How to Overcome the 5 Biggest Reimbursement Challenges in Joint & Spine Coding

Presented by:
Carolyn Neumann, CPC
Senior Manager Coding and Coverage Access

The opinions and codes denoted within are suggestions only, which reflect my understandings of the identified source and personal experiences. This information should not be construed as authoritative. Codes and values are subject to frequent change without notice. The entity billing Medicare and/or third party payors is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Therefore health care providers must use great care and validate billing and coding requirements ascribed by payors with whom they work. SHA assumes no responsibility for coding and cannot recommend codes for specific cases. When making coding decisions, we encourage you to seek input from the AMA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims.
Sets of Alphanumeric Descriptors used to Identify Individual and Class of Procedures, Diagnoses, Locations, Payment Groupings, etc.

Value of Available Remuneration for Services and Supplies.

Terms and Conditions for Payment.

CODING

REIMBURSEMENT

COVERAGE

HEALTH CARE ECONOMICS

= Chance for Error

watch for this sign to see where coding errors are likely

CPT – ICD-10 - DRG
Coding Provides the Foundation for Reimbursement

Coding Refers to the Language used Between Providers & Payors

Reimbursement is Dependent on Accurate Coding Communication

CPT Code System:
- Current Procedural Terminology
- Physician Reporting Code System Created by the AMA and Adopted by Medicare to Report Physician and OP/ASC Facility Procedures & Services

HCPCS Code System:
- Referred to as HCPCS Level II codes
- Reports Supplies, Devices and Services
- Required by OP/ASC Facilities

APC Code System:
- Ambulatory Payment Classification
- Used by Medicare to Group Procedures in the OP/ASC setting
- CPT Codes Map to Specific APCs for Reimbursement Valuation
Nearly 50% of “NEW” ICD-10-CM Diagnosis Codes Represent Musculoskeletal Dx

- Significant Increases in SPINE & JOINT “NEW” ICD-10-PCS Procedure Codes

- The Language becomes more complex in October 2014

- Reimbursement is Dependent on Accurate Coding Communication

- Diagnosis to Procedure Code Matching Increases = More Denial Possibilities

**ICD-9-CM Code Systems:**

- **Diagnosis** Coding (14,000 codes)
- **Hospital Procedure** Coding (4,000 codes)

**ICD-10 Code Systems:** *(Oct. 1, 2014)*

- CM = **Diagnosis** Coding (68,000 codes)
- PCS = **Hospital Procedure** Coding 87,000 codes

**MS-DRG Code System:**

- Medicare Severity Diagnosis Related Group
- Reports Inpatient Services for Reimbursement
- These codes group procedures, diagnoses, and patient condition to Allow Hospital Medicare Reimbursement Pursuant to the Inpatient Prospective Payment System
The Language of Coding – Barriers to Reimbursement

**Coding Systems Family Tree**

Who Creates the Codes?

- **Oversight or Creation**
  - Influence

- **Health & Human Services (HHS)**

- **Center for Medicare & Medicaid Services (CMS)**

- **AMIA**

- **Physician Reimbursement for Work Completed**

- **ICD-9-CM Hospital:**
  - Procedure Code
  - Diagnostic Code

- **HCPCS Level II Codes (CPT/AMA)**
  - Report services and products

- **American Hospital Association**

- **Grouper (Version 30)**

- **Inpatient Setting**

- **APC Codes**
  - Hospital Outpatient
  - Ambulatory Service Center

- **MS-DRG Codes**
  - Hospital Inpatient

- **Outpatient Setting**

- **Institutional Reimbursement for Facility Work, Devices and Supplies**
Why is the Language of Coding Important to Joint & Spine Reimbursement?

- **Simple errors** are the most common reason for prior authorization and claim denials. Example: **Total Knee Replacement Procedure**
  
  CPT 27447 = Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
  CPT 27477 = Arrest, epiphyseal, any method (eg, epiphysiodesis); tibia and fibula, proximal

- *When claim or PA is submitted to insurance there is an age or CCI edit that denies coverage. If not appealed or reviewed for errors the procedure is not reimbursed.*

- **Proactive Claim Audits** can help pinpoint **Simple errors** and reduce denials and post claim appeals.
**The Language of Coding – Barriers to Reimbursement**

**Why is the Language of Coding Important to Joint & Spine Reimbursement?**

- _Clinical Language_ to Coding Language – Does Not Always Translate.

**Example: Vertebral Segment/Interspace**

<table>
<thead>
<tr>
<th>Clinical Language – Vertebral Segment</th>
<th>CPT Language – Vertebral Segment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Vertebrae, Disc, Facet Joints, Ligaments</td>
<td>All Bony Components of a Vertebrae</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT Language - Interspace</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disc, Non-bony compartment, Endplates</td>
</tr>
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</table>

**Coding Use of Terminology**

<table>
<thead>
<tr>
<th>Segment</th>
<th>Interspace/Level</th>
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<tbody>
<tr>
<td>Laminectomy Codes, Corpectomy Codes, Instrumentation Codes, Osteotomy Codes</td>
<td>Discectomy Codes, Discography Codes, Injection Codes</td>
</tr>
</tbody>
</table>
The Language of Coding – Barriers to Reimbursement

Code Modifiers Can Have a Major Impact on Reimbursement

- CPT Coding Drives Physician Reimbursements
- Coding for Bilateral Procedures Requires Detailed Review of Codes
- Some CPT Codes are both Unilateral and Bilateral
- Other CPT Codes are Unilateral and Require a Bilateral Modifier
  - *Watch code descriptions closely whenever a procedure is described as being bilateral in the OP notes.*
- EXAMPLE: *Bilateral Lumbar Spine Decompressions*

**CPT 63030 - 50** – Laminotomy, hemilaminectomy
Code is a unilateral code and requires a -50 Modifier if done bilaterally

**CPT 63047** – Laminectomy
Code is a unilateral or bilateral code and reports either without modifier

Why does this Matter?

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>2013 Medicare National Average Reimbursement for Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>63030</td>
<td>$980</td>
</tr>
<tr>
<td>63030-50</td>
<td>$1470</td>
</tr>
<tr>
<td>63047</td>
<td>$1119</td>
</tr>
</tbody>
</table>
Understanding the Two Pathways to Reimbursement

Authorization
Documented
Coding Pathways

Facility

Surgeon

Inpatient
MS-DRG code

Outpatient/ASC
APC & HCPCS code

CPT Code

Communication Among all Parties is Key to Reimbursement.
Surgeon Performs 1 Level PL Fusion, PLIF with Posterior instrumentation, cage and autograft

Physician Reporting for Reimbursement = CMS 1500

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>724.03 Spinal Stenosis</td>
<td>M48.06 Spinal Stenosis, Lumbar Region</td>
</tr>
<tr>
<td>722.52 Degenerative Disc Disease</td>
<td>M51.36 Intervertebral Disc Degen, Lumbar</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>CPT Codes</th>
<th>2013</th>
<th>Pre 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthrodesis – combined PL &amp; PLIF</td>
<td>22633</td>
<td>22612 22630</td>
</tr>
<tr>
<td>Laminectomy - Lumbar</td>
<td>63047</td>
<td>63047</td>
</tr>
<tr>
<td>Posterior Instrumentation</td>
<td>22840</td>
<td>22840</td>
</tr>
<tr>
<td>Application of intervertebral device</td>
<td>22851</td>
<td>22851</td>
</tr>
<tr>
<td>Autograft, same incision</td>
<td>20936</td>
<td>20936</td>
</tr>
</tbody>
</table>
Lumbar Arthrodesis (Fusion)

Coding Pathways

Surgeon Performs 1 Level PL Fusion, PLIF with posterior instrumentation, cage and autograft

Hospital Reporting for Reimbursement = UB-04

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<tr>
<td>81.07 Lumbar Fusion Posterior Technique</td>
<td>OSG0071 Fusion of Lumbar Vertebra Joint with Auto</td>
</tr>
<tr>
<td></td>
<td>OSG00A1 Fusion of Lumbar Vertebra Joint Interbody</td>
</tr>
<tr>
<td></td>
<td>OSG00J1 Fusion of Lumbar Vertebra Joint Syn. Sub. Graft</td>
</tr>
<tr>
<td></td>
<td>OSG00K1 “ “ Nonautologous Graft</td>
</tr>
<tr>
<td></td>
<td>OSG03A1 “ “ Percutaneous Approach</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>MS-DRG</th>
<th>Description</th>
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<tr>
<td>459</td>
<td>Spinal Fusion Except Cervical with MCC</td>
</tr>
<tr>
<td>460</td>
<td>Spinal Fusion Except Cervical without MCC</td>
</tr>
</tbody>
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Inpatient Code Example – Coordinate with Surgeon
- Diagnosis
- ICD-9-CM Procedure depends on CPT codes
- Coordinate Authorizations

Every Code is a Chance for Error

ICD Diagnosis & ICD Procedure Combine to Assign MS-DRG

Working Together – Surgeons & Facilities
**Total Disc Arthroplasty (Artificial Disc Replacement)**

**Coding Pathways**

**Surgeon Performs 2 Level Anterior Cervical Disc Replacement**

**Physician Reporting for Reimbursement = CMS 1500**

|-------------------------|----------------------------------|
| 722.4 Degenerative Disc Disease | M50.30 Other cervical disc degeneration, unspecified cervical region  
M50.31 Other cervical disc degeneration, high cervical region  
M50.32 Other cervical disc degeneration, mid-cervical region  
M50.33 Other cervical disc degeneration, cervicothoracic region |

<table>
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<tr>
<th>CPT Codes</th>
<th>2013</th>
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<tr>
<td>Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical</td>
<td>22856</td>
</tr>
<tr>
<td>Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), each additional interspace, cervical (List separately in addition to code for primary procedure)</td>
<td>0092T</td>
</tr>
</tbody>
</table>

**Surgeon Code Example – Coordinate with Facility**

- Diagnosis
- CPT procedures
- Share documentation
- Coordinate Pre Auth
Total Disc Arthroplasty (Artificial Disc Replacement)
Coding Pathways

Surgeon Performs 2 Level Anterior Cervical Disc Replacement

OP & ASC Reporting for Reimbursement = UB-04

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<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>APC</th>
<th>APC Description</th>
<th>Status Indicator</th>
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<tbody>
<tr>
<td>22856</td>
<td>0208</td>
<td>Laminotomies and Laminectomies</td>
<td>Multiple Procedure Reduction Applies</td>
</tr>
<tr>
<td>0092T</td>
<td>0208</td>
<td>Laminotomies and Laminectomies</td>
<td>Multiple Procedure Reduction Applies</td>
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Possible Revenue Code for Device Reporting on UB-04

<table>
<thead>
<tr>
<th>Possible HCPCS Code – Payor Determined</th>
<th>Description – Reports Device</th>
</tr>
</thead>
<tbody>
<tr>
<td>L8699</td>
<td>Prosthetic implant, not otherwise specified</td>
</tr>
</tbody>
</table>


Second Level “T” Code requires support
Coordination and Communication Are Key to Reimbursement  

*Why does this matter?*

- With Better & Better Claim Processing Programs Payors are Coordinating their Reimbursements to Include both Physician and Facility Claims.
- When Reported Codes do not Match up – Entire Claims Are Denied – Both *Physician* and *Facility Payments* Can be Denied
- Medicare is Requiring *Surgeon* Documentation to Support Medical Necessity when Reviewing *Facility* Claims
- Even When Claims are Paid an Audit Can Take Back Payment if Documentation for a Procedure is Not Available – Both *Physician* and *Facility* are Responsible per their Payor Contracts
- Managing Prior Authorizations Together (Surgeons office, scheduler, and facility) Can Prevent Last Minute Scheduling Changes or Cancellations and Lost Reimbursements
Physician Documentation

- Detailed Documentation is More Essential Now than Ever
  (*Not Documented Not Done*)
- Procedure and Device Descriptions Need to be Precise
  - Payors Are Changing Policy Language to Justify “not medically necessary”
- Payor Guidelines Require Specific Indications and Diagnosis

- Watch for Clinical History Documentation

- Coding and Documentation Audits Are Commonplace

- New ICD-10 Codes Increase the Need for Specific & Detailed Documentation
How Can Documentation Impact Reimbursement? Why Me?

- Payors are Demanding Documented Data of Non-Surgical Treatment
- Specific Ortho and Spine Procedures are Targeted (Medicare OIG Plan)
- Denials Are Based on Support of Medical Necessity
- Facilities are Being Held Responsible for Surgeon Documentation Before the Procedure is Pre Authorized
- Or Worse Yet Claim Denial Happens After the Surgery (on the backend)
- Reviews and RAC Audits Can use Valuable Practice Time to Gather Supporting Documentation
- Why Ortho/Spine Procedures?
  - Many are Elective or Need Proof of Medical Necessity
  - Diagnosis Coding is Not Clearly Defined
  - More Emphasis on Evidence Based Medicine
  - Aging Population is Increasing Need for Procedures
  - Payor Policies are Vague at Best on Indications
  - New Technologies
Know Your Contracted Payor Guidelines

Knowing Payor Specific Policies Facilitates Reimbursement

• Know Your Revenue Process for Key Payors

• Revenue Process Involves
  • #1 Contract
  • #2 Provide Service (encounter)
  • #3 Coding & Billing Procedure
  • #4 Payment
  • #5 Performance Tracking/Appeals

• Consider Payor Mix Charts with Specific Policies
  • Specific Documentation Required for procedure / Indications
  • Coding guidelines
  • Coverage Policies and Guidelines
  • Prior Authorization Process / PA Appeal Specifics
  • Claim Denial Appeal Process

<table>
<thead>
<tr>
<th>CPT 29827</th>
<th>Requires Pre Authorization</th>
<th>Covered Procedure</th>
<th>Conservative Therapy Requirements</th>
<th>Imaging Requirements</th>
<th>Indications Or Contraindications</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Cigna</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>UHC</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Aetna</td>
<td>x</td>
<td></td>
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</table>
Coverage Considerations

Private Commercial Carriers

- Private Payors have Contracted Agreements with Providers for Reimbursement
- Carve Outs for Orthopedic & Spine Device Intensive Procedures Should Be Considered
- They May have Guidelines Other than those Established by Medicare
- Can have *Different* Reimbursement and Coverage, with *Different* Providers, in *Different* States.
- Medicare Values Often Used as Benchmark
- Policies Can Change Without Notice

UnitedHealthcare
Anthem
BlueCross BlueShield
Cigna
Humana
Aetna
Know Your Contracted Payor Guidelines

• **OP/ASCs** Should Review Each Payor Contract with **Joint & Spine Procedures** in Mind

  • Specific Codes for Common **MIS Procedures** Should be Identified

  • **HCPCS Codes** are Required to Report Most Devices used in **Joint & Spine Procedures**

  • Specific HCPCS Codes and Payment Methodologies Should Drive Contracted Fee Schedules
Coding and Coverage Considerations
Just Because There is a Valid Code Does Not Mean a Procedure is Covered

CODING
- Created by AMA/CMS
- Payor Specific Guidelines
- Reports Services
- Must Match Service Precisely
- Can be Controversial
- Must be Determined by Physician

COVERAGE
- Determined by Payor
- Coverage Varies By Payor
- Local Rules Apply
- Specific Plan has Impact
- Diagnosis Important
- New Technologies Often Uncovered
- Requires Proof of Efficacy for Coverage Decisions

Not Equal To
# FDA v CMS / Payors

## Differing Standards for Approval and Coverage

<table>
<thead>
<tr>
<th>FDA</th>
<th>CMS / Payors</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Safe and Effective”</td>
<td>“Reasonable and Necessary”</td>
</tr>
<tr>
<td>Benefits Outweigh Risks</td>
<td>Does the Evidence Permit Conclusions on Improvements in Net Health Outcome; Are Outcomes Replicable Outside the Lab; and is it Generalizable to the Medicare Population</td>
</tr>
</tbody>
</table>
What To Do With a T-Code or “unlisted” Code

- Many New Technologies & Procedures are Correctly Reported with a “T” Code or generic “unlisted” Code
- Called “T” Codes because they end with the Letter T (xxxxT)
- T- Codes are Temporary CPT Category III Codes for Emerging Technologies that have not been Fully Proved by AMA/CPT Standards
- FDA Approval, if Applicable, Should be Confirmed
- Medicare Does Not Assign RVUs or Payment Rates to T-Codes.
- At Times, Medicare Will Assign an APC Code to the T-Code
  - EXAMPLE - 0275T - Percutaneous laminotomy/laminectomy, lumbar
  - Assigned APC – 0208 – Laminotomies/Laminectomies
  - This APC Has an Assigned Medicare Reimbursement Value
  - This Can Help the OP/ASC Report for Reimbursement
- “unlisted” Codes Require Similar Treatment as T-Codes for Reimbursement
- Private Payors May Have Fee Schedules for Some “T” Codes
- Always Know Private Payor Guidelines When Using “T” Codes or “unlisted” Codes
- Yes, There is A Process that Can Help Get these Reimbursed
- Prior Authorization Time and Physician Commitment is Essential
“T” Code Strategies & “unlisted” Codes Too!

1. Include Any Common Procedures Reported with “T” Codes in Your Payor Contracts
   1. Surgeon Commitment to New Procedure A Must
   2. Both the Surgeon and the Facility Should be Involved
   3. If Both Do Not Get Reimbursed, Neither Will Continue

2. Know the Code Description Inside Out
   1. Many “T” Codes are Highly Bundled and Include Imaging, Bilateral and Multi – Levels (in spine)
   2. Make Sure to Report Correctly

3. Create a “Special Report” to describe the Procedure
   1. Include All Technical Information
   2. FDA Approval, Instructions for Use (device), Articles Supporting Efficacy
   3. Reason for Medical Necessity (Surgeon Narrative, Detailed Case Info)

4. Provide a “Crosswalk” Code for Reimbursement Valuation
   1. This should represent the Work, Skill and Time of the Procedure
   2. Do Not Report the “Crosswalk” Code
   3. Use it to Represent the Value of a Similar Procedure, Can be Different Anatomy

5. Always Take the Prior Authorization Process Through Appeal
   1. Most Payors Will Deny a Simple Prior Auth, Provide Detail & Clinical Support
Optimal Reimbursement for **Joint & Spine Surgical Procedures** Does Not Happen by Simply Submitting Codes and Waiting for Payment.

**Be Proactive**

Procedures Can and Should be Paid Correctly by Payors.

- **TRANSLATE**
  Clinical ➔ Codes

- **COOPERATE**
  Surgeon ➔ Facility

- **COMMUNICATE**
  Procedure ➔ Detailed OP Notes

- **CONTRACT**
  Provider ➔ Payor

- **INNOVATE**
  Technology ➔ Strategize

**HEALTH CARE ECONOMICS**
THANK YOU

Questions & Comments

Presented by:
Carolyn Neumann, BME, CPC
Senior Manager Coding and Coverage Access
cneumann@sha-mcra.com

FOR MORE INFORMATION CONTACT:
Todd Schuck | Senior Director- Business Development
Specialty Healthcare Advisers, LLC
63 East Center Street, Ste. 3A
Manchester, CT 06040
860.770.6742
tschuck@sha-mcra.com