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Welcome to PMI’s Webinar Presentation

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Meet the Presenter…

Maxine Collins
MBA, CPA, CMC, CMIS, CMOM
Faculty
Practice Management Institute

On the topic:
Surgical Chart Auditing
Surgery

• One of the oldest forms of treatment
• Ancient Egyptians
  – Conducted medical operations with very primitive surgical tools
    • Knives, drills, hooks, forceps, pinchers
    • Some in modified still being used today

Vagina speculum  Greek: psalis
Scalpels  Latin: forfex
Surgical Scissors
(Source: http://exhibits.hsl.virginia.edu/romansurgical/)
Introduction

• Surgical Chart Audit
  − Medical Record Scrutiny
  − More than a Coding audit
  − Must view from several different perspectives:
    • Documentation
    • Medical necessity
    • Coding
    • Quality reporting
    • Compliance
    • Patient safety

Surgical Audit – A Process

• To perform an audit of the surgical record requires knowledge of:
  − *ICD-10-CM Official Guidelines for Coding and Reporting 2016*
    • Now it is also important to have some knowledge of Hospital Procedural Coding requirements as well.
  − *CPT/HCPCS Official Guidelines and Procedural Coding Rules*
    • Correct Modifier Usage
  − Surgical terminology; Anatomy/Physiology
  − Individual Carrier Rules and Guidelines
  − National Correct Coding Initiative Edits – updated on a quarterly basis
  − Planning for Future of Surgical Reimbursements under proposed Fee schedule methodologies.
  − Analysis of collections/ Insurance reimbursement procedures and analysis and follow-up
  − Compliance Rules and Regulations
CPT – 2016 Surgery Section

- Largest section of CPT
  - Section Guidelines and Notes Important!

- Surgery Guidelines:
  - © CPT Surgery Package Definition
    - E/M services subsequent to decision for surgery on day before and/or day of surgery (including history and physical)
    - Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
    - Immediate postop care, including dictating operative notes, talking with the family and other physicians or other qualified health care professionals
    - Writing orders
    - Evaluating the patient in the postanesthesia recovery area
    - Typical postoperative follow-up care

Surgical Modifiers

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Increased Procedural Service</td>
</tr>
<tr>
<td>23</td>
<td>Unusual Anesthesia</td>
</tr>
<tr>
<td>47</td>
<td>Anesthesia by Surgeon</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral procedure</td>
</tr>
<tr>
<td>51</td>
<td>Multiple procedure</td>
</tr>
<tr>
<td>52</td>
<td>Reduced procedure</td>
</tr>
<tr>
<td>53</td>
<td>Discontinued procedure</td>
</tr>
<tr>
<td>54</td>
<td>Surgical care only</td>
</tr>
<tr>
<td>55</td>
<td>Postop management only</td>
</tr>
<tr>
<td>56</td>
<td>Preop management only</td>
</tr>
<tr>
<td>57</td>
<td>Decision for surgery</td>
</tr>
</tbody>
</table>
### Surgical Modifiers

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>58</td>
<td>Staged or related procedure or service by same physician or other qualified health care professional during the postop period</td>
</tr>
<tr>
<td>59</td>
<td>Distinct procedural service</td>
</tr>
<tr>
<td>62</td>
<td>Two surgeons</td>
</tr>
<tr>
<td>63</td>
<td>Procedure performed on infants less than 4 kg</td>
</tr>
<tr>
<td>66</td>
<td>Surgical team</td>
</tr>
<tr>
<td>76</td>
<td>Repeat procedure or service by same physician or other qualified health care professional</td>
</tr>
<tr>
<td>77</td>
<td>Repeat procedure by another physician or other qualified health care provider</td>
</tr>
<tr>
<td>78</td>
<td>Unplanned return to OR by same physician or other qualified health care professional following initial procedure for a related procedure during the postop period</td>
</tr>
<tr>
<td>79</td>
<td>Unrelated procedure or service by same physician during postop period</td>
</tr>
<tr>
<td>80</td>
<td>Assistant surgeon</td>
</tr>
<tr>
<td>81</td>
<td>Minimum Assistant surgeon</td>
</tr>
<tr>
<td>82</td>
<td>Assistant surgeon (when qualified resident surgeon not available)</td>
</tr>
</tbody>
</table>

### Examples of HCPCS Surgical Modifiers

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>LT</td>
<td>Left side</td>
</tr>
<tr>
<td>RT</td>
<td>Right side</td>
</tr>
<tr>
<td>E1</td>
<td>Upper left, eyelid</td>
</tr>
<tr>
<td>E2</td>
<td>Lower left, eyelid</td>
</tr>
<tr>
<td>E3</td>
<td>Upper right, eyelid</td>
</tr>
<tr>
<td>E4</td>
<td>Lower right, eyelid</td>
</tr>
<tr>
<td>FA</td>
<td>Left hand, thumb</td>
</tr>
<tr>
<td>F1</td>
<td>Left hand, second digit</td>
</tr>
<tr>
<td>F2</td>
<td>Left hand, third digit</td>
</tr>
<tr>
<td>F3</td>
<td>Left hand, fourth digit</td>
</tr>
<tr>
<td>F4</td>
<td>Left hand, fifth digit</td>
</tr>
</tbody>
</table>
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES The
Supplementary Appendices for the Medicare Fee-for-Service 2015
Improper Payments Report

AUDIT SCRUTINY

Table A3: Improper Payment Rate Categories by Percentage of 2015 National Improper Payments (Adjusted for Impact of A/B Rebilling)

<table>
<thead>
<tr>
<th>Error Category</th>
<th>Percent of 2015 National Improper Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Documentation</td>
<td>1.3%</td>
</tr>
<tr>
<td>Insufficient Documentation</td>
<td>67.3%</td>
</tr>
<tr>
<td>Medical Necessity</td>
<td>17.3%</td>
</tr>
<tr>
<td>Incorrect Coding</td>
<td>10.8%</td>
</tr>
<tr>
<td>Other</td>
<td>3.3%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
### Table B5: 2015 Projected Improper Payments (Dollars in Billions) by Type of Error and Clinical Setting

<table>
<thead>
<tr>
<th>Error Category</th>
<th>DMEPOS</th>
<th>Home Health Agencies</th>
<th>Hospital Outpatient Departments</th>
<th>Acute Inpatient Hospitals</th>
<th>Physician Services (All Settings)</th>
<th>Skilled Nursing Facilities</th>
<th>Other Clinical Settings</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Documentation</td>
<td>$0.1</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$0.4</td>
<td>$0.0</td>
<td>$0.1</td>
<td>$0.6</td>
</tr>
<tr>
<td>Insufficient</td>
<td>$2.6</td>
<td>$9.6</td>
<td>$4.4</td>
<td>$1.7</td>
<td>$5.3</td>
<td>$3.0</td>
<td>$2.4</td>
<td>$20.2</td>
</tr>
<tr>
<td>Documentation</td>
<td>$0.1</td>
<td>$0.4</td>
<td>$1.0</td>
<td>$7.0</td>
<td>$0.1</td>
<td>$0.1</td>
<td>$0.1</td>
<td>$8.8</td>
</tr>
<tr>
<td>Medical Necessity</td>
<td>$0.0</td>
<td>$0.0</td>
<td>$0.2</td>
<td>$1.3</td>
<td>$2.7</td>
<td>$0.3</td>
<td>$0.1</td>
<td>$4.7</td>
</tr>
<tr>
<td>Incorrect Coding</td>
<td>$0.4</td>
<td>$0.1</td>
<td>$0.2</td>
<td>$0.1</td>
<td>$0.2</td>
<td>$0.5</td>
<td>$0.0</td>
<td>$1.4</td>
</tr>
<tr>
<td>Other</td>
<td>$3.2</td>
<td>$0.1</td>
<td>$5.8</td>
<td>$18.2</td>
<td>$8.9</td>
<td>$4.0</td>
<td>$2.7</td>
<td>$44.7</td>
</tr>
</tbody>
</table>

### Table B8: Projected Improper Payments, Overpayments, and Underpayments by State

<table>
<thead>
<tr>
<th>State</th>
<th>Projected Dollars in Error</th>
<th>Overall Error Rate</th>
<th>Projected Overpayments</th>
<th>Projected Overpayment Rate</th>
<th>Projected Underpayments</th>
<th>Projected Underpayment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA</td>
<td>$4,659.8</td>
<td>14.1%</td>
<td>$4,505.6</td>
<td>13.0%</td>
<td>$154.2</td>
<td>0.5%</td>
</tr>
<tr>
<td>TX</td>
<td>$4,593.8</td>
<td>17.6%</td>
<td>$4,310.7</td>
<td>17.3%</td>
<td>$83.1</td>
<td>0.3%</td>
</tr>
<tr>
<td>FL</td>
<td>$3,569.0</td>
<td>13.1%</td>
<td>$3,440.0</td>
<td>12.7%</td>
<td>$120.9</td>
<td>0.4%</td>
</tr>
<tr>
<td>NY</td>
<td>$2,411.4</td>
<td>11.1%</td>
<td>$2,208.2</td>
<td>10.5%</td>
<td>$131.2</td>
<td>0.7%</td>
</tr>
<tr>
<td>IL</td>
<td>$2,192.8</td>
<td>13.0%</td>
<td>$2,035.6</td>
<td>14.7%</td>
<td>$39.2</td>
<td>0.2%</td>
</tr>
<tr>
<td>PA</td>
<td>$1,956.0</td>
<td>14.0%</td>
<td>$1,036.0</td>
<td>13.6%</td>
<td>$59.6</td>
<td>0.4%</td>
</tr>
<tr>
<td>NJ</td>
<td>$1,823.4</td>
<td>14.0%</td>
<td>$1,762.9</td>
<td>13.7%</td>
<td>$40.5</td>
<td>0.3%</td>
</tr>
<tr>
<td>OH</td>
<td>$1,802.0</td>
<td>13.7%</td>
<td>$1,701.7</td>
<td>13.7%</td>
<td>$11.2</td>
<td>0.1%</td>
</tr>
<tr>
<td>GA</td>
<td>$1,657.3</td>
<td>16.7%</td>
<td>$1,009.5</td>
<td>16.5%</td>
<td>$178.8</td>
<td>0.3%</td>
</tr>
<tr>
<td>MI</td>
<td>$1,520.0</td>
<td>11.3%</td>
<td>$1,491.0</td>
<td>11.1%</td>
<td>$22.8</td>
<td>0.2%</td>
</tr>
<tr>
<td>LA</td>
<td>$1,267.1</td>
<td>19.7%</td>
<td>$1,250.4</td>
<td>10.4%</td>
<td>$18.8</td>
<td>0.3%</td>
</tr>
<tr>
<td>NC</td>
<td>$1,195.7</td>
<td>10.9%</td>
<td>$1,181.2</td>
<td>10.7%</td>
<td>$25.6</td>
<td>0.2%</td>
</tr>
<tr>
<td>VA</td>
<td>$1,101.2</td>
<td>12.0%</td>
<td>$992.0</td>
<td>12.3%</td>
<td>$39.3</td>
<td>0.2%</td>
</tr>
<tr>
<td>KY</td>
<td>$910.7</td>
<td>15.9%</td>
<td>$897.7</td>
<td>15.4%</td>
<td>$32.9</td>
<td>0.6%</td>
</tr>
<tr>
<td>AL</td>
<td>$912.6</td>
<td>14.5%</td>
<td>$885.6</td>
<td>14.3%</td>
<td>$27.0</td>
<td>0.4%</td>
</tr>
<tr>
<td>MS</td>
<td>$905.0</td>
<td>6.0%</td>
<td>$807.4</td>
<td>5.3%</td>
<td>$97.6</td>
<td>0.6%</td>
</tr>
<tr>
<td>IN</td>
<td>$696.6</td>
<td>11.2%</td>
<td>$889.6</td>
<td>11.1%</td>
<td>$7.0</td>
<td>0.1%</td>
</tr>
<tr>
<td>SC</td>
<td>$823.0</td>
<td>13.2%</td>
<td>$797.3</td>
<td>12.8%</td>
<td>$25.8</td>
<td>0.4%</td>
</tr>
<tr>
<td>TN</td>
<td>$750.0</td>
<td>7.0%</td>
<td>$765.0</td>
<td>6.7%</td>
<td>$26.0</td>
<td>0.2%</td>
</tr>
<tr>
<td>MO</td>
<td>$774.6</td>
<td>10.8%</td>
<td>$741.3</td>
<td>10.3%</td>
<td>$33.3</td>
<td>0.5%</td>
</tr>
<tr>
<td>MD</td>
<td>$773.2</td>
<td>8.1%</td>
<td>$764.4</td>
<td>8.0%</td>
<td>$8.8</td>
<td>0.1%</td>
</tr>
</tbody>
</table>
# Appendix C: Medicare Access and CHIP Reauthorization Act of 2015 Section 517 Reporting

## Table C1: Services Paid under the Physician Fee Schedule (PFS) in which the Fee Schedule Amount is in Excess of $250 and the Error Rate is in Excess of 20 Percent

<table>
<thead>
<tr>
<th>Service Label</th>
<th>PFS Amount</th>
<th>Error Rate</th>
<th>Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replace aortic valve perq (33361)</td>
<td>$1,420.8</td>
<td>20.4%</td>
<td>14.7% - 37.5%</td>
</tr>
<tr>
<td>Replace aortic valve open (33362)</td>
<td>$1,553.4</td>
<td>25.8%</td>
<td>12.1% - 38.9%</td>
</tr>
<tr>
<td>CT abd &amp; pel/ w/ contrast (74177)</td>
<td>$334.1</td>
<td>21.5%</td>
<td>15.6% - 29.9%</td>
</tr>
<tr>
<td>Spine fusion extra segment (22014)</td>
<td>$414.7</td>
<td>20.8%</td>
<td>(1.8%) - 43.3%</td>
</tr>
</tbody>
</table>

---

**NATIONAL CORRECT CODING INITIATIVE EDITS**
INTRODUCTION

FOR

NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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TABLE OF CONTENTS

List of Acronyms

Chapter I - General Correct Coding Policies

A. Introduction
B. Coding Based on Standards of Medical/Surgical Practice
C. Medical/Surgical Package
D. Evaluation and Management (E&M) Services
E. Modifiers and Modifier Indicators
F. Standard Preparation/Monitoring Services for Anesthesia
G. Anesthesia Service Included in the Surgical Procedure
H. HCPCS/CPT Procedure Code Definition
I. CPT Manual and CMS Coding Manual Instructions
J. CPT “Separate Procedure” Definition
K. Family of Codes
L. More Extensive Procedure
M. Sequential Procedure
N. Laboratory Panel
O. Mixture of Column Two Code with Column One Code

Revision Date (Medicare): 1/1/2016
Physicians must report services correctly. This manual discusses general coding principles in Chapter I and principles more relevant to other specific groups of HCPCS/CPT codes in the other chapters. There are certain types of improper coding that physicians must avoid.

Procedures should be reported with the most comprehensive CPT code that describes the services performed. Physicians must not unbundle the services described by a HCPCS/CPT code. Some examples follow:

- A physician should not report a single comprehensive HCPCS/CPT code when more than one code describes the services performed. For example, if a physician performs a vaginal hysterectomy on a uterus weighing less than 250 grams with bilateral salpingo-oophorectomy, the physician should report CPT code 58262 (Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)). The physician should not report CPT code 58260 (Vaginal hysterectomy, for uterus 250 g or less) plus CPT code 56720 (Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)).

- A physician should not fragment a procedure into component parts. For example, if a physician performs an anal endoscopy with biopsy, the physician should report CPT code 46606 (Anoscopy, with biopsy, single or multiple). It is improper to unbundle this procedure and report CPT code 46600 (Anoscopy, diagnostic, single or multiple) plus CPT code 45100 (Biopsy of anal canal wall, anal approach). The latter code is not intended to be utilized with an endoscopic procedure code.

- A physician should not unbundle a bilateral procedure code into two unilateral procedure codes. For example, if a physician performs bilateral mammography, the physician should not report CPT codes 77050 and 77051 (Bilateral mammography, complete).

Revision Date (Medicare): 1/1/2016

I-7

Physicians must avoid downcoding. If a HCPCS/CPT code exists that describes the services performed, the physician must report this code rather than report a less comprehensive code with other codes describing the services not included in the less comprehensive code. For example, if a physician performs a unilateral partial mastectomy with axillary lymphadenectomy, the provider should report CPT code 19302 (Mastectomy, partial...; with axillary lymphadenectomy). A physician should not report CPT code 19301 (Mastectomy, partial...; with axillary lymphadenectomy, complete) plus CPT code 38745 (Axillary lymphadenectomy, complete).

Physicians must avoid upcoding. A HCPCS/CPT code may be reported only if all services described by that code have been performed. For example, if a physician performs a superficial axillary lymphadenectomy (CPT code 38740), the physician should not report CPT code 38745 (Axillary lymphadenectomy, complete).

Physicians must report units of service correctly. Each HCPCS/CPT code has a defined unit of service for reporting purposes. A physician should not report units of service for a HCPCS/CPT code using a criterion that deviates from the code’s defined unit of service. For example, some therapy codes are reported in fifteen minute increments (e.g., CPT codes 97110-97124). Others are reported per session (e.g., CPT codes 92507, 92508). A physician should not report a “per session” code using fifteen minute increments. CPT code 92507 or 92508 should be reported with one unit of service on a single date of service.

In 2015 the CPT Manual modified the numbering of codes so that the sequence of codes as they appear in the CPT Manual does not necessarily correspond to a sequential numbering of codes. In the National Correct Coding Initiative Policy Manual for Medicare Services, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the CPT Manual.

Revision Date (Medicare): 1/1/2016

I-8
Some services are integral to large numbers of procedures. Other services are integral to a more limited number of procedures. Examples of services integral to a large number of procedures include:

- Cleansing, shaving and prepping of skin
- Draping and positioning of patient
- Insertion of intravenous access for medication administration

Revision Date (Medicare): 1/1/2016
I-9

- Insertion of urinary catheter
- Sedative administration by the physician performing a procedure (see Chapter II, Anesthesia Services)
- Local, topical or regional anesthesia administered by the physician performing the procedure
- Surgical approach including identification of anatomical landmarks, incision, dissection, excision of abnormal tissue, debridement of traumatized tissue, lysis of adhesions, and isolation of structures limiting access to the surgical field such as bone, blood vessels, nerve, and muscles including stimulation for identification or monitoring
- Surgical cultures
- Wound irrigation
- Insertion and removal of drains, suction devices, and pumps into same site
- Surgical closure and dressings
- Application, management, and removal of postoperative dressings and analgesic devices (peri-incisional)
- Application of TENS units
- Use of Mildly Controlled Anesthesia
- Preoperative, intraoperative and postoperative documentation, including photographs, drawings, dictation, or transcription as necessary to document the services provided
- Surgical supplies, except for specific situations where CMS policy permits separate payment

Although other chapters in this Manual further address issues related to the standards of medical/surgical practice for the procedures covered by that chapter, it is not possible because of space limitations to discuss all HCPCS edits based on the principle of the standards of medical/surgical practice. However, there are several general principles that can be applied to these edits, including:

1. The component service is an accepted standard of care when performing the comprehensive service.
2. The component service is usually necessary to complete the comprehensive service.
3. The component service is not a separately distinguishable procedure when performed with the comprehensive service.

Revision Date (Medicare): 1/1/2016
I-10
CERT Quarterly Newsletter

Provider Types Affected: Physicians

Problem Description

The CERT contractor conducted a special study of claims for laparoscopic hernia repairs submitted from July through September 2014. When CERT reviews a claim, all lines submitted on the claim undergo complex medical review. The long descriptions of Healthcare Common Procedure Coding System (HCPCS) codes for laparoscopic hernia repairs are:

- 49650 - Laparoscopy, surgical; repair initial inguinal hernia.
- 49652 - Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible.
Examples of Improper Payments

Insufficient Documentation – Missing Signature

A general surgeon billed for HCPCS 43652, for a laparoscopic repair of an umbilical hernia with mesh insertion. The submitted documentation included an unsigned operative report for the correct date of service for the billed procedure. The CERT reviewer requested a signature attestation for the unsigned operative report as well as additional documentation from the billing provider and received a hospital discharge summary dated one week prior to the date of surgery. The discharge summary documented that the beneficiary had an inpatient investigation for abdominal pain and that umbilical hernia repair was scheduled for the following week. Although the discharge summary provided support for the medical necessity of the procedure, an unsigned operative report is insufficient to support this claim per Medicare guidelines. This claim was scored as an insufficient documentation error and the Medicare Administrative Contractor (MAC) recouped the payment from the provider.

Medicare requires providers of all services to sign their records. Providers should not add late signatures to the medical record, but instead may submit a signature attestation, such as the one available on the CERT Provider website. Providers should also submit an attestation if signature(s) are not legible. In order to be considered valid for Medicare medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry, must be for a specific date of service, and must contain sufficient information to identify the beneficiary.

Finding: Insufficient Documentation Caused Most of the Improper Payments

The vast majority of the improper payments were due to insufficient documentation. There were some claims with incorrect coding errors in the special study. Insufficient documentation means that something was missing from the medical records. For example, the medical record was missing one or more of the following:

- A signed operative report;
- The correct date of service; or
- A signature log or attestation for an illegible signature on a specific date of service.
Insufficient Documentation – One Procedure Billed by Two Surgeons

A urologist billed for HCPCS 55856 (laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed) and for HCPCS 49650 with modifier 51 (multiple procedure), for an initial laparoscopic repair of an inguinal hernia. Modifier 51 is appropriate to use when multiple surgical procedures are performed at the same session by the same provider. Report the primary procedure (in this case, the prostatectomy) as listed without a modifier, report modifier 51 with the additional procedure.

The submitted documentation did not support that the billing physician performed an inguinal hernia repair on the billed date of service. The urologist’s operative note indicated that during the performance of a laparoscopic prostatectomy, after the bladder was immobilized, a very large hernia and hernia sac was visualized and dissected. Once the prostatectomy was completed, a general surgeon came in to perform the inguinal hernia repair.

Findings Upon Review

A review of Medicare billing records showed a paid claim for HCPCS 49651 (laparoscopy surgical repair recurrent hernia) for the general surgeon on the same date of service for the same beneficiary. The general surgeon’s operative note documents that the beneficiary was undergoing a robotic prostatectomy by the urologist when the general surgeon was called into the operating room to evaluate a large inguinal hernia. It further documents that, once the prostatectomy was completed by the urologist, the hernia was repaired by the general surgeon. The trocar sites were then closed by the urologist. (Note that the general surgeon’s claim was not sampled by CERT). This claim was scored as an insufficient documentation error and the MAC recouped the payment from the urologist for the laparoscopic inguinal hernia repair.
Improper Payments

Example of Improper Payments due to Incorrect Coding for Laparoscopic Hernia Repair

A general surgeon billed for HCPCS 49652, for a laparoscopic repair of an umbilical hernia with mesh insertion. The submitted operative note supports the incidental discovery of an incarcerated umbilical hernia while performing a laparoscopic appendectomy for gangrenous appendicitis with perforation. The operative report does not document the placement of mesh, but states that the hernia was closed “using the fascial closure device with 3 sutures and 0 Vicryl, this seemed to close nicely.” The CERT medical reviewer recoded the claim from HCPCS 49652 to HCPCS 49653 for a laparoscopic repair of an incarcerated umbilical hernia. This claim was scored as an incorrect coding error and the MAC adjusted the payment.

Comprehensive Error Rate Testing (CERT): Lumbar Spinal Fusion

Provider Types Affected: Physicians and Suppliers

Background

Degenerative conditions of the lumbar spine are common and include spinal stenosis, degenerative spondylolisthesis, degenerative lumbar spondylosis, and degenerative disc disease. These degenerative conditions can lead to pain and disability. When these problems occur and conservative treatment (that is, non-surgical, physical therapy, injections) fails, surgery becomes an option. For some conditions, conservative treatment may not be appropriate (for example, tumor or infection, severe or increasing weakness numbness, or bladder and bowel symptoms).

Spinal fusion is surgery to permanently join together two or more bones (vertebrae) in the spine so there is no movement between them.

CERT conducted a special study of claims with lines for arthrodesis (fusion) of the lumbar spine Healthcare Common Procedure Coding System (HCPCS) codes 22612 and 22633, submitted from January through March 2014. When CERT reviews a claim, all lines submitted on the claim undergo complex medical review. The long descriptions of these HCPCS codes are:

- 22612 - Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed); and
- 22633 - Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar.
Examples of Improper Payments due to Insufficient Documentation for Lumbar Spinal Fusion

Insufficient Documentation – Missing Signatures

An orthopedic surgeon billed for HCPCS 22633 for a lumbar fusion surgical procedure with decompression, biomechanical fixation device placement, and allograft bone placement, for a date of service in February 2014. The orthopedic surgeon did not sign the operative note or the discharge summary and did not submit a signature attestation letter for the unsigned operative note or the unsigned discharge summary.

The CERT medical reviewer requested that the surgeon provide a signature attestation for the unsigned documentation; this would allow Medicare to pay the claim. The surgeon did not send an attestation but instead sent duplicate copies of the unsigned operative note and unsigned discharge summary. The surgeon sent a copy of the preoperative consultation from January 2014 which supported the medical necessity of the surgical procedure. The consultation appropriately included x-ray reports showing grade II spondylolisthesis at L4-L5 with facet arthropathy, and facet arthropathy at L5-S1 with disc space narrowing at both levels; an MRI report which showed grade II spondylolisthesis with severe central and foraminal stenosis; and documentation of failed nonsurgical intervention.

Despite support for the medical necessity of the procedure, claim payment also requires support for performance of the service. This claim was scored as an insufficient documentation error.

Insufficient Documentation – Missing Documentation to Support Medical Necessity

An orthopedic surgeon billed for HCPCS 22612 along with seven other HCPCS codes, for a lumbar fusion surgical procedure with removal of disc, lateral approach; a lumbar fusion surgical procedure, posterior or posterolateral approach; release of lower spinal cord and/or nerves; insertion of posterior spinal instrumentation for spinal stabilization, 3 to 8 vertebral segments; insertion of spinal instrumentation for spinal stabilization; and fluoroscopic guidance for spine or spinal canal injection (the professional component), for a date of service in March 2014.

The orthopedic surgeon submitted an operative report for the billed date of service; however, there were no visit notes, consultations, lumbar spinal imaging results, or other clinical documentation supporting medical necessity for the billed spinal fusion. There was no documentation of prior conservative treatments attempted or completed, nor was there documentation of a condition that would make conservative treatment inappropriate.

To support the medical necessity of the procedure, the orthopedic surgeon must submit information such as a history including the duration/character/location/radiation of pain, any limitation of activities of daily living, a physical examination, and imaging reports specific to the surgical procedure. CERT contacts providers and sends additional documentation request letters to try to obtain missing documentation. The CERT medical reviewer requested that the orthopedic surgeon submit documentation supporting medical necessity for the billed spinal fusion but instead received a duplicate operative report.
RECOVERY AUDIT CONTRACTORS

RAs

Recovery Auditor Finding: Multiple Surgeries

Provider Types Affected: Physicians and Non-Physician Practitioners

Problem Description

The Recovery Auditor conducted an automated review to identify surgical claims that contain Current Procedural Terminology (CPT®) codes with a “Multiple Procedure” Indicator Value of “2” or “3,” that were incorrectly reported by the same physician, on the same beneficiary on the same day, whether on different claims, different lines, or with a number greater than 1 in the units column for each code reported on the claim form and which resulted in an overpayment.
Description of the Issue

The “Medicare Claims Processing Manual,” Chapter 12, Section 40.6, which is available on the CMS website, states that multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same beneficiary at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same beneficiary on the same day.

The following procedures apply when billing for multiple surgeries by the same physician on the same day.

- Report the more major surgical procedure without the multiple procedures modifier “-51.”
- Report additional surgical procedures performed by the surgeon on the same day with modifier “-51.”

Resources

You can find more information on Spinal Fusions and how to avoid errors on claims for Lumbar Spinal Fusions in:

✓ The “Medicare Benefit Policy Manual,” Chapter 15, Section 30, Physician Services;
✓ The “Medicare Program Integrity Manual,” Chapter 3, Section 3.3.2.4.D, Signature Requirement;
✓ Local Coverage Articles on Spinal Fusion Services, available in the Local Coverage Determinations Alphabetical Index; and
DISSECTING THE SURGICAL NOTE

JOINT COMMISSION

Joint Commission Medical Record Documentation Requirements 2011

History & Physical (H&P) Timeliness & Components:
- H&P must be completed and documented within 24 hrs following admission of the patient, but prior to surgery or a procedure requiring anesthesia services (including moderate sedation).
- H&P Exams performed within 30 days prior to admission may be used if the following requirements are met:
  - Physician writes an update note which is written on or attached to the H&P,
  - The words ”re-examined the patient” must be present. Required by CMS.
- The H&P and any updates/assessments must be included in the medical record within 24 hrs of admission, but prior to surgery or other procedures whichever comes first.
- H&P performed more than 30 days prior to admission, outpatient evaluation, or outpatient surgery does not comply with timeliness requirements and a new H&P must be performed.
- H&P Required Components: Chief Complaint, Details of Present Illness, Relevant Past, Social and Family History, Physical Examination, Statement of conclusions

Immediate Post Operative Note Required Elements & Time Requirements:
- Name(s) of primary surgeon/physician and assistants
- Pre-operative diagnosis
- Post-operative diagnosis
- Name of the Procedure performed
- Findings of the Procedure
- Specimen removed
- Estimated Blood Loss
- Date and Time Recorded – Time is very important as it confirms that the note was recorded prior to moving the patient to the next level of care.

Operative Report Required Elements & Time Requirements:
- Detailed OP reports should contain in addition to the elements listed above,
  - Indications for the procedure
  - Intra-operative complications
  - A full description of the Procedure

****OP Reports should be dictated or handwritten immediately or within 24 hrs following procedure

Every entry in the Medical Record needs to be SIGNED, DATED & TIMED EACH AND EVERY TIME!!
- **Verbal and Telephone orders need to be signed within 24 hrs.**
ACCEPTABLE OPERATIVE REPORT # 1

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

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 ptosis 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 full-thickness 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 tissues

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 extraocular muscle movements were checked and found to be intact. There was no diplopia, no

ptosis, no ectropion. Wounds were reexamined for hemostasis, and no hematomas were noted. Cooled saline compresses were placed over the upper

and lower eyelid regions bilaterally.
Operative Report Standards Set by JCAHO and AAAHC

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.

JCAHO – JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS; AAAHC – ACCREDITATION ASSOCIATION FOR AMBULATORY CARE

(Source: http://www.abfprs.org/docs/Sample%20operative%20reports.pdf)

Unacceptable Operative Report # 2

This operative report is listed as a septrhinoplasty but contains no information that would allow the Credentials Committee to assign credit for any description that relates to a rhinoplasty procedure. The description did not include reference to:

- medial or lateral osteotomies
- dorsal straightening
- alar reduction
- tip reduction
- any type of augmentation

This operative report also does not provide:

- name of facility where procedure was performed
- date of procedure
- patient history
- CPT code
PATIENT NAME: Roberta Doe

MEDICAL RECORD: #23333

SURGEON: Robert Doctor, M.D.

Preoperative Diagnosis: Nasal valve collapse, nasal septal deviation and nasal turbinate hypertrophy.

Postoperative Diagnosis: Same

Procedure: Functional septorhinoplasty, inferior turbinate cautery, tonsillectomy

Anesthesia: General endotracheal

Findings: Caudal septum deviated to the left. More posteriorly the septum was deviated to the right with almost complete obstruction of her nasal airway. Her dorsum overall was deviated to the right.

Description of Procedure: The patient was brought to the operating room and placed supine on the OR table. General endotracheal anesthesia was introduced. Afrin was used to decongest the nose. 1% Lidocaine with 1:100,000 epinephrine was injected into the septum. A hemitransfixion incision was made. The caudal cartilage was deviated towards the left. Mucoperichondrial layer was elevated on the left-hand side having carried the incision through to the right-hand side approximately 1 cm behind the caudal most aspect of the cartilage. Deviated areas of cartilage along the floor of the nose were removed. With the bowl of the septal spur inferiorly and the deviated areas of cartilage to the left the more caudal aspect which was deviated and buckled and returned to a more natural and normal position with improvement of her nasal airway on the left. Then two bony deviations to the right were removed. Hemostasis along the floor of the nose with an ostecote was used. At the conclusion the septum was found to fit in the midline with a drastic improvement in her nasal airway and a visibly improved nasal contour.

She was extubated and transferred to recovery in good condition with a nose pad applied over her nose.
UNACCEPTABLE OPERATIVE REPORT # 4

This operative report does not provide:
- name of facility where procedure was performed
- patient history
- pre-operative or post-operative diagnosis
- adequate description of procedure performed
- instructions and medications for patient’s post-operative care
- CPT code

FACELIFT

Dr. Robert Doctor

Patient: Jane Doe

The risks and benefits were reviewed with patient. Skin marker was used to mark incision lines. Local anesthesia carried out with Lidocaine 1% Epinephrine. The patient was prepped and draped in the usual manner.

Beginning on the left side, a left facelift incision was made beginning just below the temporal tuft of hair, continuing in the curve of the pre-auricular area, around the lobule and posteriorly over the mastoid. Using sharp and blunt dissection, a skin flap was elevated over the cheek and neck. Bleeding was controlled with hyfrecator cautery. The SMAS and platysma was then plicated posterosuperiorly with 2-0 nylon suture. The skin flap was repositioned. Skin was trimmed. The incision was closed with a running 5-0 nylon suture. The same was done on the right side to complete the surgery.

The incision lines were cleansed, steri-strips were applied along with antibiotic ointment. The patient left the office in satisfactory condition.

Physician signature: R. Doctor

Date: January 5, 2012
FOR IMMEDIATE RELEASE
Tuesday, January 12, 2016

Local Dermatologist, Cordova-based Medical Practice to Pay $450,000 for Overbilling Medicare

Memphis, TN – A doctor and his Cordova-based medical practice will pay $450,000 to the government to resolve allegations that it billed Medicare for unnecessary dermatological surgical procedures and office visits. Edward L. Stanton III, U.S. Attorney for the Western District of Tennessee, announced the settlement today.

Under federal law, Medicare reimburses medical providers only for procedures that are medically necessary. The United States contends that from 2008 to 2011, Dr. George R. Woodbury and his medical practice, Rheumatology & Dermatology Associates, P.C., billed Medicare for multiple medically unnecessary procedures. Specifically, the complaint alleged that Woodbury billed for tissue rearrangement surgeries, excisions which were larger than actually performed, benign excisions as malignant, overstated repair or closure sizes, and for unnecessary office visits.

In October 2014, the allegations resolved in this settlement were first raised in a lawsuit filed against the defendant under provisions of the False Claims Act. The law provides the United States with a cause of action against any person who knowingly presents or causes to be presented a false or fraudulent claim for payment or approval. Damages for liability under the False Claims Act are up to triple the amount of actual damages suffered by the United States, plus a mandatory civil penalty of $5,500 to $11,000 for each claim.

“Billing Medicare for dermatological surgical procedures that are not necessary or appropriate contributes to the soaring costs of health care and harms patients,” said U.S. Attorney Stanton. “Settlements like this protect public funds and safeguard the beneficiaries of federal health care programs.”

The investigation was conducted by the United States Department of Health and Human Services – Office of the Inspector General, along with the Federal Bureau of Investigation.

Assistant U.S. Attorneys Stuart J. Canale and David Brackstone represented the United States in this matter.

The claims settled by this agreement are allegations only, and there has been no determination of liability.
Bilateral Eligible List

The UnitedHealthcare Bilateral Eligible Procedures Policy List is developed based on the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule (NPF5) Relative Value File status indicators.

All codes in the NPF5 with the "bilateral" status indicators "1" or "3" are considered by UnitedHealthcare to be eligible for bilateral services as indicated by the bilateral modifier 50.

When a bilateral eligible code with a bilateral indicator of "1" is reported with modifier 50 and is subject to reductions under either UnitedHealthcare’s Multiple Procedure or Radiology Multiple Imaging Reduction Policies, the code will be eligible for reimbursement at 150% of the allowable amount not to exceed billed charges for a single procedure code, with one side reimbursed at 100% and the other side reimbursed at 50%. When other reducible procedure codes are reported on the same date of service, an additional multiple procedure/imaging reduction may or may not be applied to the line paid at 100% depending on whether another procedure code is ranked as primary or not.

When a bilateral eligible code with a bilateral indicator of "3" is reported with modifier 50 and is not subject to reductions under either the Multiple Procedure or Radiology Multiple Imaging Reduction Policies, the code will be eligible for reimbursement at 100% of the allowable amount for each side for a sum of 200% of the allowable amount not to exceed billed charges.

For a list of procedure codes that are subject to multiple procedure reductions, see UnitedHealthcare’s Multiple Procedure Policy.

For a list of radiological procedure codes that are subject to multiple imaging reductions, see UnitedHealthcare’s Radiology Multiple Imaging Reduction Policy.

2016 Bilateral Eligible Procedures Policy List
CMS Files for Download
Facet Joint Injections

Number: SUR702.015

Effective Date: 04-15-2015

Coverage:

Facet joint injections that are performed under fluoroscopic guidance may be considered medically necessary when the following criteria are met:

1. The lumbar back or cervical neck pain is chronic (i.e., persisting for more than 3 months); AND
2. Conservative therapy (e.g., physical and/or chiropractic therapy, oral analgesia and/or steroids and/or relaxants, activity modification) fails or is not feasible; AND
3. No evidence of contraindications, such as severe spinal stenosis resulting in intraspinal obstruction, infection, or predominantly psychogenic pain; AND
4. The pain is non-radicular (i.e., there is no radiation of pain into an upper or lower extremity), radiculopathy has been ruled out by an magnetic resonance imaging (MRI), and no signs of dural tension exists (as evidenced by negative "straight leg raise" on physical exam); AND
5. Suspected spinal facet joint syndrome, as evidenced by low back pain that is exacerbated by extension and by prolonged standing/sitting and that is relieved by rest; AND
6. Absence of a prior fusion at the clinically suspect levels; AND
7. Absence of an unexplained neurological deficit; AND
8. Repeat interventions only upon return of pain and deterioration in functional status.

*Schedule: When the above criteria are met, the following schedule for diagnostic and therapeutic facet joint injection(s) that are performed under fluoroscopic guidance may be considered medically necessary:
BCBSTX Reimbursement for Modifiers

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>REIMB %</th>
<th>MODIFIER</th>
<th>REIMB %</th>
</tr>
</thead>
<tbody>
<tr>
<td>78</td>
<td>75%</td>
<td>53</td>
<td>40%</td>
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<td>40%</td>
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<tr>
<td>82</td>
<td>16%</td>
<td>AS</td>
<td>16%</td>
</tr>
<tr>
<td>SA</td>
<td>85%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Source: www.bcbstx.com)
PATIENT SAFETY

Safe Surgery 2015: South Carolina Checklist Template

**Before Induction of Anesthesia**
- Nurse and Anesthesia Provider Verify:
  - Patient identification (name and DOB)
  - Surgical site
  - Surgical Procedure to be performed matches the consent
  - Site marked
  - Known allergies
  - Patient Positioning
  - The anesthesia safety checklist has been completed

**Anesthesia Provider Shares Patient Specific Information with the Team:**
- Anticipated airway or aspiration risk
- Risk of significant blood loss
  - Two big drains/access and fluids planned
  - Type and crossmatched screen
  - Blood availability
- Risk of hypothermia - operation >1h
  - Warming in place
- Risk of venous thromboembolism
  - Boots and/or anticoagulants in place

**Before Skin Incision**
- Entire Surgical Team:
  - Is everyone ready to perform the time out?
  - Please state your name and role
- Patient’s name
- Surgical procedure to be performed
- Surgical site
- Essential imaging available
- Have antibiotic prophylaxis been given within the last 60 minutes?
  - Plan for redoing discussed

**Briefing**

**Before Patient Leaves Room**

**Nurse Reviews with Team:**
- Instrument, sponge and needle counts are correct
- Name of the procedure performed
- Specimen labeling
  - Read back specimen labeling including patient’s name

**Debriefing**
- Entire Surgical Team Discusses:
  - Equipment problems that need to be addressed.
  - Key concerns for patient recovery and management.
  - What could have been done to make this case safer or more efficient

---

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged. Based on the WHO Surgical Safety Checklist, URL: http://www.who.int/patientsafety/safesurgery/en/

Version: 4-24-12
HOW DOES THE TRANSITION TO “10 PCS” AFFECT SURGEONS?

ICD-10-PCS
PROCEDURAL CODING SYSTEM

Example: Table 0DB Excerpt

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Esophagus, Upper</td>
<td>O Open</td>
<td>Z No Device</td>
<td>Z No Qualifier</td>
</tr>
<tr>
<td>2. Esophagus, Middle</td>
<td>3 Percutaneous</td>
<td>4 Percutaneous Endoscopic</td>
<td></td>
</tr>
<tr>
<td>3. Esophagus, Lower</td>
<td>5 Percutaneous Endoscopic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Esophagogastric Junction</td>
<td>7 Via Natural or Artificial Opening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Esophagus</td>
<td>8 Via Natural or Artificial Opening Endoscopic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Stomach, Pylorus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Small Intestine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Duedenum</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9. Appendix</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>10. Ileum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Ileocecal Valve</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>12. Large Intestine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Large Intestine, Right</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>14. Large Intestine, Left</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SURGICAL AUDIT
TEMPLATES

SURGERY AUDIT FORM - 2016

TYPE OF SURGERY: ____________________________

SURGEON/PERFORMED BY: ______________________

OFFICE/FACILITY: _____________________________

DATE OF SURGICAL PROCEDURE: ________________

PATIENT NAME: ______________________________

PATIENT DOB: ________________________________

PATIENT MEDICAL RECORD #: __________________

ASSISTANT SURGEON: _________________________

ANESTHESIOLOGIST: __________________________

TYPE OF ANESTHESIA: _________________________

LET PROCEDURE CODES: DESCRIPTION: MODIFIED

__________________________________________

__________________________________________

__________________________________________

__________________________________________

ICD-9/10-CM CODE(S): (ICD-10-CM CODE(S) SHOWN ON OP REPORT): DESCRIPTION

__________________________________________

__________________________________________

__________________________________________

__________________________________________

ICD-9/10 - CODE(S) SHOWN IN OFFICE NOTES SUBSTANTIATING MEDICAL NECESSITY FOR ORDER OF PROCEDURE:

__________________________________________

__________________________________________

__________________________________________
<table>
<thead>
<tr>
<th>Considerations for Improvement Upon Conversion to EMR/EMR Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Name and DOS on every page of Op Report?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Medical Record No. on every page of Report?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Location of Procedure Indicated?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Position of Patient for Procedure Documented?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>MEDICAL NECESSITY FOR PROCEDURE SHOWN IN PROCEDURE NOTES?</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>MEDICAL NECESSITY FOR PROCEDURE SHOWN IN OFFICE NOTES OR VISIT DECISION FOR SURGERY MADE?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sterile Precautions Taken Documented?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Approach for Procedures Documented?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Antibiotics given to patient prior to procedure?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Pre-op Diagnosis Indicated?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Post-op Diagnoses Indicated?</strong> Yes____ No____</td>
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<td><strong>Procedure Details Documented?</strong> Yes____ No____</td>
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<tr>
<td><strong>Check made for Patient Identity and Location of Procedure?</strong> Yes____ No____</td>
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<tr>
<td><strong>Type of Instruments used Documented?</strong> Yes____ No____</td>
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<tr>
<td><strong>Complications Noted?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Depth and extent of incisions indicated?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Clinical findings indicated during procedures?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Depth of instrument penetrations through body orifices or</strong></td>
</tr>
<tr>
<td><strong>Cavities Indicated?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Foreign bodies observed or removed indicated?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Nature and amount of material drained indicated?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Location, number, and size of lesions excised</strong></td>
</tr>
<tr>
<td><strong>Biopsied, curedt, frozen, exposed to laser light</strong></td>
</tr>
<tr>
<td><strong>Or otherwise removed indicated?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Nature, source, and size of specimens sent to Pathology</strong></td>
</tr>
<tr>
<td><strong>Indicated?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Were the words difficult, complicated, unusual, blood</strong></td>
</tr>
<tr>
<td><strong>Loss over 100 cc/s or extended use in describing</strong></td>
</tr>
<tr>
<td><strong>Operation/procedure required?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Estimated Blood Loss documented?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Treatment plan reviewed with patient?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Post-Op Condition of Patient Documented?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Vitals indicated before and After Procedure?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Time and date Patient transferred to Recovery Noted?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Post-op Instructions stated in Notes and Patient forms?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Patient vitals monitored and Document in Recovery?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Date, time and Condition of Patient Documented Upon</strong></td>
</tr>
<tr>
<td><strong>Release from Office/Facility with Patient/Guardian</strong></td>
</tr>
<tr>
<td><strong>Signature?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>All release documents given to Patient/Guardian and</strong></td>
</tr>
<tr>
<td><strong>Signed off on by Provider and Patient?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Are Facility notes/billing available for review?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Does Facility documentation tie back to Procedure notes?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>What Diagnosis was billed on Facility billing?</strong></td>
</tr>
<tr>
<td><strong>What diagnosis was shown on any Pathology Reports?</strong></td>
</tr>
<tr>
<td><strong>Does Patient name, DOB and DOS reflect same on Facility</strong></td>
</tr>
<tr>
<td><strong>And Physician notes?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Does Patient’s signature and initals appear the same on</strong></td>
</tr>
<tr>
<td><strong>Facility Records and Physician Records?</strong> Yes____ No____</td>
</tr>
<tr>
<td><strong>Does other Patient information check back to physician records?</strong> Yes____ No____</td>
</tr>
</tbody>
</table>
Completing the Audit Process

- Surgical Notes are then evaluated and scored – depending on type of surgical procedure.
- Report is prepared showing overall and detailed results of audit
- Recommendations provided
- Relevant rules, regulations, guidelines are presented for future reference for practice.
Another Excellent Resource for Cancer Surgery – NIH National Cancer Institute – SEER Training Modules
http://training.seer.cancer.gov/treatment/surgery/review.html

SUCCESS!

VALUE BASED PURCHASING SYSTEM/
BUNDLED EPISODES OF CARE

FUTURE OF PHYSICIAN REIMBURSEMENT WILL INCREASE DOCUMENTATION AND QUALITY ACCOUNTABILITY
Agency for Healthcare Research and Quality (AHRQ)

- “What Do Value-Based Purchasers Do?”
- Because quality is a broad concept with many dimensions, value-based purchasing encompasses a wide range of initiatives designed to achieve a variety of short-term and long-term objectives.
- Who is impacted?
- Those who are eligible for or receive health care (e.g., employees, patients).
- Those who provide health care (e.g., health plans, physicians, hospitals).
- The third parties who pay for health care (e.g., insurance companies).

AETNA’s Move to Value-based Purchasing Contracts

A bar chart showing the percentage of total spending on value-based payments from 2013 to 2018. The data source is Aetna Investor Presentation.
CMS.GOV – Comprehensive Care for Joint Replacement Model
Comprehensive Care for Joint Replacement Model

• Hip and knees most common surgery for Medicare patients.
  – In 2014, more than 400,000 procedures
  – Costing more than $7 billion for hospitalizations alone.
  – Rate of complications can be more than 3x higher at some facilities due to high volume and varying quality among providers and increases chances for readmissions.
  – Average cost for surgery, hospitalization and recovery ranges from $16,500 to $33,000 across geographic areas.

Episode of Care Under Program

• Episode begins with admission and ends 90 days post-discharge
  – 67 geographic areas implemented in metropolitan statistical areas with populations of at least 50,000 – Start date April 1, 2016.
  – Episode includes all related items and services paid under Medicare Part A and Part B for all Medicare FFS beneficiaries, with exception of certain exclusions
  – Every year in 5 year performance model, hospitals will receive separate episode target prices. All providers paid under usual payment system rules throughout year. At end of performance year, actual spending for the episode is compared to Medicare target episode price for responsible hospital. Depending on the participant hospital’s quality and episode spending performance, the hospital may receive an additional payment from Medicare or be required to repay Medicare for a portion of the episode spending.
Episode of Care Under Program

• To support better and more efficient care for beneficiaries undergoing the most common inpatient surgeries.

• Bundled payment and Quality measurement for an episode of care associate with hip and knee replacements to encourage hospitals, physicians, and post-acute providers to work together to improve quality and coordination of care.

QUESTIONS?

THANK YOU!