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Meet the Presenters…

Aimee Wilcox,
CPMA, CCS-P, CST, MA, MT

On the topic:
Auditing Surgical Services
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Auditing Surgical Services

Aimee L. Wilcox, CCS-P, CPMA, CMHP, CST, MA, MT
Director of Content

Time To Glove Up

Aimee L. Wilcox, CCS-P, CPMA, CMHP, CST, MA, MT
Director of Content
Find-A-Code, LLC

Surgical Coding & Auditing
Experience & Resources

Type of Auditor
- Student
- Newly certified
- Certified 1-5 years
- Certified 6+ years
- New specialty
- Coding validation (provider &/or coder work)
- Compliance
- Payer auditor
- Defense auditor
- Other

Available Resources
- Books
- Encoder software
- Auto-coding software
- Paper audit forms
- Excel Spreadsheets
- Payer policies
  - NCD/LCD
  - Commercial
  - E/M Guidelines
  - Contracts
- CPT/HCPCS/ICD-10-CM
- CPT Assistant
- Decision Health
- Internal policies
- Fee schedules/RVUs
- NCCI edits and Policy Manual
- CERT Findings
- Other

Global Periods

Global Indicators
XXX Global concept doesn’t apply
000 Zero days
010 Ten days (really 11)
090 Ninety days (really 92)
MMM Maternity codes (OB package)
YYY Unlisted codes (payer review)
ZZZ Add-on (+) codes (see primary)

What’s Included in the Global Period?
- E/M service (pre- & postop)
- Services (normal & necessary)
  - Incision
  - Suturing
  - Local
  - Cautery
  - Closure
- Customary supplies
  - Needles & Dressings, etc.
- Local/Regional anesthetic
- Suture and staple removal
- Dressing changes, packing, splints, etc.
National Correct Coding Initiative (NCCI)

CMS identifies code pairs & bundles them.

When Column 1 and 2 billed together, Column 1 will be paid; Column 2 will be denied.

NCCI Indicators
0 – Modifier will NOT override the edit
1 – Modifier can override the edit

Appropriate Unbundling

- NCCI indicator 1 indicates modifier MAY be reported to unbundle code pair.
- Applicable modifiers include 59 or X {EPSU}
- Follow payer rules
- Documentation MUST support the modifier

Online resources
- FindACode and other online encoders provide NCCI tools to streamline auditing processes

Modifiers

Surgical Details
- 22 Increased procedural services
- 50 Bilateral procedure
- 51 Multiple procedures
- 52 Reduced services
- 53 Discontinued procedure
- 58 Staged/Related Procedure by same MD during postop period
- 59 Distinct Procedural Service
- 63 Procedure performed on infant less than 4kg (<9 lbs)

Surgical Services
- 73 Discontinued before anesthesia (Outpatient Hospital/ASC)
- 74 Discontinued after anesthesia (Outpatient Hospital/ASC)

Surgical Assistants
- 62 Two surgeons
- 66 Surgical Team
- 80 Assistant Surgeon
- 81 Minimum assistant surgeon
- 82 Assist surgeon (no qualified resident surgeon available)

Repeat Surgical Services
- 76 Repeat proc/service; same MD/QHP
- 77 Repeat proc/service: other MD/QHP
- 78 Unplanned return to O.R.; same MD/QHP
- 79 Repeat procedure during postop
- 79 Unrelated procedure by same MD/QHP during postop

Anesthesia
- 23 Unusual anesthesia
- 47 Unusual anesthesia (related)
Diagnostic vs Therapeutic

**WATCH for BUNDLING**
Diagnostic procedures may stand alone or may be bundled into a therapeutic procedure; even within the same session.

Examples
- Facet injections*
- Biopsies
- Endoscopy
- Laryngoscopy
- Interventional procedures
- Image guidance
- Pathology driven procedures
- Endoscopy & Endo to Open
- Laparoscopy & Lap to Open

*Ablation of spinal nerves has a pre-surgery requirement of:
- tried and failed conservative treatment
- 2 initial facet injections (diagnostic) with 80% relief
- strict utilization limitations.

Alert:
There may not be an NCCI edit specific to the Endo + Sx or Lap + Sx code combination – but it is the rule.

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**Operative Report Format**

DATE: 12/01/17

PATIENT: John Smith

SURGEON: Peter Nichols, MD

ASSISTANT SURGEON: None

PREOPERATIVE DIAGNOSIS: Obstructive adenotonsillar hypertrophy with chronic recurrent pharyngitis.

POSTOPERATIVE DIAGNOSIS: Obstructive adenotonsillar hypertrophy with chronic recurrent pharyngitis.

SURGICAL PROCEDURE PERFORMED: Tonsillectomy and adenoidectomy

ANESTHESIA: General endotracheal technique.

SURGICAL FINDINGS: A 4+/4+ cryptic and hypertrophic tonsils with 2+/3+ hypertrophic adenoid pads.

INDICATIONS: We were requested to evaluate the patient for complaints of enlarged tonsils, which cause difficulty swallowing, recurrent pharyngitis, and sleep-induced respiratory disturbance. She was evaluated and scheduled for an elective procedure.
DESCRIPTION OF SURGERY: This 8-year-old female patient was brought to the operative suite and placed supine on the operating room table. General anesthetic was administered. Once appropriate anesthetic findings were achieved, the patient was intubated and prepped and draped in the usual sterile manner for a tonsillectomy. He was placed in semi-Rose position and a Crowe Davis-type mouth gag was introduced into the oropharynx. Under an operating headlight, the oropharynx was clearly visualized. The right tonsil was grasped with the fossa triangularis and using electrocautery enucleation technique, was removed from its fossa. This followed placing the patient in a suspension position using a McIvor-type mouth gag and a red rubber Robinson catheter via the right naris. Once the right tonsil was removed, the left tonsil was removed in a similar manner, once again using a needle point Bovie dissection at 20 watts. With the tonsils removed, it was possible to visualize the adenoid pads. The oropharynx was irrigated and the adenoid pad evaluated with an indirect mirror technique. The adenoid pad was greater than 2+/4 and hypertrophic. It was removed with successive passes of electrocautery suction. The tonsillar fossa was then once again hemostased with suction cautery, injected with 0.5% ropivacaine with 1:100,000 adrenal solution and then closed with 2-0 Monocryl on an SH needle. The redundant soft tissue of the uvula was removed posteriorly and cauterized with electrocautery to prevent swelling of the uvula in the postoperative period. The patient's oropharynx and nasopharynx were irrigated with copious amounts of normal saline contained with small amount of iodine, and she was recovered from her general endotracheal anesthetic. She was extubated and left the operating room in good condition to the postoperative recovery room area. Estimated blood loss was minimal. There were no complications. Specimens produced were right and left tonsils. The adenoid pad and uvula were ablated with electrocautery.
“Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.”

Medicare

PLUS (+)
- Medical necessity
- Accurate (detailed) documentation
- Published policies
- NCCI Edits and Rules
DATE OF SERVICE: 12/01/2017
PATIENT NAME: Wouldn’t Ulike2Know

This 68-year old patient is here for repeat knee joint and trigger point injections. The last time she had the injections was in November, which provided significant relief. Patient was scheduled for repeat injections today.

PROCEDURES:
1. Bilateral knee joint injections. After alcohol prep on each knee, taking lateral approach, posterior to the patella, a 25-gauge, 3.5-inch needle was advanced into the knee joint. Five mL of 0.25% Marcaine with 20 mg of Kenalog was injected into each side for a total of two injections.

2. Trigger points were identified bilaterally in the supraspinatus muscles. A total of 10 mL of 0.25% Marcaine, 5 mL per side, with 40 mg of Kenalog total was used to inject the two trigger points. There were no complications.

IMPRESSION:
1. Osteoarthritis of the knees (M17.9).
2. Myofascial pain syndrome (M79.1).

PLAN: Return in about two months for repeat injections.

John Smack, MD
12/01/2017 09:10:56
(Electronic signature requirements met)
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Multi-Dose Vials as "Multi-Dose V require labeling" and Always contain an antimicrobial preservative

Single Dose/Use vials aren’t always labeled "single dose" but should be “preservative free”

Claims require NDC#. If no NDC# exists, then report with:
- J3490 Unclassified drug
- J3590 Unclassified biologic

CMS1500 box 19 include: drug name, strength, and quantity

Multi-Dose Vials

Claim information for:
Marcaine - Bupivacaine HCl inj 0.25% 2.5 Mg/ml Hydrochloride Perineural Solution

The following documentation and billing codes are suggested by the indications for this drug. Consult your payer for specifics on documenting and billing for drugs and pharmaceuticals. The presence of a code here DOES NOT guarantee payment or reflect the medical or legal appropriateness for using any of the following codes.

- ICD-10-CM codes: 1
- CPT codes: 0
- HCPCS codes: 1
- 5020 Injection, bupivacaine hydrochloride, 30 ml
- ICD-10-PCS codes: 0
- Indications/Diseases: 2
- NDCs & Prices: 3
- Packages: 3
- Patient Information

Potential issues:
- NCCI edits
- Modifiers
- Right drug - Check label
- Unlisted drug code - Identify
- Payer policy regarding Marcaine
- Utilization issues
- EM service same day
- Unspecified ICD-10-CM code

Audit findings:

<table>
<thead>
<tr>
<th>Code</th>
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LCD Coverage Guidance

Major Criteria (must meet 4 of 4)
- Goal: Identify & treat cause of pain; not just the symptoms
- Defines “muscle groups”
- TPs should be part of an overall management plan – not the whole thing.

Medical Necessity Delineated
- “When it is currently causing tenderness and/or weakness, restricting motion and/or causing referred pain when compressed.”
  (see list of approved ICD-10-CM codes)

Treatments Denied Include
- Prolotherapy
- Acupuncture
- Dry needling

Utilization Guidelines
- Three sessions in a 3 month period; to perform more, the reasons for them should be documented in the record and made available at the contractor’s request.

Indications and Limitations of Coverage and/or Medical Necessity

Myofascial trigger points are small, circumscripted, hyperirritable foci in muscles and fascia often found with a firm or taut band of skeletal muscle. These trigger points produce a referred pain pattern characteristic for the individual muscle. Each patient becomes a single case of a single muscle syndrome. To successfully treat chronic myofascial pain, trigger points of the same muscle syndrome need to be identified along with every perpetuating factor.

The pain of active trigger points can begin as an acute single muscle syndrome resulting from stress overload or injury to the muscle, or can develop slowly because of chronic or repetitive muscle strain. The pain normally refers distal to the specific hypereactive trigger point. Trigger point injections are used to alleviate this pain.

There is no laboratory or imaging test for establishing the diagnosis of trigger points; it depends therefore upon the detailed history and thorough examination. The following diagnostic criteria are adopted by this A/B MAC from Simmons:

Major criteria: All four must be present to establish the diagnosis.
- A. Regional pain complaint
- B. Pain complaint or altered sensation in the expected distribution of referred pain from a trigger point
- C. Taut band palpable in an accessible muscle with exquisite tenderness at one point along the length of it
- D. Some degree of restricted range of motion, when measurable

Minor criteria: Only one of four needed for the diagnosis.
- A. Reproduction of referred pain pattern by stimulating the trigger point
- B. Altered sensation by pressure on the tender spot
- C. Local response elicited by snapping palpation at the tender spot or by needle insertion into the tender spot
- D. Pain alleviated by stretching or injecting the tender spot

Inform Providers

Review LCDs/NCDs for common or at-risk services (OIG Work Plan) and create Documentation Guides for your providers.
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Outcome of Audit

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Provider Charges

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Compliance

Is a Compliance Plan Mandatory?
If you take a penny of Medicaid or Medicare Advantage YOU MUST have a LIVING compliance plan.

How will a Compliance Plan help?
- Get a pulse on your practice
- Identify potential areas of concern
- Get providers on the SAME PAGE
- Everyone knows the rules

What type of audits are there?
- Responding to payer audits or requests for patient documentation to support previously submitted claims.
- External vs. Internal
- Pro- vs. Retrospective
- Focused

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