Mark Rekant M.D.

Associate Professor
Department of Orthopaedic Surgery
Philadelphia Hand to Shoulder Center
Thomas Jefferson University

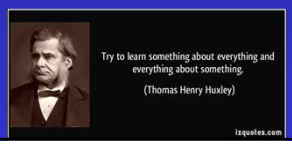
PHILADELPHIA HAND TO SHOULDER CENTER Formerly The Philadelphia & South Jersey Hand Center

Jefferson University and Hospitals

Coding Tips
Take 'em or Leave 'em

Educational objectives

- Illustrate how the documentation of a patient encounter is converted into revenue
- Utilize common coding/billing terms
- Outline variables that can affect reimbursement
  - Global packages
  - Medicaid/Medicare requirements
- Discuss common reasons claims are declined



Why do physicians need to know about coding and billing? Won't the office staff take care of it?

- Physicians must…
  - Create an accurate medical record that is compliant with coding terminology and rules.
  - Provide good patient care
  - Minimize liability and fraud issues
  - Develop habits that will translate into time-savings and reimbursement for services.

You can't bill just for what is done…you only can bill for what is done *and documented*!

Ramifications of Coding and Compliance

- **Institutional**: Multi-million dollar fines
- **Practice Group:**
  - Increase collections
  - Decrease claim inquiries and denials
- **Individual:**
  - Compensation and measurement of work performed
  - Protect against criminal prosecution for fraud
- **For the Patient:**
  - Describes patient conditions and treatment

Coding Basics 101

- Basic coding terminology and how it impacts billing and reimbursement:
  - CPT *Current Procedural Terminology*
  - ICD-10 *International Classification of Diseases, 10th revision*
  - RBRVs (RVUs) *Resource-Based Relative Value Scale*
  - E/M codes *Evaluation and Management*

CPT Codes

CTS – 64721
ORIF DR fx – 25609
Digital Artery Repair - 35206

- Each code is unique and consists of 5 digits
- The first digit of each code is determined by its category
  - 2/3/6 XXXX indicates a surgical (or procedural) code
  - 7XXXX indicates a radiological code
  - 9XXXX indicates a medical code
- Any of these codes can be used by any type of physician, they are not restricted to a speciality
- CPT codes and their descriptors are created by the AMA CPT Editorial Panel assisted by the AMA CPT Advisory Committee

RBRVS (Resource-Based Relative Value Scale)

- Schema used to determine how much medical providers should be paid by CMS for any given code
- RBRVS assigns procedures *relative value units (RVU)* which are adjusted by geographic region
- This value is then multiplied by a fixed *conversion factor,* which changes annually, to determine $$
- RBRVS determines prices based on three separate factors:
  - Physician work (52%)
  - Practice expense (44%)
  - Malpractice expense (4%)

Same procedure, differing reimbursement based on location

- **Example for determining reimbursement for a biopsy**

Performed in a Physician's Office in Wyoming

	RVUs		GPCI		RVUs
Work	1.53	x	1.000	=	1.5300
Practice Expense	1.38	x	1.000	=	1.3800
Liability	0.19	x	1.050	=	0.1995
Total adjusted RVUs (3.1095) x Conversion Factor ($35.89) = $111.60					

Practice expense is more in office

Performed in a Surgery Center in Wyoming

	RVUs		GPCI		RVUs
Work	1.53	x	1.000	=	1.5300
Practice Expense	0.78	x	1.000	=	0.7800
Liability	0.19	x	1.050	=	0.1995
Total adjusted RVUs (2.5005) x Conversion Factor ($35.89) = $89.74					

Adapted from ACOG Coding Cases 2017

BH147

Same procedure, differing reimbursement based on geography

- Example for determining reimbursement for a biopsy

Performed in a Physician's Office in Kentucky

	RVUs		GPCI		RVUs
Work	1.53	x	1.000	=	1.5300
Practice Expense	1.38	x	0.876	=	1.2089
Liability	0.19	x	0.807	=	0.1533
Total adjusted RVUs (2.8922) x Conversion Factor ($35.89) = $103.80					

Cost of providing the service is more in Chicago

Adapted from ACOG Coding Cases 2017

Performed in Physician's Office in Chicago

	RVUs		GPCI		RVUs
Work	1.53	x	1.012	=	1.5484
Practice Expense	1.38	x	1.036	=	1.4297
Liability	0.19	x	1.972	=	0.3747
Total adjusted RVUs (3.3528) x Conversion Factor ($35.89) = $120.33					

RUC Committee

- RUC stands for AMA/Specialty Society Relative Value Scale Update Committee (RUC)
- This committee acts as an expert panel in developing RVS update recommendations to CMS in making adjustments to the RBRVS

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Our Government

- CMS is mandated to make appropriate adjustments to the RBRVS in response to the Omnibus Budget Reconciliation Act of 1989 to account for changes in medical practice coding and new data and procedures

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Slide 10

BH147 Yes, it should be updated to refer to 2017.
Bradley Hart, 6/23/2017

Make-Up of RUC Committee

- The committee has 31 members
- The AMA Board of Trustees selects the RUC chair and also the AMA representative to the RUC
- The individual RUC members are nominated by the specialty societies and are approved by the AMA
- Orthopaedic representation is minimal (one)

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All of these terms are used to denote some aspect of your "work" converted to Insurance Payor language

- ICD-10- diagnosis (Why you provided services)
- CPT- services provided. (What you did)
- RVUs- numeric value assigned to each CPT code that translates into "work" and $.

Like a slot machine, you need 3 cherries to get paid:

- Correct CPT code for a medically necessary service
- Correct ICD-10 code to support the CPT code
- *The service is covered by the patient's policy or contract*

However, it is not a matter of luck -- it is all within your control.

Breaking it down…

- Patient Encounter
  - Doing the Work
- **Documentation**
  - **Accurately recording the Work**
- Coding
  - Converting the Work into numeric code(s)
- Billing
  - Charging for the Work
- Payment
  - Receiving Reimbursement for the Work

Basic Documentation & Coding

Document: **What** you did (CPT)
Why you did it (ICD-10)

and code: **What** you documented

Documentation

- Important part of the coding of a procedure
- It is critical that what was done be documented in a manner that can be easily understood by another person who might have a reason to read the operative report
- If the documentary evidence does not support the coding, it is problematic

The 7 Key Documentation Elements:

1. Acuity – acute versus chronic
2. Site – be as specific as possible
3. Laterality – right, left, bilateral for paired organs and anatomic sites
4. Etiology – causative disease or contributory drug, chemical, or non-medicinal substance
5. Manifestations – any other associated conditions
6. External Cause of Injury – circumstances of the injury or accident and the place of occurrence
7. Signs & Symptoms – clarify if related to a specific condition or disease process

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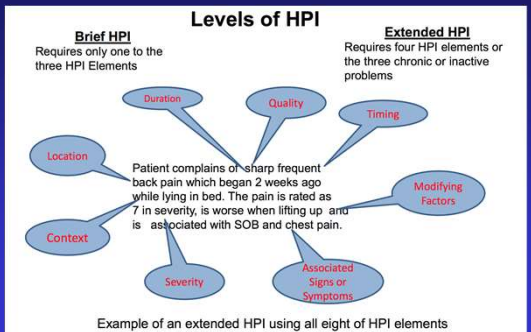
Documentation Tips



Example of an extended HPI using all eight of HPI elements

Documentation Strategy

- Document to the highest level of specificity
- All diagnoses must include assessment/plan
- Avoid "h/o" or "s/p" for active disease: implies past condition
- Use linking terms: "due to" or "secondary to"
- For each diagnosis,
  - Indicate "treatment plan" such as "refer to…", "observation…
  - Indicate "assessment" such as "stable", "worsening", "not responsive to …"

Documentation Summary

- ***Golden Rule of Documentation***
  - If it isn't documented by the physician, it didn't happen
  - If it didn't happen, it can't be billed
- The purpose in documentation is to tell the story of what was performed and what is diagnosed accurately
  - What services were rendered and what is the severity of illness
- **Claims review & payment**
- **Continuity of care (**Improved coordination of care)
- **Research/education**
- **Medical necessity/risks**
- **Medical Liability**

Breaking it down…

- Patient Encounter
  - Doing the Work
- Documentation
  - Accurately recording the Work
- **Coding**
  - **Converting the Work into numeric code(s)**
- Billing
  - Charging for the Work
- Payment
  - Receiving Reimbursement for the Work

Coding your diagnosis-ICD10

- **International Classification of Diseases, 10th Edition**
- Implemented October 1, 2015:
- ICD-10-CM :
  - For use in all U.S. health care settings
  - Uses 3–7 alpha-numeric characters
  - ~68,000 individual diagnosis codes

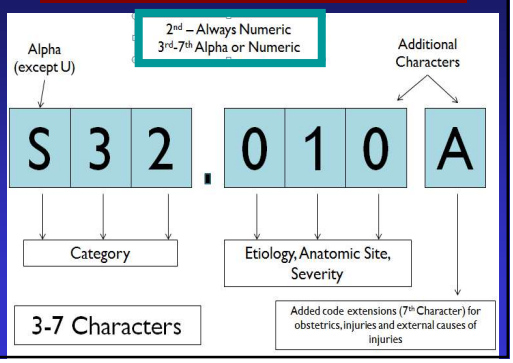
ICD-10 replaced ICD-9

- Provides greater specificity and clinical information
  - Improved ability to measure health care services
  - Enhanced ability to conduct public health surveillance
- Captures additional advancements in clinical medicine

Diagnosis Code Structure

ICD-9-CM (Volume 1 & 2)	ICD-10-CM
3-5 characters in length	3-7 characters in length
Approximately 14,000 codes	Approximately 68,000 codes
First digit may be alpha (E or V) or numeric; digits 2-5 are numeric	Digit 1 is alpha (to indicate the category); Digit 2 is numeric (in the future, alpha characters may be used if code expansion is needed); Digits 3-7 can be alpha or numeric
Limited space for adding new codes	Flexible for adding new codes
Lacks detail	Very specific
Lacks laterality	Includes laterality (i.e., codes identifying right vs. left)

ICD-10-CM Diagnosis Code Format



Fifth/Sixth Characters

- Identifies the most precise level of specificity
- Example:
  - S55.011- Laceration of ulnar artery at forearm level, right arm

3 - S55 is a category for injury of blood vessels at forearm level
4 - S55.0 specifies the injury is at the ulnar artery at the forearm level
5 - S55.01 specifies it is a laceration
6 - S55.011 specifies it is of the right arm

- A 7th character extender is also required

Seventh Character Extenders

- Required for certain categories
- Must always remain in the 7th character
- Explains the status or encounter

Seventh Character Extenders

Examples:

A – Initial Encounter

D – Subsequent Encounter

S – Sequela- complications or conditions arising from the injury

Dummy Placeholders

- Used for those codes that require a 7th character extender that do not consist of 6 characters and represented by the letter "x"

Dummy Placeholders

- Used for those codes that require a 7th character extender that do not consist of 6 characters and represented by the letter "x"

Example

- A patient is treated for the first time for a pathological fracture.
  - M84.40**XA** Pathological fracture, unspecified site, initial encounter for fracture

Coding Strategy

- Code to highest level of specificity
- Only code confirmed diagnosis or diagnoses
  - Code the presenting signs and/or symptoms. ONLY if diagnosis is not yet confirmed
- Code all conditions managed on that visit
- Code all conditions that co-exist at time of encounter that impact visit diagnosis

How can I find all this information??

- Professional Organizations
  - AMA / AAOS
  - ASSH / AAHS
- Governmental Agencies
  - Centers for Medicare and Medicaid Services- CMS (cms.gov)
- Books, Computer Programs, Mobile Phone Apps
- Conferences
  - CODING WORKSHOPS!!!!
- Come to Philly for a visit (**and an Eagles game**)

OK. Basic E/M coding . . .

Evaluation and Management (E/M) Services Codes

- **Services** provided in the **diagnosis and treatment** of illness, disease, and symptoms (ICD-10).
- Divided into broad categories:
  - **-Office visits, hospital visits, consultations**
- Subcategorized as:
  - **-New vs. established** patient
  - **-Initial vs subsequent** hospital visits.

Choosing The Correct E/M Code

- Location where services are rendered
- Type of service
- Chief complaint
- Components of History documented- HPI, ROS, Past, Family, and Social History (PFSH)
- Components of Examination
- Medical Decision-making
- +/- Time, counseling, coordination of care

- New Patient- must meet 3 of 3
- Established Patient- need 2 of 3

E/M Coding

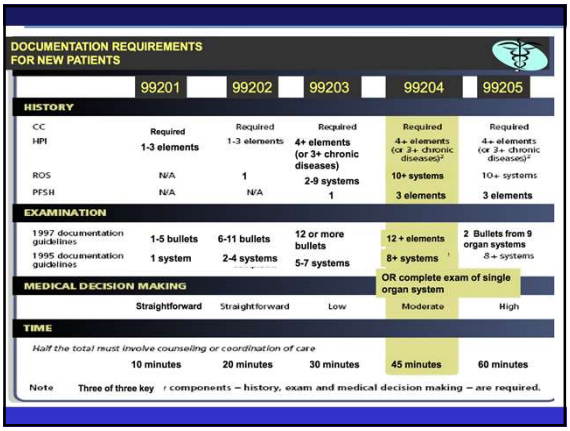
- **Key areas of documentation**
  - **History**
    - Chief Complaint
    - History of Present Illness
    - Past Medical History, Allergies, Medications, Social History, Family History, Review of Systems
  - **Physical Examination**
    - Examination of up to 14 organ systems
  - **Medical Decision-Making**
    - Differential diagnosis, Complexity of case

Who is a NEW patient?

- **New** Patient
  - Has **not** been seen by same specialty and subspecialty member of your group in past 3 years
  - E/M must **meet all 3** key components (History, Exam, Medical decision-making) or be based on time.
- **Established** Patient
  - Seen by same specialty and subspecialty member of your group in past 3 years
  - E/M must **meet 2 of 3** key components (History, Exam, Decision-making) or be based on time.

Rules on Time with E/M codes

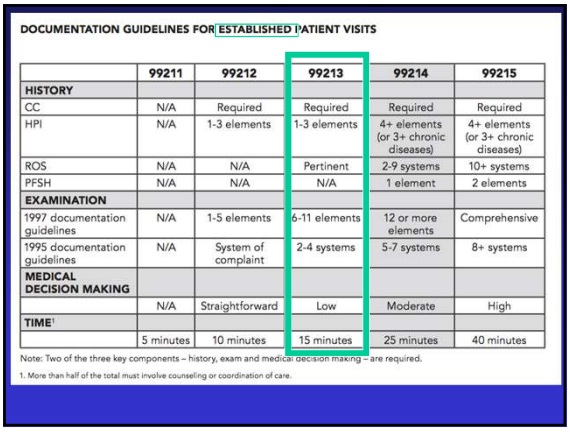
- Time determines the E/M level **only** where counseling or coordination of care dominates >50% of the encounter.
- **Documentation should include:**
  - Total amount of time spent by MD
  - Amount of time spent in counseling
  - Summarized content of encounter
  - Clear medical necessity



DOCUMENTATION REQUIREMENTS FOR NEW PATIENTS

	99201	99202	99203	99204	99205
HISTORY					
CC	Required	Required	Required	Required	Required
HPI	1-3 elements	1-3 elements	4+ elements (or 3+ chronic diseases)	4+ elements (or 3+ chronic diseases)[2]	4+ elements (or 3+ chronic diseases)[2]
ROS	N/A	1	2-9 systems	10+ systems	10+ systems
PFSH	N/A	N/A	1	3 elements	3 elements
EXAMINATION					
1997 documentation guidelines	1-5 bullets	6-11 bullets	12 or more bullets	12+ elements	2 Bullets from 9 organ systems
1995 documentation guidelines	1 system	2-4 systems	5-7 systems	8+ systems	8+ systems
MEDICAL DECISION MAKING				OR complete exam of single organ system	
	Straightforward	Straightforward	Low	Moderate	High
TIME					
Half the total must involve counseling or coordination of care					
	10 minutes	20 minutes	30 minutes	45 minutes	60 minutes

Note: Three of three key components – history, exam and medical decision making – are required.



DOCUMENTATION GUIDELINES FOR ESTABLISHED PATIENT VISITS

	99211	99212	99213	99214	99215
HISTORY					
CC	N/A	Required	Required	Required	Required
HPI	N/A	1-3 elements	1-3 elements	4+ elements (or 3+ chronic diseases)	4+ elements (or 3+ chronic diseases)
ROS	N/A	N/A	Pertinent	2-9 systems	10+ systems
PFSH	N/A	N/A	N/A	1 element	2 elements
EXAMINATION					
1997 documentation guidelines	N/A	1-5 elements	6-11 elements	12 or more elements	Comprehensive
1995 documentation guidelines	N/A	System of complaint	2-4 systems	5-7 systems	8+ systems
MEDICAL DECISION MAKING					
	N/A	Straightforward	Low	Moderate	High
TIME[1]					
	5 minutes	10 minutes	15 minutes	25 minutes	40 minutes

Note: Two of the three key components – history, exam and medical decision making – are required.

1. More than half of the total must involve counseling or coordination of care.

DOCUMENTATION GUIDELINES FOR ESTABLISHED PATIENT VISITS

	99211	99212	99213	99214	99215
HISTORY					
CC	N/A	Required	Required	Required	Required
HPI	N/A	1-3 elements	1-3 elements	4+ elements (or 3+ chronic diseases)	4+ elements (or 3+ chronic diseases)
ROS	N/A	N/A	Pertinent	2-9 systems	10+ systems
PFSH	N/A	N/A	N/A	1 element	2 elements
EXAMINATION					
1997 documentation guidelines	N/A	1-5 elements	6-11 elements	12 or more elements	Comprehensive
1995 documentation guidelines	N/A	System of complaint	2-4 systems	5-7 systems	8+ systems
MEDICAL DECISION MAKING					
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TIME[1]					
	5 minutes	10 minutes	15 minutes	25 minutes	40 minutes

Note: Two of the three key components – history, exam and medical decision making – are required.

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Who is Interested Now ?

99211	$35.51
99212	$51.73
99213	$71.67
99214	$97.36
99215	$117.36

50%

DOCUMENTATION GUIDELINES FOR ESTABLISHED PATIENT VISITS

	99211	99212	99213	99214	99215
HISTORY					
CC	N/A	Required	Required	Required	Required
HPI	N/A	1-3 elements	1-3 elements	4+ elements (or 3+ chronic diseases)	4+ elements (or 3+ chronic diseases)
ROS	N/A	N/A	Pertinent	2-9 systems	10+ systems
PFSH	N/A	N/A	N/A	1 element	2 elements
EXAMINATION					
1997 documentation guidelines	N/A	1-5 elements	6-11 elements	12 or more elements	Comprehensive
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MEDICAL DECISION MAKING					
	N/A	Straightforward	Low	Moderate	High
TIME[1]					
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HISTORY					
CC	N/A	Required	Required	Required	Required
HPI	N/A	1-3 elements	1-3 elements	4+ elements (or 3+ chronic diseases)	4+ elements (or 3+ chronic diseases)
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EXAMINATION					
1997 documentation guidelines	N/A	1-5 elements	6-11 elements	12 or more elements	Comprehensive
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MEDICAL DECISION MAKING					
	N/A	Straightforward	Low	Moderate	High
TIME[1]					
	5 minutes	10 minutes	15 minutes	25 minutes	40 minutes

Note: Two of the three key components – history, exam and medical decision making – are required.

1. More than half of the total must involve counseling or coordination of care.

The importance of a ROS

	99201	99202	99203	99204	99205
HISTORY					
CC	Required	Required	Required	Required	Required
HPI	1-3 elements	1-3 elements	≥ 4 elements OR ≥ 3 chronic or Inactive conditions	≥ 4 elements OR ≥ 3 chronic or Inactive conditions	≥ 4 elements OR ≥ 3 chronic or Inactive conditions
ROS	N/A	1 system	2-9 systems	10-14 systems	10-14 systems
PFSH	N/A	N/A	1 element	3 elements	3 elements
PHYSICAL EXAMINATION					
1995	1 System	2-4 systems	5-7 systems	≥ 8 systems	≥ 8 systems
1997	1-5 elements	6-11 elements	≥ 12 elements	Comprehensive	Comprehensive
MEDICAL DECISION MAKING					
Level	SF	SF	Low	Moderate	High
TIME					
Face-to-face	10 min	20 min.	30 min	45 min.	60 min

1.24 RVU =$45.74

3.05 RVU =$112.51

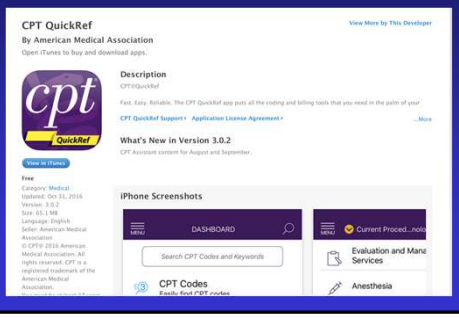
You forget to document an ROS, you automatically go to a **Level I MAX** for a new patient

How do I keep it straight???

- A good form or well-constructed template can be your friend…
- Place commonly used diagnosis and/or CPT and E/M codes in one area
  - This is true with paper charts and EMR

E/M Codes- Helpful tools

- Pocket Reference Cards
- Apps



I got it….What? There's more??

- There are still several more things you need to know…
  - Global Periods and Packages
  - Variables that can affect your reimbursement
    - Multiple procedures
    - Bilateral Procedures
    - Asst Surgeon Fees
  - Modifiers

Multiple Procedures

- You are paid 100% for the 1st procedure and 50% for each procedure thereafter
- Know total RVUs for each procedure to determine which procedure to list as Primary
- Medicare – pays up to 4 procedures (5th free)

Global Periods

- Defined as the period of time for which one may not bill related office visits/consultations
- For Medicare this is either
  - 0 days (minor surgeries)
  - 10 days (minor surgeries)
  - 90 days (major surgeries)

How do I know which one has what??

Check that RVU table!

CODE	MEDICARE DESCRIPTION	RELATIVE VALUE UNITS (RVUs) Work	PRACTICE EXPENSE Non-Facility	PRACTICE EXPENSE Facility	Practice Liability	TOTAL RVUs Non-Facility	TOTAL RVUs Facili	GLOBAL SURGICAL DAYS	LOBAL PACKAGE % DISTRIBUTION re-Op	Intra-Op	Post-Op	PAYMENT ADJUSTED FOR Multiple Procs	Bilateral Procs	ADDITIONAL PAYMENT FOR Asst Surgeon	Co-Surgeon
58661	Laparoscopy remove adnexa	11.35	5.55	5.55	1.62	18.52	[illegible]	010	[illegible]	80%	10%	Endo 49320	Yes	Yes	Yes
58662	Laparoscopy excise lesions	12.15	6.41	6.41	1.67	20.23	[illegible]	090	[illegible]	84%	7%	Endo 49320	No	Yes	Yes
58670	Laparoscopy tubal cautery	5.91	3.74	3.74	0.70	10.35	[illegible]	090	[illegible]	80%	10%	Endo 49320	No	No	Yes
58671	Laparoscopy tubal block	5.91	3.73	3.73	0.68	10.32	[illegible]	090	[illegible]	80%	10%	Endo 49320	No	No	Yes
58672	Laparoscopy fimbrioplasty	12.91	6.41	6.41	1.50	20.82	[illegible]	090	[illegible]	80%	10%	Endo 49320	Yes	Yes	No
58673	Laparoscopy salpingostomy	14.04	6.96	6.96	1.66	22.66	[illegible]	090	[illegible]	80%	10%	Endo 49320	Yes	Yes	No
58674	Laps abltj uterine fibroids	14.08	7.51	7.51	1.64	23.23	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Yes
58700	Removal of fallopian tube	12.95	7.24	7.24	2.03	22.22	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58720	Removal of ovary/tube(s)	12.16	6.88	6.88	2.04	21.08	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58740	Adhesiolysis tube ovary	14.90	8.05	8.05	2.25	25.20	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58750	Repair oviduct	15.64	8.78	8.78	3.03	27.45	[illegible]	090	[illegible]	74%	14%	Yes	Yes	Yes	Maybe
58752	Revise ovarian tube(s)	15.64	8.04	8.04	2.12	25.80	[illegible]	090	[illegible]	74%	14%	Yes	Yes	Yes	No
58760	Fimbrioplasty	13.93	7.38	7.38	1.62	22.93	[illegible]	090	[illegible]	74%	14%	Yes	Yes	Yes	Maybe
58770	Create new tubal opening	14.77	7.47	7.47	2.58	24.82	[illegible]	090	[illegible]	74%	14%	Yes	Yes	Yes	No
					Ovary										
58800	Drainage of ovarian cyst(s)	4.62	3.80	3.25	0.56	8.98	[illegible]	090	[illegible]	74%	14%	Yes	No	No	No
58805	Drainage of ovarian cyst(s)	6.42	4.33	4.33	0.76	11.51	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58820	Drain ovary abscess open	4.70	3.75	3.75	0.84	9.29	[illegible]	090	[illegible]	74%	14%	Yes	Yes	Yes	No
58822	Drain ovary abscess percut	11.81	6.64	6.64	1.37	19.82	[illegible]	090	[illegible]	74%	14%	Yes	Yes	Yes	Maybe
58825	Transposition ovary(s)	11.78	7.24	7.24	2.56	21.58	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58900	Biopsy of ovary(s)	6.59	4.35	4.35	0.80	11.74	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58920	Partial removal of ovary(s)	11.95	6.84	6.84	2.76	21.55	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58925	Removal of ovarian cyst(s)	12.43	6.95	6.95	1.92	21.30	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58940	Removal of ovary(s)	8.22	5.38	5.38	1.44	15.04	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58943	Removal of ovary(s)	19.52	10.35	10.35	3.85	33.72	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58950	Resect ovarian malignancy	18.37	10.40	10.40	3.74	32.51	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58951	Resect ovarian malignancy	24.26	12.65	12.65	4.99	41.90	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58952	Resect ovarian malignancy	27.29	14.42	14.42	5.71	47.42	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58953	Tah rad dissect for debulk	34.13	17.43	17.43	7.11	58.67	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58954	Tah rad debulk/lymph remove	37.13	18.77	18.77	7.84	63.74	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58956	Bso omentectomy w/tah	22.80	12.40	12.40	4.63	39.83	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58957	Resect recurrent gyn mal	26.22	14.00	14.00	5.58	45.80	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58958	Resect recur gyn mal w/lym	29.22	15.26	15.26	6.04	50.52	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
58960	Exploration of abdomen	15.79	8.87	8.87	3.21	27.87	[illegible]	090	[illegible]	74%	14%	Yes	No	Yes	Maybe
					In Vitro Fertilizatio										
58970	Retrieval of oocyte	3.52	2.38	1.75	0.42	6.32	[illegible]	000	[illegible]	0%	0%	Yes	No	Maybe	No
58974	Transfer of embryo	0.00	0.00	0.00	0.00	0.00	[illegible]	000	[illegible]	0%	0%	Yes	No	Yes	Maybe
58976	Transfer of embryo	3.82	2.84	1.88	0.52	7.18	[illegible]	000	[illegible]	0%	0%	Yes	No	Yes	Maybe
					MATERNITY CARE AND D LIVERY										
					Antepartum Servic										
59000	Amniocentesis diagnostic	1.30	1.97	0.72	0.33	3.60	[illegible]	000	[illegible]	0%	0%	Yes	No	No	No
59001	Amniocentesis therapeutic	3.00	1.45	1.45	0.76	5.21	[illegible]	000	[illegible]	0%	0%	Yes	No	No	No
59012	Fetal cord puncture prenatal	3.44	1.57	1.57	0.88	5.89	[illegible]	000	[illegible]	0%	0%	Yes	No	Maybe	No
59015	Chorion biopsy	2.20	1.72	1.08	0.57	4.49	[illegible]	000	[illegible]	0%	0%	Yes	No	Maybe	No
59020	Fetal contract stress test	0.66	1.21	1.21	0.16	2.03	[illegible]	000	[illegible]	0%	0%	No	No	Maybe	No

Post-op complications and the global fee

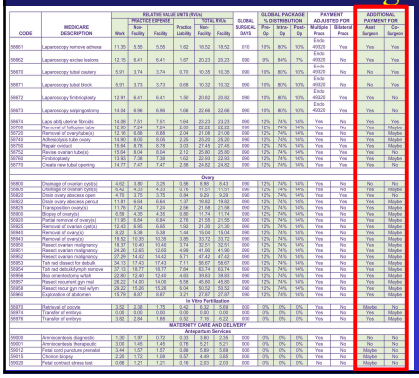
- The global fee generally covers all additional medical or surgical services required of the surgeon during the postoperative period of surgery because of complications **which do not require an additional trip to the operating room**

Co-surgeon vs Assistant

- What if my partner helps me??
  - Some procedures allow for payment of co-surgeons or assistants
    - Co-surgeons each receive 62.5% of allowable amount
    - Asst surgeon receives 16% of allowable amount
    - Primary surgeon still receives 100%

How do I know if an assistant is allowed??

Check the RVU table- again



An asst surgeon is SAME specialty
A co-surgeon is DIFFERENT boarded specialty

"Maybe" requires documentation of medical necessity for both surgeons

Modifiers

Used to describe special circumstances, such as:

- Unusual events
- A service that was:
  - Provided more than once
  - Prolonged
  - Unrelated to the original surgery or procedure
  - Mandated by a 3rd party carrier
- A service/procedure with both a professional & technical component.

E/M Modifiers

-22 Procedure requiring significantly more work than typical

-24 Unrelated E/M service during postop period

-25 Significant, separately identifiable E/M service on same day of procedure

-26 Professional component only

-32 Mandated services

-52 Reduced services or procedure

-57 E/M service that resulted in decision for surgery on day of or day before surgery

E/M and Procedure Same Visit

- Generally insurers will not pay for an office visit and a procedure on the same day unless you apply a modifier
- Modifier -25 applies to a "significant, separately identifiable E&M service by the same provider on the day of a procedure"
  - Example: A patient is seen for a trigger finger, you evaluate, and you provide a cortisone injection at the same visit.
  - Use Two different ICD-10 codes (painful finger & trigger finger) – ONE FOR EACH CPT code

Procedure Only Visit

- If the patient presents for procedure only, you should NOT bill an E/M code in addition to the CPT procedural code.
  - Intra-office trigger finger release

Why didn't I get paid?

- Poor documentation
  - Doesn't justify the procedure done
  - Doesn't support the level of service coded
  - CPT or ICD-10 code is invalid or doesn't match
- Didn't file the claim in a timely manner
- Missing or misplaced information on the claim form
  - Patient ID
  - Date of Service
  - Provider name/NPI number mission
  - Provider tax ID missing/incorrect
  - Filing duplicate claim forms
- Not a covered service

Did I get paid properly ?

- Look at the explanation for denial
  - Fix the problem, if there is one, then resubmit
    - Provide the information they are asking for
  - Resubmit your claim as it stands with a letter requesting reconsideration
    - Include why you did what you did in the letter
- This can be a lot of work…can take a lot of time…and you may still not get reimbursed
- Endeavor to do it right the first time !
  - Clear documentation
  - Appropriate ICD10 code
  - CPT supported by documentation

References and Resources

- Centers for Medicare & Medicaid Services
  - www.cms.gov
- American Academy of Orthopaedic Surgery
  - www.aaos.org
    - Committee on Health Economics and Coding
    - RVU charts
- American Medical Association
  - www.ama-assn.org
- E/M University
  - Emuniversity.com