Coding Errors That Cost You Money

Academic Orthopaedic Consortium

Boston, Massachusetts
October 1 – 3, 2019
Significant CMS & CPT Proposed E/M Changes for 2021 To-Do List
Evaluation and Management (E/M)

2021
ER Visits
Inpatient Visits
Consultations
Observation

History

Exam

MDM

Level of E/M Service

2021
Outpatient Visits
New & Established
99202-99215
(99201 deleted)

Time

OR

MDM
Updated Configuration
Payor Confusion Adds to Chaos

Surgeon performed fixation of multiple metacarpal fractures.
They reported:

26615  (7.07 wRVUs)
26615-59 (3.53 wRVUs)
26615-59 (3.53 wRVUs)

Medicare paid the first code then denied the others as duplicates.
Medicare Says “No 59” to a CPT Code Reported More Than Once

Instead they require 76 – repeat procedures.

26615
26615-76 (different DX code!)
26615-76
Plus Bilateral Mania

-50
RT/LT
Units (for fingers and toes)
F1-F9 or T1-T9
59 + Anatomic Part
59 + 76
Fracture Coding Comparisons

**Medicare**
“If a patient has two nondisplaced metacarpal fractures treated nonsurgically with a single cast, Medicare requires the use of CPT code 26605 – Closed treatment of metacarpal fractures, single; with manipulation, each bone – to be reported and paid one time.”

**CPT Private Payors**
“But under CPT rules, for a private payer patient with the same condition and treatment (two nondisplaced metacarpal fractures treated without manipulation and a single cast for immobilization), the surgeon would report 26605 and 26605-59.”
Now Add in RVU Issues

26605     3.30 wRVUS
26605-59    1.15 RVUs
(submit full charge)
Medicare Physician Payments

Fees Could Better Reflect Efficiencies Achieved When Services Are Provided Together
NCCI Edits Accepted as “The Bible”

“The official Guidance only applies to Medicare fee-for-service claims from physician or other practitioner claims billed under the Medicare fee-for-Service Part B physician fee schedule. Each commercial payer will have to determine whether it will offer similar audit flexibilities.”
Missing Fixation Devices

Old coders may use old rules!

In audits, external fixation devices are often missed. Back along the trail you could not bill for them.
Fixation/Hardware Devices

- Often missed when placing devices during open treatments.

- Trying to bill 20680 multiple times for same site despite multiple incisions doesn’t work!
“This is the way we’ve always done it…”
thinking is costly.

“No time to train.”
Are Clinically Savvy, But Coding “Dummies” Dictating Op Reports?

“If it’s not documented it’s not done.”

= 

Increasing denials for Medical Necessity
Exceptional Educators
Sample Errors

1. Lack of specificity in documentation of tendon repair and fracture management.

2. If intra-articular repair of fraction—must specify the number of fragments—1, 2, 3 or more!

3. Unbundling and insufficient documentation of amputation services.
Lost Reimbursement To Poor OP Notes

Debridement codes 11010, 11011, and 11012 were revised in 2011 to describe debridement including the removal of foreign material at the site of an open fracture and/or an open dislocation (eg, excisional debridement) for the skin and subcutaneous tissues, muscle fascia, muscle, and bone.

This is not pulsatile lavage, this not irrigation and debridement with 1 liter of saline. They must document the depth of tissue excised and what removed (eg. Devitalized tissue, rocks, gravel, etc.). If they say “down to” bone, 11012 is not supported; if they say “down to” muscle, 11011 is not supported.
Provide Training and Tools
AAOS + KZA Training
2019 Chicago November 1 - 2

2020 Orthopaedic Coding Workshops
January 30 - February 1 - Las Vegas
February 13 – 15 - Orlando
March 5 – 7 - New York
March 19 – 21 – Dallas
May 7 - 9 - Chicago
Free, Free, Free
AAOS Webinars for Residents!

October 2nd Debut!

Medical Necessity

with
Margi Maley, BSN
and
Brad Henley, MD
Top 5 Recurrent Mistakes in ICD-10 Coding

1. Misunderstandings in the acute hospital setting related to specificity in documentation detail, such as the use of the seventh character for trauma and fracture codes.
2. Problems that occur when coders rely on procedures codes to determine diagnostic-related group codes.
Top 5 Recurrent Mistakes in ICD-10 Coding

3. Confusion around using respiratory failure as a principal diagnosis and around sepsis coding.

4. Mistakes around whether dye was used during procedures with guidance tools, such as fluoroscopy or ultrasound.

5. A lack of specificity related to devices, components and grafting materials during medical procedures.
Injury Guy

- **S0**: Head
- **S1**: Neck
- **S2**: Thoracic
- **S3**: Spine Low Back Pelvis
- **S4**: Shoulder Humerus
- **S5**: Elbow Radius Ulna
- **S6**: Wrist Hand Fingers
- **S7**: Hip Femur
- **S8**: Knee Tibia Fibula
- **S9**: Ankle Foot Toes
- **S82**: Fx Ankle/Malleolus
  - Pilon
  - Bimalleolar
  - Trimalleolar
  - Medial Malleolar
  - Lateral Malleolar
- **S92**: Fx Calcaneus
  - Talus
  - Tarsals, Toes
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<thead>
<tr>
<th>Column</th>
<th>Description</th>
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<tbody>
<tr>
<td>A</td>
<td>initial encounter for <strong>CLOSED</strong> fracture</td>
</tr>
<tr>
<td>B</td>
<td>initial encounter for <strong>open</strong> fracture I or II or NOS</td>
</tr>
<tr>
<td>C</td>
<td>initial encounter for <strong>open</strong> fracture III A, B, or C</td>
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<tr>
<td>D</td>
<td>subsequent encounter for <strong>CLOSED</strong> fracture</td>
</tr>
<tr>
<td>E</td>
<td>subsequent encounter for <strong>open</strong> fracture I or II</td>
</tr>
<tr>
<td>F</td>
<td>subsequent encounter for <strong>open</strong> fracture III A, B, or C</td>
</tr>
<tr>
<td>G</td>
<td>subsequent encounter for <strong>CLOSED</strong> fracture</td>
</tr>
<tr>
<td>H</td>
<td>subsequent encounter for <strong>open</strong> fracture I or II</td>
</tr>
<tr>
<td>J</td>
<td>subsequent encounter for <strong>open</strong> fracture III A, B, or C</td>
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<tr>
<td>K</td>
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<tr>
<td>M</td>
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<tr>
<td>N</td>
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<tr>
<td>R</td>
<td>subsequent encounter for <strong>open</strong> fracture III A, B, or C</td>
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<tr>
<td>S</td>
<td>sequela</td>
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Injury Chapter 19 Fracture

7th Character Traumatic Shaft Fractures Closed or Open with Gustilo Classification
Limb & Joint Guy
<table>
<thead>
<tr>
<th>#</th>
<th>Limb</th>
<th>Joint</th>
<th>5&lt;sup&gt;th&lt;/sup&gt; Character</th>
<th>6&lt;sup&gt;th&lt;/sup&gt; Character</th>
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<tbody>
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<td>0</td>
<td>Unspecified</td>
<td>Unspecified</td>
<td>1</td>
<td>2</td>
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<tr>
<td>1</td>
<td>Shoulder</td>
<td>Shoulder</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>Upper arm</td>
<td>Elbow</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>Forearm</td>
<td>Wrist</td>
<td>1</td>
<td>2</td>
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<tr>
<td>4</td>
<td>Hand</td>
<td>Hand/finger</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>Thigh</td>
<td>Hip</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>Lower leg</td>
<td>Knee</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>Ankle/foot</td>
<td>Ankle and foot/toe</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>Other</td>
<td>Vertebral/Other</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>Multiple</td>
<td>Polymyalgia/Multiple sites</td>
<td>1</td>
<td>2</td>
</tr>
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1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> 4<sup>th</sup> 5<sup>th</sup> 6<sup>th</sup> 7<sup>th</sup>
Broken Feedback Loop

Attending MD → Resident MD → EOB

$ or $ received

? CPT + ICD-10 CODES

Biller/Coder

The End → Payment Poster
You Need To Monitor Denials
Residents and Fellows are eligible to receive a $150 discount on two day programs*
Questions?
Thank You

Presented by: Karen Zupko, President

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