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MEET THE PRESENTER

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On the topic:
Compliance Auditing for Surgical Procedures
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CPT® is a registered trademark of the American Medical Association.
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Compliance Auditing for Surgical Procedures

Agenda

- Review —
  - Auditing Criteria
    - Documentation
  - Global Surgical Days
  - Modifiers
  - CCI Edits
  - Operative/Procedure Note
  - ICD-10 CM Surgical Guidelines
  - Common Mistakes
Why

- All Medical Services are now subject to external review by federal/state agencies or contractors.
- Bounty Hunter approach
- Review is more than just looking at the coding.

Knowledge Needed

- Medical Terminology
- MAC Rules
- CPT Rules
- ICD Coding Guidelines
- CCI Edits
CPT

- Surgical Section
  - 16 subsection
  - By body area, hand
  - Then by site, finger
  - There are coding guidelines for each section
  - Must follow these coding guidelines

Coding Guidelines

- Procedural Coding Expert—excellent resource to ensure accuracy in review of surgical/procedural records
- Includes Global Days
- Medically Unlikely Edit (MUE)
- Modifier Crosswalk
- CPT Assistant Article Reference
These codes are used for the removal of foreign material and devitalized or contaminated tissue from eczematous or infected skin until surrounding healthy tissue is exposed. After debridement, antibiotics or topical lubricants are applied to the skin. Code 11000 reports debridement of up to 10% of the body surface. Use code 11001 together with 11000 for each additional 10% of body surface area debrided or any additional percentage within that amount.

Incomplete/or missing results in
- Reimbursement/recoupments
- RVU calculation issues
- Data analysis
- Incorrect clinical data information
- Increased administrative costs
Benefit of Complete Documentation

- Get to keep your money
- Improved patient outcomes
- Correct data for research
- Medical/legal issues protected
- Data analysis—correct

Audit Criteria

- Medical necessity
- Documentation to coding and billing guidelines
- Documentation issues—opportunities for improvement
- Quality improvement activities or evidenced-based outcomes
Medical Necessity - Federal

- Section 1862(a)(1) states: no Medicare payments shall be made for expenses . . . that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the function of a malformed body member.”

What’s in the Global Surgical Procedure?

- Services rendered during this period may include, but not be limited to the following:
  - One preoperative visit, unless the decision to perform major surgery was made during the visit on the day of the surgery. If the decision to perform surgery was made the same day as the surgery was performed then append modifier -57 to the appropriate level of EM service for proper reimbursement.
  - Intra-operative care including the performance of the surgery.
  - Postoperative Care: All standard postoperative care of the patient including but not limited to removal of sutures, staples, casts, drains, tubes, packs, etc. Any wound care or dressing changes. Any care required of the surgeon due to postoperative complications or problems that do not require the patient to be taken back to the operating room for further procedures.
  - Supplies used to treat any postoperative surgical complications or treatments, unless otherwise stated as exclusive.
  - If the patient must be returned to the operating room for surgery for a procedure that is staged then this must be reported with modifier -58. If the procedure is unrelated, then modifier -79 would be reported. If there is an unplanned return to the operating room for a related procedure (by the performing physician) then -78 would be appended.
  - Post-operative pain management.
  - Office visits related to the recovery from the surgical procedure.
  - Office visits related to complications that arose from the surgical procedure.
What Is NOT Included in the Global Surgical Package?

- The initial consultation or the EM service in which the decision for surgery is made is payable with modifier -57 appended to the EM service. Modifier -57 is only applicable to major procedures and is not applicable to the minor, 10-day global period procedures.
- Return trips to the operating room for complications from the surgery. If a return trip to the operating room is required then the global surgical period starts over again with the second surgery.
- If a second, more costly procedure is required due to failure of the less expensive procedure, both are billable and payable (see modifier section below for details).
- Office visits in which attention to diagnoses or medical conditions that are unrelated to the surgical are given are payable (see modifier section below for details).
- Diagnostic procedures such as x-rays, ultrasound or other imaging services, laboratory, or durable medical equipment.
- Medication management for conditions/diagnoses unrelated to the surgical procedure.

Global Days — Three Types

- **Simple Procedures** (Zero Global Period)
  - There is no preoperative/postoperative period so the global period is only the day of the procedure.
  - Unless special circumstances exist, a visit on the same day as surgery is not payable.
  - Services are generally simple minor procedures and some endoscopic procedures.

- **Minor surgical procedures** (10-day global period)
  - There is no preoperative period so the global period starts the day of the procedure.
  - Unless special circumstances exist, a visit on the same day as surgery is not payable.
  - There are 11 days in the global surgical package beginning the day of the procedure and then the 10 days following it.

- **Major surgical procedures** (90-day global period)
  - There is one day of preoperative care so the global period starts the day prior to the surgery.
  - Care on the day of the surgery is included in the global period unless the decision to perform the surgery was made during the visit on this day. (See modifier -57).
  - There are 92 days in the global surgical period beginning the day before the procedure, the day of the procedure, and the 90 days following it.
National Correct Coding Initiative

- The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims.

- The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

- The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual).

Unbundling

- A physician records the services that he provides to treat his patients using Current Procedural Terminology (CPT) codes.

- Each treatment has its own code, including a minor treatment that may be a part of a major procedure, such as surgery.

- An insurance provider determines how much to reimburse the physician by using the codes that he reports, so a physician may be able to increase his income by splitting a major procedure into several smaller procedures, which is known as CPT unbundling.

Surgical Modifiers - 22

- Unusual Procedural Services
- Surgeries for which services performed are significantly greater than usually required may be billed with modifier 22.
- Bill modifier 22 with the CPT code for the procedure performed.
- Sufficiently document services billed with modifier 22 to support the service furnished was significantly greater than usually required. Supporting documentation must include an operative report and statement on how the services furnished differ from the usual services furnished. Include in electronic submissions a statement that documentation is available in the extra narrative field.
- Modifier 22 may be used to document only services with 000, 010, 090 or YYY global periods on the Medicare Physician Fee Relative Value File.

Surgical Modifier - 24

- Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period
- Bill modifier 24 with the appropriate level of E/M service.
- Documentation supports E/M visits submitted with modifier 24 are unrelated to the post operative care of the procedure. ICD-9 codes that clearly indicate the reason for the encounter was unrelated to surgical post operative care may provide sufficient documentation.
- If sufficiently documented, use Modifier 24 when furnishing an E/M service that is exclusively for treatment of the underlying condition and not for post-operative care.
- Physicians who are managing immunosuppressant therapy during the post-operative period of a transplant may bill for the E/M service with modifier 24. ICD-9-CM V07.2 may be appropriate to document the need for this service.
- Physicians who are managing chemotherapy during the post-operative period of a procedure may bill for the E/M service with modifier 24. ICD-9-CM V58.1 may be appropriate to document the need for this service.
- Do not use modifier 24 Unrelated E/M service the same day as a procedure or to document treatment of a wound infection.
Surgical Modifiers - 50

- Bilateral Procedure

Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day.

- Check, the MPSFDB to be sure the surgical code is billable as bilateral. Checking the "Bilt Surg" column on the database.

- The following MPFSDB indicators show which procedures Medicare accepts with a modifier 50.
  - "0" indicates a unilateral code; Modifier 50 is not billable
  - "1" indicates modifier 50 can be appropriate.
  - "2" indicates a bilateral code; Modifier 50 is not billable.
  - "3" indicates primary radiology codes; Modifier 50 is billable.
  - "9" indicates that the concept does not apply (office visit).

- The CPT book specifies that a service could be a. unilateral, b. bilateral, or c. unilateral or bilateral. This modifier is not appropriate on codes where the CPT specifies b or c.

- Inappropriately use receives an unprocessable denial message.

Surgical Modifiers - 52

- Reduced Service

Surgeries for which services performed are significantly less than usually required are billable with modifier 52.

- Bill modifier 52 with the CPT code furnished service.

- Sufficiently document services billed with modifier 52 to support services furnished was less than usually required.
Discontinued Procedure

- Use Modifier 53 if a physician elects to terminate a surgical or diagnostic procedure due to extenuating circumstances, or those threatening the well being of the patient.

- Bill modifier 53 in the first modifier field.

- Procedure code 45378-53 is the only code CMS already assigned Relative Value Units (RVUS) and a fee schedule amount.

- All other codes 53 are subject to carrier medical review and pricing, including additional documentation requests.

Surgical Care Only – 54

- Modifier 54 indicates the surgeon is relinquishing all or part of the postoperative care to a physician outside the same group.

Postoperative Management Only – 55

- The surgeon who furnished a portion of the outpatient postoperative care and the physician, other than the surgeon, who furnished postoperative management services bill with the 55 modifier.
Surgical Modifiers - 57

- Decision for Surgery

- E/M service resulting in the decision to perform the surgery on the day before major surgery or on the day of major surgery (90-day post op) is not included in the global surgery payment and is separately billable.

Surgical Modifiers – 58

- Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

- Modifier 58 indicates the physician, or member of the same group, planned the performance of a procedure or service during the postoperative period prospectively or at the time of the original procedure.
Surgical Modifier - 59

- Distinct Procedural Service

- Modifier 59 indicates a procedure or service was distinct or separate from other services performed on the same day.

- Represented by a different session or patient encounter, different procedure or surgery, different site, separate session, or separate injury (or area of injury)

Surgical Modifiers - 78

- Return To The Operating Room For A Related Procedure During The Post Operative Period

- Used to indicate the performance of a procedure during the postoperative period or on the same day as the original procedure to treat complications, which required return to the operating room
Surgical Modifier - 79

- Unrelated Procedure or Service by the Same Physician During the Postoperative Period

- Modifier 79 indicates the performance of a procedure or service during a post-operative period was unrelated to the post-operative care of the original procedure.

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Surgical operation

Preoperative phase ➔ Assessment ➔ preparation

Intraoperative phase ➔ Anaesthesia ➔ Surgery

Postoperative phase ➔ Postoperative care ➔ follow up
This operative report follows the standards set by the JCAHO and AAAHC for sufficient information to:

- identify the patient
- support the diagnosis
- justify the treatment
- document the postoperative course and results
- promote continuity of care

This operative report also provides:

- name of facility where procedure was performed
- date of procedure
- patient history
- CPT code

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Blair General Hospital
123 Main Street
Anytown, USA 56789

Patient Name: Betty Doe
Date: January 1, 2005
Preoperative Diagnosis: Bilateral upper eyelid dermatochalasis
Postoperative Diagnosis: Same
Procedure: Bilateral upper lid blepharoplasty, (CPT 15822)

Surgeon: John D. Good, M.D.
Assistant: N/A

NAME: Doe, William

Anesthesia: Lidocaine with 1:100,000 epinephrine
Anesthesiologist: John Smith, M.D.
Dictated by: John D. Good, M.D.
This 65-year-old female demonstrates conditions described above of excess and redundant eyelid skin with puffiness and has requested surgical correction. The procedure, alternatives, risks and limitations in this individual case have been very carefully discussed with the patient. All questions have been thoroughly answered, and the patient understands the surgery indicated. She has requested this corrective repair be undertaken, and a consent was signed.

The patient was brought into the operating room and placed in the supine position on the operating table. An intravenous line was started, and sedation and sedation anesthesia was administered IV after preoperative P.O. sedation. The patient was monitored for cardiac rate, blood pressure, and oxygen saturation continuously.

The excess and redundant skin of the upper lids producing redundancy and impairment of lateral vision was carefully measured, and the incisions were marked for fusiform excision with a marking pen. The surgical calipers were used to measure the supratarsal incisions so that the incision was symmetrical from the ciliary margin bilaterally.

The upper eyelid areas were bilaterally injected with 1% Lidocaine with 1:100,000 Epinephrine for anesthesia and vasoconstriction. The plane of injection was superficial and external to the orbital septum of the upper and lower eyelids bilaterally.

The face was prepped and draped in the usual sterile manner. After waiting a period of approximately ten minutes for adequate vasoconstriction, the previously outlined excessive skin of the right upper eyelid was excised with blunt dissection. Hemostasis was obtained with a bipolar cautery. A thin strip of orbicularis oculi muscle was excised in order to expose the orbital septum on the right. The defect in the orbital septum was identified, and herniated orbital fat was exposed. The abnormally protruding positions in the medial pocket were carefully excised and the stalk meticulously cauterized with the bipolar cautery unit. A similar procedure was performed exposing herniated portion of the nasal pocket. Great care was taken to obtain perfect hemostasis with this maneuver. A similar procedure of removing skin and taking care of the herniated fat was performed on the left upper eyelid in the same fashion. Careful hemostasis had been obtained on the upper lid areas. The lateral aspects of the upper eyelid incisions were closed with a couple of interrupted 7–0 blue prolene sutures.
At the end of the operation the patient's vision and extra ocular muscle movements were checked and found to be intact. There was no diplopia, no ptosis, no ectropion. Wounds were re-examined for hemostasis, and no hematomas were noted. Cooled saline compresses were placed over the upper and lower eyelid regions bilaterally. The procedures were completed without complication and tolerated well.

The patient left the operating room in satisfactory condition. A follow-up appointment was scheduled, routine post-op medications prescribed, and post-op instructions given to the responsible party.

The patient was released to return home in satisfactory condition.

John D. Good, M.D

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**Step One**

- Read the Report
- Mark Locations, structures, procedure methods, type, size, number, special surgical instruments, robot, laparoscope, other medical devices
Step Two – Process – How To

- Preoperative information
  - Patient demographics
  - Surgery date
  - Preoperative anesthesia
  - Indications for procedure
  - Diagnostic reports
  - Intraoperative information
  - Preoperative diagnosis
  - Postoperative diagnosis
- Surgeon/assistant surgeon/cosurgeons
- Procedure title
- Findings
- Procedure details
- Tissue/organ removal
- Materials removed/inserted
- Closure information
- Blood loss/replacement
- Wound status
- Drainage
- Complications noted
- Postoperative condition of patient
- IV infusion record
- Signatures
- Legibility and typo’s
- Supports procedure
- Supports medical necessity

Step Three

- Report your findings.
- Review with healthcare provider.
- Provide a detailed and summary report.
- Finalize after meeting with the healthcare provider.
AUDIT - PIONEER

- One of the first ever clinical audits was undertaken by Florence Nightingale during the Crimean War of 1853-1855.
- She and her team of 38 nurses applied strict sanitary routines and standards of hygiene to the hospital and equipment.
- Kept meticulous records of the mortality rates among the hospital patients.
- Following these changes the mortality rates fell from 40% to 2%.

THE AUDIT CYCLE

1. Identify areas for improvement
2. Audit (Data collected)
3. Make necessary changes
4. Criteria agreed and standards set
5. Re-audit
6. Problem or objective identified
Taking Consent - Stages

- Lead in
- Explore
- Diagnosis
- Treatment
- Options

- Introduce yourself and identify the patient
- How much does the patient know
- Why the operation is being proposed
- Explain whether the treatment proposed is in accordance with protocols
- Discuss all the options

Taking Consent - Stages

- Results
- Eventualities
- Adverse events
- Sound mind
- Open question
- Notes

- Explain likely outcome
- For example, the possibility of needing to remove the testicle in a hernia operation
- Myocardial infarction, stroke and embolus & bleeding
- Ask if they have understood
- Check if further clarification
- Document everything discussed and agreed
Contact Information

- Doug Arrington
- doug.arrington@outlook.com

- I have no conflicts of interest. I have no financial interest other than my own consulting company.
PMI Discussion Forum

Questions?

Post yours on PMI’s Discussion Forum:
– Click Accept to continue

Discussion Forum Walk Through

1) Go to www.pmiMD.com.

2) Hover the cursor over “Practice Tools” which is the fourth button from the left on the top of the page. This will give you a dropdown menu.

3) Click on the second option listed: “Discussion Forum.”
-This will bring you to the Discussion Forum Disclaimer page. You will click, “Accept.”

After clicking on the “Accept” button, you will be guided to the actual discussion forum.
LOGIN OPTION 1
In order to Login to the Discussion Forum, please follow the following steps:

- In the Forum Home block located to the left, click on the “Login” option (this button will have a picture of a key next to the option).

- This will bring you to the “Forum Login” page.

- Enter your username and password

- You will be given the option of whether you will like to be kept logged in. This option is purely up to you.

- You will also be asked if you would like to be added to the active users list. You will want to click yes.