

Tough Coding Issues Facing ASCs

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ASC Communications

Overview

- Quality of medical records
- MD query
- Incomplete documentation
- Documenting medical necessity
- Missing information
- NCCI or not?
- Claims match
- Specialty specifics
- Conclusion

Quality of Medical Records

[REDACTED]

PROCEDURE NOTE

DATE: [REDACTED]

PATIENT: [REDACTED]

PREOPERATIVE DIAGNOSIS: 1. Bilateral Knee DJD

POST OPERATIVE DIAGNOSIS: 1. Same

SURGEON: [REDACTED]
ASSISTANT: [REDACTED]

PROCEDURE: Left hip intraarticular injection under
fluoroscopic guidance

COMPLICATION: NONE
ANESTHESIA: LOCAL

PROCEDURE IN DETAIL:

After informed consent was obtained, the patient was placed in the prone position. The patient was prepped and draped in the usual sterile manner using Beta dine. The area was then anesthetized with 1% lidocaine. A 25-gauge needle was advanced under fluoroscopy to the left hip target region along with 1cc of Celestone was injected with resolution of pain to the left wrist. The patient tolerated the procedure extremely well without sedation.
Xray reviewed no evidence of fracture.

POST PROCEDURE: The patient noted no complication

PLAN: The patient is to return to the clinic in 1 week

[REDACTED]

MD Query

NMBS SURGEON QUERY FORM

Facility:

Patient Name:

Date of Service:

Date of Birth:

Physician:

Please take a moment to clarify the following information. This form will become part of the patient's medical record as an addendum to the operative report. The information that follows is required to complete the coding on this patient's account. Please check the correct line item box OR provide the missing information and sign below.

Please clarify which compartment(s) synovectomy was performed:

medial compartment

lateral compartment

patellofemoral compartment

MD Signature _____

Thank you,
Jessica Edmiston, CPC

Incomplete Documentation

- Inconsistencies within the operative report
- Procedure headings vs. actual description
- Blanks in the medical records
- Path reports and H&Ps

Medical Policies and LCDs

- Know how your carriers edit
- What if dictation doesn't support medical necessity?
- Leading vs. educating providers

Medical Policies and LCDs cont.

- United Healthcare
 - Ablative treatment for spinal pain
 - Frequency of six months or longer (maximum of two times over a 12 month period) and provided there has been a 50% or greater documented reduction in pain for 10-12 weeks
 - Documentation requirements must include:
 - Temperature of the administration
 - Duration of ablation
 - Specific identification of side and level of medial branch blocks
 - Specific cervical, thoracic and/or lumbar ablated by side and level
 - Percentage of pain relief with prior ablation if applicable
 - Duration of improvement from previous ablation if applicable
 - Specific diagnosis codes to support medical necessity

Medical Policies and LCDs cont.

- Anthem
 - Percutaneous neurolysis for chronic neck and back pain
 - Medical necessity
 - No prior spinal fusion surgery in the vertebral level
 - Pain that is not radicular
 - Low back or neck pain, suggesting facet joint origin
 - Pain that has failed to respond to three months of conservative management
 - A diagnostic temporary block with local anesthetic of the facet nerve or injection in to the facet joint that has resulted in at least a 50% reduction in pain
 - A minimum of six months has elapsed since prior RF treatment (per side, per anatomical level of the spine)

Medical Policy and LCDs cont.

- Medicare
 - Diagnostic colonoscopy
 - Medical necessity examples
 - Unexplained iron deficiency anemia
 - Evaluation within six months of the removal of sessile polyps to determine and document total excision. If evaluation indicates that residual polyp is present, excision should be done with repeat colonoscopy within six months. After evidence of total excision without return of the polyp, repeat colonoscopy yearly.
 - Evaluation at one and four year intervals after resection of multiple or large (> 10mm) adenomatous polyps. Subsequent surveillance intervals may then be increased to every five years.
 - Evaluation in one year after the removal of multiple adenomas. If examination proves negative then repeat in three years. After one negative three year follow up examination, repeat exam every five years.
 - Specific diagnosis codes to support medical necessity

Missing Information

- Reconciliation process
- Tracking for timely filing
- Potential lost revenue
- Approaching surgeons
- Unbilled report

NCCI or Not?

- What is your facility's policy?
- Which carriers utilize NCCI?
- What about workers' compensation?
- How do edit systems affect cash?

Claims Match

- Do you know when your facility codes do not match the professional codes?
- Do you know what happens when they don't?
- Put together a process to correct claims which do not match
- Negative balance invoicing

Common Specialty Clarifications: Screening Colonoscopy

- Diagnostic test only and symptoms should not be present
- Diagnosis on the operative report should list screening
- If other indications are listed as diagnoses, confirm with surgeon

Common Specialty Clarifications: Screening Colonoscopy Example

Colonoscopy Procedure Report

Patient:

Patient ID:

Exam Date:

Introduction: A 64 year old male patient presents for an elective outpatient Colonoscopy.

Indications: Indication of the procedure was

- * Change in bowel habits (787.99).
- * Screening.

Consent: The risks, hazards, and alternatives to continuous sedation were discussed with the patient. The nature of the procedure, its rationale, alternatives of the procedure, its potential benefits and complications (including, but not limited to, bleeding, perforation, infection, and adverse drug reaction) were explained to the patient who seemed to understand and indicated this. An opportunity for questions was provided and informed consent was obtained from the patient.

Preparation: EKG, pulse, pulse oximetry, and blood pressure were monitored throughout the procedure.

Medications:

- * MAC anesthesia.

Rectal Exam: Normal rectal exam.

Procedure: The colonoscope was passed through the anus under direct visualization and was advanced without difficulty to the cecum and terminal ileum, confirmed by appendiceal orifice, ileocecal valve, RLQ palpation, and landmarks. The scope was withdrawn and the mucosa was carefully examined. The quality of the preparation was good. The patient's toleration of the procedure was good. The views were good.

Findings: Normal TI and cecum. Fair prep. No large lesions seen but can not rule out small lesions. Mild sigmoid diverticulosis. No colitis seen, random biopsies done. Small internal hemorrhoids.

Unplanned Events: There were no unplanned events.

Summary:

- * Normal TI and cecum.
- * Fair prep. No large lesions seen but can not rule out small lesions.
- * Mild sigmoid diverticulosis.
- * No colitis seen, random biopsies done.
- * Small internal hemorrhoids.

Recommendations:

- * Follow-up on the results of the biopsy specimens in 2 weeks.
- * Start a high fiber diet
- * Daily fiber of your choice.
- * Annual FOBT per PMD
- * Repeat colonoscopy in 3 years with a 2 days prep.
- * Follow-up appointment with [REDACTED], M.D. in 2 weeks.
- * Follow-up appointment with referring physician on an as needed basis.

Procedure Codes:

- * [45378]Colonoscopy
- * [45380]Colonoscopy with biopsy

Common Specialty Clarifications: Bunionectomy

- Diagnosis driven procedure
- Patient must have a current bunion or bunion history
- AMA response for correction of hallux rigidus with implant

Common Specialty Clarifications: Bunionectomy Example

OPERATIVE REPORT
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OPERATIVE REPORT

PATIENT NAME:
DATE OF SURGERY:
HOSPITAL NUMBER:
PHYSICIAN:

PREOPERATIVE DIAGNOSIS: Hallux rigidus deformity, left foot.

POSTOPERATIVE DIAGNOSIS: Hallux rigidus deformity, left foot.

PROCEDURE PERFORMED: Keller arthroplasty with Arthrex hemi-implant, left foot.

ANESTHESIA: MAC.

DESCRIPTION OF PROCEDURE: The patient was brought to the operating room and placed on the operating room table in the supine position. The patient was given intravenous sedation by Anesthesia and then a total ankle block was performed using 9 mL of 1% Xylocaine mixed with 9 mL of 0.5% Marcaine plain. A pneumatic tourniquet was placed about the left ankle. The limb was then prepped and draped in the usual sterile manner, elevated at 45 degrees for 3 minutes, and then exsanguination was completed using an Esmarch bandage. At this time, the pneumatic tourniquet was inflated to 250 mmHg.

Attention was directed to the first MP joint on the left foot where a 6-cm dorsal linear incision was made. The incision was carried deep in the same plane with sharp and blunt dissection. Bleeders were bovied as necessary. Using a 15-blade, a linear capsulotomy was performed. All soft tissue attachments were dissected free from bone thus bringing the head of the first metatarsal into the surgical field. Inspection of the joint showed degenerative changes. There was damage to the cartilage on the metatarsal head and on the base of the proximal phalanx. Using a power saw, a small portion at the base of the proximal phalanx was resected. Also, removed were a medial eminence and the dorsal and lateral exostosis. The metatarsal head was then remodeled using power saw. A 0.045 K-wire was then used to fenestrate the areas of denuded cartilage on the metatarsal head down to good bleeding subchondral bone. The wounds were then flushed with sterile saline solution. Using proper instrumentation and sizes, it was determined that a 20-mm Arthrex hemi-implant would be appropriate.

This was then inserted into the joint using proper technique. The range of motion was extended without crepitus at this point. The wounds were then flushed with sterile saline solution and capsular repair was accomplished using 3-0 Vicryl, and then the skin edges were brought using 5-0 Vicryl subcuticularly. The skin was then dressed with tincture, benzoin, and Steri-Strips. At this time, 10 mL of 0.5% Marcaine plain was used for postoperative anesthesia. The wounds were then dressed with Adaptic, 4x4s, fluffs, and Kling in a compressive type manner. The pneumatic tourniquet was deflated and a normal hyperemia flush was seen to return in all digits on the left foot. An Ace wrap was applied from the toes to above the ankle in a decreasing compressive type manner. The patient tolerated the procedure and the anesthesia well, and left the OR to the recovery room with all vital signs stable and in apparent satisfactory condition.

Common Specialty Clarifications: Pain Management

- Transforaminal injections/selective nerve root block (CPT 64479-64483)
 - Transforaminal injection is reported per facet joint level
 - Selective nerve root block is reported per nerve
- New codes for RFAs (CPT 64633 – 64636)
 - Prior to 2012, reported per nerve
 - Effective 2012, reported per facet joint

Common Specialty Clarifications: Distal Radial Fracture

- CPT codes 25607, 25608 and 25609
- Is the fracture extra-articular or intra-articular?
- If intra-articular, need to know number of fragments fixated
- Accurate documentation necessary

Common Specialty Clarifications: Distal Radial Fracture Example

OPERATIVE REPORT

PATIENT NAME:
PATIENT ACCOUNT #:
SURGEON:
DATE OF OPERATION:

DATE OF BIRTH:

PREOPERATIVE DIAGNOSIS: Right distal radius diaphyseal displaced angulated fracture.

POSTOPERATIVE DIAGNOSIS: Right distal radius fracture, displaced angulated; oblique minimally angulated fracture of ulna.

OPERATION PERFORMED: Open reduction and internal fixation of right distal radius diaphyseal fracture, K-wire fixation x2.

ANESTHETIC: General.

ANESTHETIST:

FINDINGS: There was a transverse mildly comminuted fracture of the diaphyseal of the distal radius. This was reduced open and was stabilized with two cross 0.062 K-wires. In addition, there was an oblique minimally angulated fracture of the distal ulna, which did not require fracture fixation. The ulna was in good alignment after fixation of the radius. Blood loss was minimal. The compartments were soft.

INDICATIONS FOR PROCEDURE: This is an active 8-year-old male who recently sustained an injury to his right upper extremity while cross-country skiing in Valdez. He was seen and was noted to have a displaced angulated fracture of his distal radius. He was placed in splint then referred to Anchorage for further orthopedic treatment. He was brought to the operating room for stabilization and fixation of a displaced angulated distal radius fracture.

DESCRIPTION OF PROCEDURE: Following informed consent, the patient was brought to the operating room where general anesthetic was induced. The patient received 1 gram of Ancef intravenously. The splint of the right upper extremity was removed. The compartments were soft. A padded tourniquet was placed high on the right arm. The upper extremity was prepped with Hibiclens and then draped in the usual sterile technique.

OPERATIVE REPORT

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With an Esmarch bandage the limb was exsanguinated and the tourniquet was inflated to 200 mmHg and remained elevated during the procedure. Using 2.5X loupe magnification, a dorsal radial incision was centered over the fracture site. Subcutaneous bleeders were cauterized. The superficial fascia was incised. The sensory nerve was identified and gently retracted. The brachioradialis tendon was retracted. The periosteum was incised. The fracture hematoma was irrigated and removed. The fracture was grasped with reduction forceps distally and proximally. The fracture was reduced and then it was held with reduction forceps. Two 0.062 K-wires were placed from distal aspect of the radius from the radial and ulnar aspect of distal radius in a crisscross fashion across the fracture site stabilizing the fracture. Biplanar fluoroscopic imaging was used. There was also an oblique fracture of the ulna, which was overall in good alignment and was felt not to require any fixation. The elbow showed no fractures or dislocation. The K-wires were bent and were trimmed and placed with protective plastic caps. The wound was irrigated with saline then was closed in layers with 4-0 Monocryl at the periosteum, 3-0 Vicryl subcutaneous, and 4-0 Monocryl subcuticular skin closure. The skin was approximated with 1/2-inch Steri-Strips and then a sterile bandage was applied with Xeroform gauze over the pin sites, gauze over the Steri-Strips, followed by sterile cast padding. Then, 3-inch tubular stockinette was applied in the upper extremity followed by very well-padded volar and dorsal splint holding the wrist in neutral position. The tourniquet was deflated and removed. There was brisk return of capillary refill to the limb. Before closure, 15 mL of 0.5% Marcaine plain was infiltrated into subcutaneous and subperiosteal area for local anesthetic. The patient was awakened and brought to the recovery room having tolerated the procedure well.

POSTOPERATIVE PLAN: The postoperative plan is for recheck in approximately 1-1/2 to 2 weeks. At that time for splint removal, to be use entire right forearm and application of a fiberglass cast.

Common Specialty Clarifications: FESS/Turbinectomies

- Partial ethmoidectomy vs. total (CPT 31254 and CPT 31255)
- Is the specific turbinate mentioned?
- Is the specific method mentioned?
- Was tissue removed and, if so, what type?
- Accurate documentation of the different sinuses necessary

Common Specialty Clarifications: FESS/Turbinectomies Example

SURGEON:

SURGERY DATE:

PREOPERATIVE DIAGNOSIS

Nasal deformity secondary to nasal fracture
Septal deviation
Hypertrophy of turbinates

POSTOPERATIVE DIAGNOSIS

Nasal deformity secondary to nasal fracture
Septal deviation
* Hypertrophy of turbinates

PROCEDURE

* Septoplasty
* Turbinoplasty
Rhinoplasty

ESTIMATED BLOOD LOSS

100 ml

COMPLICATIONS

None

FINDINGS

Dorsal irregularity with osteochondral hump, wide dorsum
Left obstructive septal deviation anteriorly, severe right deviation at chondroethmoidal junction
* Hypertrophy of turbinates.

SPECIMENS

none

ANESTHESIA

OPERATIVE INDICATIONS

The patient is a 20 years old man with nasal deformity after nasal trauma. Pt also complaints of persistent severe nasal obstruction despite medical treatment with nasal sprays. Office evaluation revealed described deformity, with left obstructive septal deviation. R/B/A were discussed with patient, preop pictures were reviewed.

PROCEDURE IN DETAIL

The patient was positively identified and transferred onto the operating table in the supine position. Appropriate monitoring devices were put in place, general anesthesia was administered by anesthesiologist and patient intubated without complications, tube taped in midline.

The patient was prepped and draped in the usual clean fashion. Before proceeding further, a time-out was taken during which the patient's identification and planned surgical procedure were confirmed.

Topical oxymetazoline was applied with cotton pledgets to nasal cavities and 1% lidocaine with 1/100,000 epinephrine was injected to the septum on both right and left sides, intercartilaginous mucosa, and dorsum. After allowing adequate time for anesthetic and vasoconstrictive effect, surgery was begun by making an incision with a 15 blade along the intercartilaginous mucosa and caudal margin of the septum on the right side. Parallel incisions were done on left vestibule. Septal mucoperichondrial and mucoperiosteal flaps were elevated with the iris scissors and freer elevator bilaterally. Dorsal dissection was accomplished with iris scissors along the septal dorsal edge as well as the intercartilaginous space and above the superior lateral cartilages. An Aufrich elevator was used at the completion of dissection allowing visualization of dorsal deformity.

Attention was then brought to the septum, septal cartilage incised with freer, angled septal cartilage was removed. Septum Hartman scissors used to cut wedge of posterior septum removing the horizontal segment that was removed with Takahashi forceps. Nasal crest was medialized with agreeen stick fracture accomplished with Halstead forceps. Bilateral nasal cavities were then re-examined, and the longest nasal speculum could be passed back along the septum on both sides without meeting any resistance.

* Attention was then placed to turbinates, turbinoplasty performed by endocauterization achieved with coblation needle and out fracturing the turbinates

Attention was brought to the dorsum, and dorsal hump was excised with 15 blade on the cartilaginous portion and Citelli osteotome on the bony portion. Bone was rasped over the irregular R nasal bone until a smooth contour and straight profile was achieved. Medial and lateral osteotomies were performed, mobilizing nasal bones, correcting the nasal scoliosis.

Harvested septal graft was then carved into a wedge for a spreader graft. The spreader grafts was placed and fixed with 4/0 plain gut sutches on the left side, to counteract the curve of the cartilage. The lateral cartilages were sutured to the septum with 4-0 chromic sutches.

The incisions were closed using 4-0 chromic sutches. A 4/0 plain gut suture on a small Keith needle was used to place mattress type sutches to mucoperichondrial flaps. Septal splints were placed bilaterally and fixed with a 4/0 prolene transfexion stitch. The nasopharynx was then suctioned free of blood and secretions. Nasal Steristrip and dressing was applied.

Anesthesia was discontinued, draps were removed, patient awakened, extubated and taken to the recovery room in stable condition. All counts were correct at the end of the case, and no complications were encountered.

Common Specialty Clarifications: Lesion Excisions

- Depth
- Size
- Separate incisions
- Additional reimbursement

Common Specialty Clarifications: Lesion Excisions Example

OPERATIVE NOTE

PATIENT NAME:
DOB:
ID#

PROCEDURE DATE:
SURGEON:

PREOPERATIVE DIAGNOSES:

1. Chest wall mass.
2. Left shoulder mass.

POSTOPERATIVE DIAGNOSES:

1. Chest wall mass.
2. Left shoulder mass.

NAME OF PROCEDURE:

1. Resection of chest wall mass.
2. Resection of left shoulder mass.

ANESTHESIA: Local 1% lidocaine with IV sedation.

COMPLICATIONS: None.

ESTIMATED BLOOD LOSS: Minimal.

INDICATIONS FOR THE PROCEDURE: A 30-year-old female with symptomatic chest wall mass and symptomatic left shoulder mass.

PATHOLOGY: Two separate masses were labeled chest wall and left shoulder and sent to pathology.

DESCRIPTION OF PROCEDURE: Informed consent was achieved, and the patient was taken to the operating room and placed in the supine position on the operating table. IV sedation was administered in divided doses of Versed and Fentanyl. The patient's cardiovascular status was monitored. Total treatment time was one hour.

Both the chest wall mass and the left shoulder mass were prepped and draped in the usual sterile fashion. Time-out was performed and 1% lidocaine was utilized for local anesthesia. An ellipse of skin was taken from both the left shoulder as well as the mid chest/mid sternal region to account for the entire full-thickness extent of the lesion. Hemostasis was achieved in both wounds. Both wounds were

OPERATIVE NOTE

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closed in two-layers using 4-0 Vicryl and 4-0 Vicryl subcuticular sutures. Benzoin, Steri-Strips, and Telfa, and Tegaderm were placed. The patient was taken to the recovery room. She tolerated the procedure well. There were no complications.

Common Specialty Clarifications: Pain Block

- Medicare's National Correct Coding Initiative Policy Manual

- Chapter 8, section C. Nervous System, #15

“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, 62310-62319, 64400-64484, and 96360-96376 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.”

Common Specialty Clarifications: Conscious Sedation

- AMA issued opinion that all procedures whose description involves time must have an intra-service duration of more than 50% of the time interval to be billed
- Intra-service refers to the time spent providing the service as oppose to pre-time or post time.
- Conscious sedation (CPT 99144) for the first 30 minutes must span at least 16 minutes to be billed
- Conscious sedation (CPT 99145) for each additional 15 minutes must have an intra-service time of at least eight minutes to be billed
- Start and stop time must be documented in order to bill for service

Common Specialty Clarifications: Topaz Ablation Including Wand

- Topaz grid procedure performed for plantar fasciitis in the foot and epicondylitis of the elbow
- Minimally invasive procedure
- CPT code is unlisted due to procedure performed for Topaz grid procedure

Common Specialty Clarifications: Subtalar Arthrodesis vs. Arthroereisis

- Arthrodesis (CPT 28725) is fusing a joint due to instability
- Arthroereisis (CPT 28899, S2117) is placing an implant to reposition and stabilize the rear foot

Common Specialty Clarifications: Subacromial Decompression

- Arthroscopic subacromial decompression (CPT 29826) changes for 2012
 - Add on code to 29806 – 29825, 29827, 29828
 - Cannot be reported as a stand alone code
 - What if it's being billed with an open rotator cuff repair?

Conclusion

Revenue Cycle Management
It's All We Do. It's All We Think About.
And We Excel At It.

Thank You



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