899** or **64999** unlisted procedure nervous system.
- MILD involves a fluoroscopic, needle based procedure without DIRECT visualization of critical neural structures. It involves fluoroscopically guided placement of a guide wire obliquely introduced into the facet joint. An epidurogram is performed to identify the dura. Facet/ligament is resected. AMA CPT Assist Nov 2010 volume 20 issue 11

RACS – WHAT WE ARE SEEING....

- AUTOMATED REVIEWS
- DEMAND LETTERS/FINDINGS
- REBUTTALS/OUTCOME

Thank You!

Presented by
Cristina Bentin, CPC-H, CCS-P, CMA
cristina@ccmpro.com
www.ccmpro.com
225.752.8390
