2013 CODING AND DOCUMENTATION UPDATE
Inpatient Facility and Physician Spine Surgery

Presented by:
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IMPACT!

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Faculty and Planner Disclosure

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**Inpatient DRG Determination**

- Principal diagnosis
- Secondary diagnoses
- Procedure codes
- Gender
- Age
- Discharge Disposition

Not always a factor

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**Chief Complaint vs. Principal Diagnosis**

- The **CHIEF COMPLAINT** can be defined as the ‘presenting problem’ for which the patient presents to the hospital or other site for care.

- The **PRINCIPAL DIAGNOSIS** is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.”
Guidelines for Reporting Diagnoses

- Report all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay.

- Conditions documented at discharge as uncertain (e.g., rule out, possible, probable or suspected) are coded as if they exist, in anticipation that further diagnostic studies may be performed.

- Report conditions affecting patient care
  - clinical evaluation
  - therapeutic treatment
  - diagnostic procedures
  - extended LOS
  - increased nursing care or monitoring

Inpatient “CC’s” -- Complications & Comorbidities

- Complication – A condition that arises during the hospital stay that extends the length of stay by at least one day in 75% of the cases.

- Comorbidity – Pre-existing condition that will extend the length of stay by at least one day in 75% of the cases because it coexists with the principal diagnosis.

- The MS-DRG system recognizes both CC and major CC (MCC).
Inpatient “CC’s” -- Complications & Comorbidities

<table>
<thead>
<tr>
<th>Examples of Vague Language</th>
<th>More Specific Documentation Which May Affect DRG Assignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes poorly controlled</td>
<td>Uncontrolled diabetes, specific manifestations</td>
</tr>
<tr>
<td>Anemia</td>
<td>Specific type of anemia (eg, acute blood loss)</td>
</tr>
<tr>
<td>Respiratory insufficiency</td>
<td>Respiratory failure, and acute vs. chronic</td>
</tr>
<tr>
<td>NA = 120</td>
<td>Hyponatremia, and cause if known</td>
</tr>
<tr>
<td>Renal insufficiency</td>
<td>Severity of chronic kidney disease</td>
</tr>
<tr>
<td>Tachycardia</td>
<td>Specific type of tachycardia</td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>Pressure ulcer stage, site, and if pre-existing</td>
</tr>
<tr>
<td>Obesity</td>
<td>Morbid obesity, and body mass index</td>
</tr>
</tbody>
</table>

CMS Focus on Patient Safety

- Hospital Acquired Conditions (HAC) -- Secondary diagnoses must be reported with an appropriate POA (Present on Admission) indicator. Relevant HACs to orthopaedic care include:
  - pressure ulcer stages III and IV;
  - surgical site infection following certain orthopedic procedures;
  - deep vein thrombosis and pulmonary embolism following certain orthopaedic procedures.

- "Never Events"

<table>
<thead>
<tr>
<th>Type of Error</th>
<th>Inpatient Remarks Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong Surgery on Patient</td>
<td>MX</td>
</tr>
<tr>
<td>Surgery on Wrong Body Part</td>
<td>MY</td>
</tr>
<tr>
<td>Surgery on Wrong Patient</td>
<td>MZ</td>
</tr>
</tbody>
</table>
MS-DRG Assignment

- The relationships between principal diagnosis, secondary diagnoses, and valid O.R. procedures drive MS-DRG assignment.
- The MS-DRG titles do not necessarily reflect all of the elements of an individual patient’s course of care.
- *Code according to the documented facts and coding guidelines.*

New Coverage Criteria Trends

- Healthcare payor entities have been adopting increasingly stringent coverage criteria.
- These guidelines may be more conservative than the clinical standards of care developed by specialty medical societies.
- The stricter criteria lead to a need for more specific documentation of patient history and other findings to support medical necessity.
Facility / Physician Coding Issues

Facilities may report procedures using one of two different coding systems:

- For inpatient services -- ICD-9-CM Volume III
- For outpatient services -- CPT / HCPCS Codes

Physicians report procedures in all settings with CPT.

These two coding systems do not directly “translate” on a code by code basis.

The payment methodologies and bundling issues are not the same, even when both facility and physician report with CPT codes.
Documentation Drives Coding

In all circumstances, documentation indicates the services which may be reported. **The importance of consistent, complete documentation in the medical record cannot be overemphasized.**

Coding is case and patient specific. It is important for the coder and physician to communicate to ensure accurate documentation and coding.

Continued monitoring of complex cases which may arise will help ensure accurate coding.

Basic ICD-9-CM Procedure Coding

• If the descriptor for the procedure code does not include “bilateral,” the service may be coded twice to designate both left and right.

• In most circumstances, the operative approach is not reported separately from the procedure. There is usually an instructional note of “omit code.”

• When a procedure is initiated, but not fully completed, code only to the extent of services provided.

• The Principal procedure is that performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or necessary to take care of a complication, according to sequencing hierarchy.
Major Spinal Procedures

- Spinal fusion procedures
  - Initial fusion or refusion
  - Spinal level
  - Approach
  - Column fused
  - Multiple codes reported for combined techniques

- Number of vertebrae fused

- Excision of intervertebral disc:
  - That with decompression of spinal nerve root at same level as fusion (80.51)
  - Additional code for decompression of spinal nerve root at different level from excision site (03.09)
Ancillary Spinal Procedures

- Insertion of spinal devices
  - Interbody spinal fusion device
  - Other spinal devices
- Locally harvested bone for graft
- Computer assisted surgery (00.31 – 00.39)
- Robotic assisted procedures (17.41 – 17.49)
- Intraoperative neurophysiologic monitoring
- Various forms of traction and fixation devices
Case Study #1: Combined, Multi-Level Anterior-Posterior Spinal Fusion Surgery for Scoliosis

62 year-old male with a diagnosis of lumbar scoliosis extending from T11 to L5. Patient has a past medical history of type 2 diabetes, asthma, and hypertension.

Patient underwent an anterior fusion procedure using a mini-open direct lateral exposure of the intervertebral discs at L2–3 and L3–4 interspaces. Retraction or spreading of the psoas muscle allowed for disc or vertebral body removal, anterior release, and anterior height restoration. Direct local stimulation as well as continuous live EMG were used in all cases involving a transpsoas approach.

The anterior reconstruction was achieved using polyetheretherketone interbody cages at each interspace. Posterior supplemental fixation was performed during the same surgical session from L4-S1 with the use of (brand) percutaneous pedicle screws and connecting rods introduced through the proximal or distal screw entry site. The screw insertion technique was based on using primarily anteroposterior fluoroscopy, and no image guidance was used.
Case Study #1: Combined, Multi-Level Anterior-Posterior Spinal Fusion Surgery for Scoliosis

Posterolateral intersegmental fusion was achieved at L5-S1 without interbody fusion by exposing the facet joints and transverse processes of interest, decorticating with a high speed burr, and laying in of autograft.

Patient was discharged to home on day 6 post-operatively with orders for home health, physical and occupational therapy.

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>CPT PROCEDURE CODES</th>
<th>ICD-9 PROCEDURE CODES</th>
<th>DIAGNOSIS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excision of intervertebral disc (L2–L3 and L3–L4)</td>
<td>Bundled</td>
<td>80.51</td>
<td></td>
</tr>
<tr>
<td>Lumbar and lumbosacral fusion, anterior column, anterior technique (L2–L3 &amp; L3–L4)</td>
<td>22558 22585</td>
<td>81.06</td>
<td></td>
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<tr>
<td>Lumbar and lumbosacral fusion, posterior column, posterior technique (L5–S1)</td>
<td>22612-51</td>
<td>81.07</td>
<td></td>
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<tr>
<td>Insertion of interbody spinal fusion device</td>
<td>22851 x 2</td>
<td>84.51</td>
<td></td>
</tr>
<tr>
<td>Autograft for spine surgery; local</td>
<td>20936</td>
<td>77.79</td>
<td></td>
</tr>
<tr>
<td>Fusion or refusion of 2-3 vertebrae</td>
<td>N/A</td>
<td>81.62</td>
<td></td>
</tr>
<tr>
<td>Posterior segmental instrumentation; 3 to 6 vertebral segments (L4–S1)</td>
<td>22842</td>
<td>Bundled</td>
<td></td>
</tr>
<tr>
<td>Intraoperative neurophysiology monitoring</td>
<td>(95920)</td>
<td>00.94</td>
<td></td>
</tr>
</tbody>
</table>
### Case Study #1: Combined, Multi-Level Anterior-Posterior Spinal Fusion Surgery for Scoliosis

**Clinical Indication:**

“62 year-old male with a diagnosis of lumbar scoliosis extending from T11 to L5. Patient has a past medical history of type 2 diabetes, asthma, and hypertension.”

**Is this sufficient?**

1. Yes
2. No
Example – Florida Medicare LCD

Lumbar spinal fusion should be a last step in the treatment of chronic back pain and may be covered for the following:

- Lumbar spinal instability, confirmed by diagnostic testing.
- Spinal stenosis with associated spondylolisthesis with ALL the following:
  - Back pain with symptoms of neurogenic claudication or radicular pain, and
  - Radiographic evidence of spondylolisthesis, when applicable, and
  - Pain and significant functional impairment despite a history of 3 months of conservative therapy.
- Spondylolysis and isthmic spondylolisthesis, with ANY of the following:
  - Confirmed progressive deformity
  - Neurologic compromise
  - Multilevel spondylolysis or high grade spondylolisthesis demonstrated on plain x-rays
  - Symptomatic pain and significant functional impairment despite a history of 3 months of conservative therapy.
- Single level degenerative disc disease (DDD) without instability, with pain and significant functional impairment despite a history of at least 6 months of conservative therapy.

Excerpted from Local Coverage Determination (LCD) for Lumbar Spinal Fusion for Instability and Degenerative Disc Conditions (L32076); http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx. Enter “L32076” in Search by Document ID, and effective date of 01/01/2012 to access a copy of the complete LCD.

Case Study #1: Combined, Multi-Level Anterior-Posterior Spinal Fusion Surgery for Scoliosis

Additional detail may be found in pre-procedure history and other documents in chart:

- Ensure record clearly documents presence of advanced joint disease demonstrated by:
  - Radiographic or MRI evidence of progression of deformity, including a measurement of degree; and
  - Documented pain that interferes with ADLs; and
  - Failure of a minimum of 3 months conservative age appropriate therapy.

- For patients with significant conditions or co-morbidities, the risk/benefit of surgery should be appropriately addressed in the medical record.
Case Study #2: Multi-Level Posterior Instrumented Fusion for Adolescent Idiopathic Scoliosis

16-year-old girl presented with a Lenke 1AN 60 degree curve due to adolescent idiopathic scoliosis (AIS). She had originally presented with a 35 degree curve at age 9. MRI revealed no intraspinal anomalies. She progressed despite being braced in a TLSO for 16 hours/day. On physical examination her right shoulder was elevated, and on Adams forward bending test the inclinometer read 17 degrees. Neurological examination was within normal limits.

The patient was brought to the operating room for a posterior spine fusion (PSF) utilizing a muscle sparing approach. After standard prep and drape, the fluoroscopy machine was used to plan a midline incision from T2-L2. The skin was opened sharply and undermined laterally maintaining fascial integrity. Under fluoroscopic guidance the (brand) needles were placed into the pedicle to a depth of 20 mm.

This was done sequentially from L2-T2 bilaterally, skipping T4 on the right. Subsequently, guide wires were advanced with removal of the (brand) needles. At this point, the fluoroscopy machine was positioned for a lateral projection and a muscle protective sleeve passed over the guide wires. A cannulated awl was used to start the pedicle hole, followed by the appropriate size tap. At this point, each facet was visualized with a hand held retractor and the facets drilled with a high speed burr. Care was taken to ensure adequate decortication and the grafting material was placed. This consisted of a mixture of corticancellous chips, aspirated blood from the pedicle. Subsequently, the appropriate size pedicle screw was inserted and the guide wire removed.
Case Study #2: Multi-Level Posterior Instrumented Fusion for Adolescent Idiopathic Scoliosis

Curve correction and derotation were performed by first placing two rods through the slots of the screw extensions on the convexity. Controlled, forceful separation of the rods resulted in coronal and axial correction. Once the correction was attained, an appropriately sized cobalt chrome rod bent into the appropriate sagittal contour was introduced on the concavity. The rod was inserted through L2 and sequentially up. Tactile and visual feedback guided passage of the rod through the screw extensions. Once all screw extensions were engaged, set screws were placed and the rod reduced using reduction instruments. The concave rod was turned into the appropriate sagittal plane, and the set screws tightened. In a similar manner, the rod on the convexity of the curve was placed. Prior to placement of the convex rod, an en bloc derotation maneuver was performed.

Intraoperative x-rays confirmed good correction and the wound was closed in a standard manner. Intraoperative blood loss was 250 cc.

On day-4 post op, patient presented with erythematic wound and partial wound dehiscence (T6-T9) associated with the drainage of purulent fluid at the spine incision site. Patient returned to the operative suite and was treated with an aggressive irrigation and debridement procedure and placed on IV (antibiotics). Patient was discharged on day 9 with a regimen of 6-weeks IV antibiotics for home administration.
Case Study #2: Multi-Level Posterior Instrumented Fusion for Adolescent Idiopathic Scoliosis

<table>
<thead>
<tr>
<th>PROCEDURES</th>
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<th>ICD-9 PROCEDURE CODES</th>
<th>DIAGNOSIS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dorsal and dorsolumbar fusion, posterior technique</td>
<td>22804</td>
<td>81.05</td>
<td>737.30</td>
</tr>
<tr>
<td>Fusion or refusion of 9 or more vertebrae (13 segments: T2 – L2)</td>
<td></td>
<td>81.64</td>
<td></td>
</tr>
<tr>
<td>Posterior segmental instrumentation; 13 or more vertebral segments</td>
<td>22844</td>
<td>Bundled</td>
<td></td>
</tr>
<tr>
<td>Autograft for spine surgery; local</td>
<td>20936</td>
<td>77.79</td>
<td></td>
</tr>
<tr>
<td>Intraoperative x-ray of thoracic spine</td>
<td>720xx</td>
<td>87.23</td>
<td></td>
</tr>
<tr>
<td>Debridement of wound, infection, or burn</td>
<td>11042 / 11043</td>
<td>86.22 / 86.28</td>
<td>998.59 / 998.32</td>
</tr>
</tbody>
</table>

Case Study #3: Combined Posterior Interbody and Posterior Lumbar Fusion

A 68-year old female presents with severe disc degeneration and lateral listhesis at L4-L5 with compression of spinal nerves and radiculopathy, above an L5-S1 lytic or ischemic spondylolisthesis. She has significant low back pain and radiculopathy that has not responded to nonoperative treatment and undergoes fusion at L4-L5 and L5-S1.

The affected spinal segments are identified and the posterolateral elements of the spine are exposed. The necessary portion of the facet joint is removed along with the lateral aspect of the lamina to expose the disc space. The thecal sac and nerve roots are identified, dissected, and retracted.
## Case Study #3: Combined Posterior Interbody and Posterior Lumbar Fusion

Laminotomy with decompression of spinal nerves is performed at L4-L5. The posterior annulus of the disc is incised followed by removal of disc material sufficient to allow creation of a bone graft recipient bed at each level.

Following this, intervertebral cages and morcelized autograft bone are placed at each interspace. The transverse process and facet joints are decorticated and bone graft is placed posterolaterally for posterior fusion at each level. Posterior segmental instrumentation is inserted from L-4 to S-1.

The patient tolerated the procedure well and was returned to the recovery room in stable condition.

### Procedures Table

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>CPT PROCEDURE CODES</th>
<th>ICD-9 PROCEDURE CODES</th>
<th>DIAGNOSIS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique; lumbar (L4-L5 &amp; L5-S1)</td>
<td>22633  22634</td>
<td>81.08  81.07  81.62</td>
<td>722.52  724.4  738.4</td>
</tr>
<tr>
<td>Laminotomy and discectomy with decompression, lumbar</td>
<td>63030-59</td>
<td>80.51</td>
<td></td>
</tr>
<tr>
<td>Posterior segmental instrumentation; 3 to 6 vertebral segments</td>
<td>22842</td>
<td>Bundled</td>
<td></td>
</tr>
<tr>
<td>Application of intervertebral biomechanical device</td>
<td>22851 x 2</td>
<td>84.51</td>
<td></td>
</tr>
<tr>
<td>Autograft for spine surgery; local</td>
<td>20936</td>
<td>77.79</td>
<td></td>
</tr>
</tbody>
</table>
Case Study #3: Combined Posterior Interbody and Posterior Lumbar Fusion

**CASE NOTES:** Code 63030 is defined in CPT as laminotomy, which is term used in note, whereas 63047 is described as laminectomy.

**Note:** The codes for PLIF include laminectomy and/or discectomy to prepare interspace, other than that for decompression. Several of the decompression codes are bundled with PLIF in CCI (63030, 63047, 63005, 63012, 63017), and so a clear description of how the additional decompression is a distinct service vs. incidental to that which is already required in preparation for the arthrodesis should be identified in the medical record to support reporting additionally.

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CPT 2012 New Codes

- **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

- **22634** each additional interspace and segment (List separately in addition to code for primary procedure)

Codes for lumbar posterior or posterolateral fusion (22612, 22614) and posterior interbody fusion (22630, 22632) are still valid, but may no longer be reported together for combined technique.
Bone grafting codes 20930-20938 and spinal instrumentation codes 22840-22851 are separately reportable when performed with arthrodesis procedures; however, CPT inadvertently omitted the new codes 22633 and 22634 from the parenthetical notes for the graft and instrumentation codes. This omission caused some payors to inappropriately deny payment for the codes.

The American Medical Association (AMA) has posted a correction on the CPT website dated May 23, 2012, although it was not included in the first published CPT Errata document. Surgeons who have been denied payment for the graft and instrumentation codes used with the new bundled codes could flag the claims and resubmit when the CPT clarifications were published.

The parenthetical notes were revised in CPT 2013 to include 22633 and 22634.

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**PREOPERATIVE DIAGNOSIS:** Severe low back pain.  
**POSTOPERATIVE DIAGNOSIS:** Severe low back pain.  

**OPERATIONS PERFORMED:** Anterior lumbar fusion, L4-L5, L5-S1, [brand] interbody vertebral spacer, structural autograft from L5 vertebral body, and anterior plate.

**CLINICAL INDICATIONS:** This is a 51-year-old man who reports 15-year history of low back pain and intermittent bilateral leg pain and achiness. He has tried multiple conservative treatments including physical therapy, epidural steroid injections, etc. MRI scan shows a very degenerated disk at L5-S1, less so at L3-L4 and L4-L5. A discogram was positive with the lower 3 levels, but he has pain, which starts below the iliac crest and I feel that the L3-L4 disk is probably that symptomatic. An anterior lumbar interbody fusion was suggested. Procedure, risks, and complications were explained.
Case Study #4 – Anterior Lumbar Fusion

OPERATION IN DETAIL: The patient was placed under general endotracheal anesthesia. The abdomen was prepped and draped in the usual fashion. Dr. X made the approach, and once the L5-S1 disk space was identified, we incised this with a knife and then removed a large core of bone taking rotating cutters. I was able to remove additional disk space and score the vertebral bodies. The rest of the disk removal was done with the curette, scraping the endplates. I tried various sized spacers, and at this point, we exposed the L5 body and took a dowel from the body and filled the hole with a 15 x 20-mm [brand] tricalcium phosphate plug. We placed a 13-mm [brand] vertebral spacer at L5-S1. Half of the excised structural autograft was used to fill the spacer at L5-S1 and then it was tapped into place.

We then moved the vessels over the opposite way approaching the L4-L5 disk space laterally, and the disk was removed in a similar fashion and we also used a 13-mm [brand] vertebral spacer. This was filled with structural autograft bone. Once this was done, we were able to place an 87-mm [brand] sacral plate down over the three vertebral bodies and place the screws. We used a two-level 87-mm [brand] sacral plate with 28 x 6-mm screws, two each at L4 and L5 and 36 x 6-mm screws at S1. Following this, bleeding points were controlled and Dr. X proceeded with the closure of the abdomen.

ANESTHESIA: General endotracheal.
ESTIMATED BLOOD LOSS: Less than 50 mL.
DRAINS: None.
COMPLICATIONS: None.
## Case Study #4 – Anterior Lumbar Fusion

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>CPT PROCEDURE CODES</th>
<th>ICD-9 PROCEDURE CODES</th>
<th>DIAGNOSIS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lumbar interbody fusion, anterior column, anterior approach</td>
<td>22558-62 22585-62</td>
<td>81.06 81.62</td>
<td>724.4 724.2 722.52</td>
</tr>
<tr>
<td>Application of intervertebral biomechanical device</td>
<td>22851 x 2</td>
<td>84.51</td>
<td></td>
</tr>
<tr>
<td>Anterior instrumentation, 2-3 levels</td>
<td>22845</td>
<td>Bundled</td>
<td></td>
</tr>
<tr>
<td>Autograft for spine surgery; local</td>
<td>20936</td>
<td>77.79</td>
<td></td>
</tr>
</tbody>
</table>

### DR. X – PROCEDURES

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>CPT PROCEDURE CODES</th>
<th>ICD-9 PROCEDURE CODES</th>
<th>DIAGNOSIS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lumbar interbody fusion, anterior column, anterior approach</td>
<td>22558-62 22585-62</td>
<td>N/A</td>
<td>722.52</td>
</tr>
</tbody>
</table>

**CASE NOTES:** When two surgeons work together as primary surgeons performing distinct parts of a single reportable procedure, each physician reports his/her distinct operative work by modifier -62 to the single definitive procedure code. If additional procedure(s) are performed during the same surgical session, separate code(s) may be reported by each co-surgeon, with modifier 62.

Reimbursement is often based on Medicare guidelines, which is 62.5% of the standard allowable for each physician.

Cosurgery does not affect facility coding and reimbursement.
Case Study #5: Anterior Cervical Discectomy and Fusion


PREOPERATIVE DIAGNOSES

POSTOPERATIVE DIAGNOSES
1. Herniated nucleus pulposus C2-C3. 722.0
2. Spinal stenosis C3-C4. 723.0

PROCEDURES
1. Anterior cervical discectomy, C3-C4, C2-C3.
3. Removal of old instrumentation, C4-C5.

PROCEDURE IN DETAIL: The patient was placed in the supine position. The neck was prepped and draped in the usual fashion for anterior cervical discectomy. A high incision was made to allow access to C2-C3. Skin and subcutaneous tissue and the platysma were divided sharply exposing the carotid sheath which was retracted laterally and the trachea and esophagus were retracted medially. This exposed the vertebral bodies of C2-C3 and C4-C5 which was bridged by a plate.

We placed in self-retaining retractors. With the tooth beneath the blades, the longus colli muscles were dissected away from the vertebral bodies of C2, C3, C4, and C5. After having done this, we used the all-purpose instrumentation to remove the instrumentation at C4-C5, we could see that fusion at C4-C5 was solid.

22855
Case Study #5: Anterior Cervical Discectomy and Fusion

We next proceeded with the discectomy at C2-C3 and C3-C4 with disc removal. In a similar fashion using a curette to clean up the disc space and the space was fairly widened, as well as drilling up the vertebral joints using high-speed cutting followed by diamond drill bit. It was obvious that the C3-C4 neural foramina were almost totally obliterated due to the osteophytosis and foraminal stenosis. With the operating microscope; however, we had good visualization of these nerve roots, and we were able to decompress both at C2-C3 and C3-C4.

We then placed the [brand] 55-mm plate from C2 down to C4. These were secured with 16-mm titanium screws after excellent purchase. We took an x-ray which showed excellent position of the plate, the screws, and the graft themselves. The next step was to irrigate the wound copiously with saline and bacitracin solution and a drain was placed in the prevertebral space and brought out through a separate incision.

The wound was closed with 2-0 suture for subcutaneous tissues and adhesive strips used to close the skin. Blood loss was about 50 mL. No complication of the surgery. Needle count, sponge count, cottonoid count was correct.

The operating microscope was used for the entirety for both visualization and magnification and illumination which was quite superb. At the time of surgery, he had total collapse of the C2, C3, and C4 disc with osteophyte formation. At both levels, he has high-grade spinal stenosis at these levels, especially foramen stenosis causing the compression, neck pain, headaches, and arm and shoulder pain. He does have degenerative changes at C5-C6, C6-C7, C7-T1; however, they do not appear to be symptomatic, although x-rays show the disks to be partially collapsed at all levels with osteophyte formation beginning to form.
Case Study #5: Anterior Cervical Discectomy and Fusion

**PROCEDURES** | **CPT PROCEDURE CODES** | **ICD-9 PROCEDURE CODES** | **DIAGNOSIS CODES**
--- | --- | --- | ---
Arthrodesis, cervical, anterior interbody technique | 22551 22552 | 81.02 | 81.62
Fusion or refusion of 2-3 vertebrae (C2-C3 and C3-C4) | | | 80.51
Discectomy for decompression, cervical (C2-C3 and C3-C4) | | | 722.0 723.0 723.4
Anterior instrumentation, 2-3 vertebral segments (C2-C4) | 22845 | Bundled | N/A
Removal of anterior instrumentation (C4-C5) | 22855 | Bundled | N/A
Autograft or allograft | 2093? | 77.79? | N/A
X-ray, spine, single level | 72020-26/TC | 87.22 | N/A
Operating microscope | Bundled | Bundled | N/A

**CASE NOTES:** Documentation of the actual fusion and placement of graft material is weak. Clarification with the physician regarding the type of graft used is recommended.

CPT Instructions: “Only the appropriate insertion code should be reported when previously placed spinal instrumentation is being removed or revised during the same session where new instrumentation is inserted at levels including all or part of the previously instrumented segments. Do not report the reinsertion or removal codes in addition to the insertion of the new instrumentation.”

The new instrumentation spans C2-C4 interspaces, the old instrumentation spanned C4-C5. Although screws would have been inserted into C4 in both cases, the segments spanned are different.
Case Study #6: Anterior Cervical Discectomy and Fusion

32 year old male was admitted for scheduled outpatient fusion surgery to address C4-5 and C5-6 radiculopathy.

After endotracheal anesthesia was applied, the patient was placed in the supine position with the head in a Halter head distraction holder with 10 pounds of axial distraction. The anterior cervical region was prepared and draped in a sterile fashion. After intraoperative fluoroscopic localization of the correct cervical level, a transverse incision was made at the level of the interspace that was to be treated. Patient underwent a left-sided Smith–Robinson approach.

Case Study #6: Anterior Cervical Discectomy and Fusion

After adequate decompression of the thecal sac and neural foramen, C4-C6 end plates were prepared accordingly. C4-C6 disc spaces filled with autogenous bone from the osteophytectomy placed into each disc space. An appropriately sized anterior cervical plate was then placed and secured with 14-mm (female) or 16-mm (male) screws at C4 and C6.

Patient was placed in a soft collar and admitted to observation status until 21 hours post-op, at which time he presented w/o complications and was discharged to home in stable condition.
Case Study #6: Anterior Cervical Discectomy and Fusion

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>CPT PROCEDURE CODES</th>
<th>ICD-9 PROCEDURE CODES</th>
<th>DIAGNOSIS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthrodesis, cervical, anterior interbody technique</td>
<td>22551</td>
<td>22552</td>
<td>81.02</td>
</tr>
<tr>
<td>Fusion or refusion of 2-3 vertebrae (C4-C5 and C5-C6)</td>
<td></td>
<td></td>
<td>81.62</td>
</tr>
<tr>
<td>Discetomy for decompression, cervical (C4-C5 and C5-C6)</td>
<td></td>
<td></td>
<td>80.51</td>
</tr>
<tr>
<td>Anterior instrumentation; 2 to 3 vertebral segments</td>
<td>22845</td>
<td></td>
<td>Bundled</td>
</tr>
<tr>
<td>Autograft for spine surgery; local</td>
<td>20936</td>
<td></td>
<td>77.79</td>
</tr>
<tr>
<td>Intraoperative x-ray of cervical spine</td>
<td>72020</td>
<td></td>
<td>87.22</td>
</tr>
</tbody>
</table>

A question to consider is whether this patient would most appropriately be reported as an inpatient or outpatient.

- At least one RAC is performing Medical Necessity Review (MNR) to establish whether it was medically necessary to receive care in an inpatient setting for MS DRG 473 -- Cervical Spinal Fusion w/o CC/MCC.
- It should be noted that anterior spinal fusion at multiple levels is mandatory inpatient-only by Medicare – so this particular case would be appropriate, so long as there is an appropriate physician order – however, a single level anterior fusion is not, and documentation of medical necessity for an inpatient level of care may come under scrutiny.
- Also, several of the MACs have begun tying together an inpatient status denial with postpayment recoupments of the physician’s claim.
When reviewing claims for procedures with DRGs, the CMS online Manual, Pub 100-08, Chapter 6, Section, 6.5.2 states the following:

“Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.”

Documentation Considerations

To meet Medicare’s reasonable and necessary (R&N) threshold for coverage of a procedure, the physician’s documentation for the case should clearly support both the diagnostic criteria for the indication and the medical need:

• the procedure does not exceed the medical need and is at least as beneficial as existing alternatives
• the procedure is furnished within accepted standards of medical practice
• the procedure is furnished in a setting appropriate for the patient’s medical needs and condition

Lacking compelling arguments for an exception in the supporting documentation, the services can be denied.

The clinical judgment of the treating physician is always a consideration if clearly addressed in the record and consistent with the episode of care.
Total Disc Arthroplasty

84.62  Insertion of total spinal disc prosthesis, cervical
84.66  Revision or replacement of artificial spinal disc prosthesis, cervical

22856 Total disc arthroplasty, cervical, single interspace
22861 Total disc arthroplasty, cervical, single interspace, revision/replacement
22864 Total disc arthroplasty, cervical, single interspace, removal

Cervical artificial total disc replacement at more than one cervical spine level is unproven and not covered.

Example Payor Coverage Policy

Cervical artificial total disc replacement via an open anterior approach is proven for the treatment of degenerative disc disease at a single level between C3-C7 in skeletally mature patients when used according to U.S. Food and Drug Administration (FDA) labeled indications, for patients WITH:

• intractable symptomatic radiculopathy AND/OR
• intractable symptomatic myelopathy

WITH AT LEAST ONE of the following conditions producing symptomatic nerve root and/or spinal cord compression:

• herniated disc AND/OR osteophyte formation

AND BOTH of the following:

• documented patient history of neck and/or arm pain and/or a functional/neurological deficit associated with the cervical level to be treated
• failed at least six weeks of non-operative treatment prior to implantation (only applicable for elective surgery; emergent surgery does not require prior non-operative treatment)

Source: United Health Care Policy, October 1, 2012
New Technologies

Coding for newer technologies is often difficult, as precise codes may or may not exist for new procedures. For CPT, new services may need to be reported with an ‘unlisted’ code, or may be assigned Category III code(s), which are:

- Temporary codes for emerging technology, services, and procedures.
- Released semi-annually.
- Generally carrier priced.
- Often limited in coverage.
- Used to collect data, so should always be used in preference to an “unlisted” code if one describes a service provided.

ICD-9-CM procedures also have unlisted procedure codes. Codes may also be introduced at different times into ICD vs. CPT.

UPDATE ON ICD-10-CM AND ICD-10-PCS
Diagnostic Coding Issues

• Annual code changes are effective Oct. 1st.
• ICD-9-CM is published as a three-volume set
  • Volume 1 -- Tabular List of Diseases
  • Volume 2 -- Alphabetic Index
  • Volume 3 -- Procedures
• There are sixteen basic guidelines for reporting diagnoses for inpatient services.
• A copy of the complete guidelines are available from the Center for Healthcare Statistics:
• ICD-9-CM Diagnosis Changes for FY 2013 -- NONE

Data Collection Challenges

• Quality data extracted from current coding is clinically less specific
• Retrospective chart review, while clinically more specific, is burdensome
• The current clinical classification system (ICD-9-CM) is not designed for quality or safety reporting or risk stratification
ICD-10-CM

- ICD-10 is the international standard to report and monitor diseases and mortality, with U.S. implementation scheduled for October 2013.
- ICD-10-CM reflects advances in medicine and medical terminology.
- ICD-10-CM provides codes to allow comparison of mortality and morbidity data.
- ICD-10 provides better data for:
  - Measuring care furnished to patients;
  - Designing payment systems;
  - Processing claims;
  - Making clinical decisions;
  - Tracking public health;
  - Identifying fraud and abuse; and
  - Conducting research.

ICD-10-CM

On January 16, 2009, the Department of Health and Human Services (HHS) published a Final Rule for the adoption of ICD-10-CM and ICD-10-PCS, with a compliance date of October 1, 2013 (now 2014).

Under the electronic health transaction standards final rule, also issued on January 16, 2009, covered entities must comply with Version 5010 (for some health care transactions) and Version D.0 (pharmacy transactions) on January 1, 2012 (extended to July 1).


However, the codes in ICD-10 are not currently valid for any purpose or use in the United States.
**ICD-9-CM vs. ICD-10-CM**

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
<th>Implementation Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5 digit codes</td>
<td>3-6 digit codes (possibly 7)</td>
<td>All computer fields must be able to accommodate additional characters</td>
</tr>
<tr>
<td>0 as spacer</td>
<td>X as spacer</td>
<td>Ensure fields can accept alphabetic characters in any digit position. Ensure distinction between numbers and letters (although 0 and I not used, to minimize confusion).</td>
</tr>
<tr>
<td>Numeric values except V and E codes</td>
<td>All alphanumeric, including 1st and sometimes subsequent digits</td>
<td>Ensure fields can accept alphabetic characters in any digit position. Ensure distinction between numbers and letters (although 0 and I not used, to minimize confusion).</td>
</tr>
<tr>
<td>1-2 digits after decimal</td>
<td>1-4 digits after decimal</td>
<td>Ensure system can accept up to 4 digits after decimal.</td>
</tr>
<tr>
<td>Partial descriptors for 4th &amp; 5th digits</td>
<td>Full descriptors for every code</td>
<td>Ensure format reflects full descriptors, not “cumulative” data.</td>
</tr>
<tr>
<td>Hierarchical structure</td>
<td>Hierarchical structure</td>
<td>Programming expanded to recognize at least one more level to hierarchy</td>
</tr>
<tr>
<td>Approximately 17,000 diagnosis codes and 5,000 procedure codes</td>
<td>Potentially 70,000 diagnosis codes and almost 120,000 procedure codes</td>
<td>Additional training and education, documentation improvements, revised reference guides, computerized coding support</td>
</tr>
</tbody>
</table>

**ICD-9-CM vs. ICD-10-CM**

- Some codes do have direct translations from ICD-9-CM to ICD-10-CM.
- Some ICD-10 diagnosis codes combine multiple presentations or facets of a condition into a single code – such as incorporating underlying cause, concurrent condition, or complication as a subclassification – which in ICD-9-CM requires 2 or more codes.
- For some categories, terms may be defined in different ways, or whole chapters are organized along a different axis of classification, such that the mapping is only a series of approximations or possible compromises.
- There are cases where ICD-9 contains more detail than ICD-10, where a clinical concept or axis of classification is no longer deemed essential information.
- ICD-9 may also contain more detail than ICD-10 when ICD-9-CM captured information on issues relating to procedures, which ICD-10 does not consider an appropriate element of the diagnosis code.
Sample Code Comparisons

And many of the ICD-10 categories offer a much greater degree of specificity / granularity than is possible with ICD-9, such as more precise anatomic site, laterality, and/or episode of care.

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>722.xx</td>
<td>Intervertebral disc disorders</td>
</tr>
<tr>
<td>4th digits include:</td>
<td></td>
</tr>
<tr>
<td>.0-.2</td>
<td>Displacement without myelopathy</td>
</tr>
<tr>
<td>.3</td>
<td>Schmorl's nodes</td>
</tr>
<tr>
<td>.4-.6</td>
<td>Disc degeneration</td>
</tr>
<tr>
<td>.7</td>
<td>Disc disorder with myelopathy</td>
</tr>
<tr>
<td>8</td>
<td>Postlaminectomy</td>
</tr>
<tr>
<td>9</td>
<td>Other &amp; unspecified</td>
</tr>
<tr>
<td>5th digits specify level for a total of 24 codes.</td>
<td></td>
</tr>
</tbody>
</table>

ICD-10 has 61 codes for intervertebral disc disorders and related syndromes, which include subclassifications describing:

- Anatomic site is higher hierarchy than condition:
  - Cervical spine has 4 subcategories of level
  - Thoracic and lumbar spine each have two

- Related manifestations are a subclassification:
  - With radiculopathy
  - With displacement
  - With degeneration
  - Other disorder
  - Unspecified disorder

- Distinct code set for spinal instabilities

M48.4 Fatigue fracture of vertebra

Stress fracture of vertebra

Excludes: pathological fracture NOS (M84.4-)
pathological fracture of vertebra due to neoplasia (M84.58)
pathological fracture of vertebra due to other diagnosis (M84.68)
pathological fracture of vertebra due to osteoporosis (M83.4+)
traumatic fracture of vertebrae (S12.0-S12.3, S22.0, S22.0-)

The appropriate 7th character is to be added to each code from subcategory M48.4:

A - initial encounter for fracture
D - subsequent encounter for fracture with routine healing
G - subsequent encounter for fracture with delayed healing
S - sequela of fracture

M48.40 Fatigue fracture of vertebra, site unspecified

M48.41 Fatigue fracture of vertebra, occipito-atlanto-axial region

M48.42 Fatigue fracture of vertebra, cervical region

M48.43 Fatigue fracture of vertebra, cervicothoracic region

M48.44 Fatigue fracture of vertebra, thoracic region

M48.45 Fatigue fracture of vertebra, thoracolumbar region

M48.46 Fatigue fracture of vertebra, lumbar region

M48.47 Fatigue fracture of vertebra, lumbosacral region

M48.48 Fatigue fracture of vertebra, sacral and sacrococcygeal region
ICD-10-PCS

ICD-10-PCS is designed to permit assignment of a unique code to each substantially different procedure, with the flexible open structure easily allowing the incorporation of future new procedures. There is no numeric listing of codes; rather, there are 16 sections with sub-tables to determine code selection.

<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Root Operation</th>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Medical and Surgical</td>
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<td>3</td>
<td>Administration</td>
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</tr>
<tr>
<td>4</td>
<td>Measurement and Monitoring</td>
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<tr>
<td>5</td>
<td>Extracorporeal Assistance and Performance</td>
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<td></td>
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</tr>
<tr>
<td>6</td>
<td>Extracorporeal Therapies</td>
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<tr>
<td>7</td>
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<tr>
<td>8</td>
<td>Other Procedures</td>
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<td>C</td>
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<tr>
<td>F</td>
<td>Physical Rehabilitation and Diagnostic Audiology</td>
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<td>G</td>
<td>Mental Health</td>
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<tr>
<td>H</td>
<td>Substance Abuse Treatment</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

The first character identifies the type of service/procedure provided (the section), and each subsequent place in the code also has a specific function, the meaning of which may differ from one section to another. For example:

**Medical and Surgical Codes (Section 0):**

<table>
<thead>
<tr>
<th>1</th>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Body System</td>
</tr>
<tr>
<td>3</td>
<td>Root Operation</td>
</tr>
<tr>
<td>4</td>
<td>Body Part</td>
</tr>
<tr>
<td>5</td>
<td>Approach</td>
</tr>
<tr>
<td>6</td>
<td>Device</td>
</tr>
<tr>
<td>7</td>
<td>Qualifier</td>
</tr>
</tbody>
</table>

**Imaging Codes (Section B):**

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</tr>
<tr>
<td>4</td>
<td>Body Part</td>
</tr>
<tr>
<td>5</td>
<td>Contrast</td>
</tr>
<tr>
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</tr>
<tr>
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</table>

**Extracorporeal Assistance and Performance Codes (Section 5):**

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<td>6</td>
<td>Function</td>
</tr>
<tr>
<td>7</td>
<td>Qualifier</td>
</tr>
</tbody>
</table>
ICD-10-PCS

- All terminology is standardized, and defined within the reference tables
- Diagnosis information is not part of the procedure code descriptor
- There are no eponyms (procedures identified by a person’s name, rather than clinical description)

- If multiple procedures as defined by distinct objectives are performed, then multiple codes should be assigned

<table>
<thead>
<tr>
<th>Section</th>
<th>Medical and Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body System</td>
<td>Lower Joints</td>
</tr>
<tr>
<td>Operation</td>
<td>Fusion: Joining together portions of an articular body part rendering the articular body part immobile</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lumbar Vertebreal Joint, 1 or more</td>
<td>Open</td>
<td>Autologous Tissue Substitute</td>
<td>Anterior Approach, Anterior Column</td>
</tr>
<tr>
<td>Lower Joints</td>
<td>Percutaneous</td>
<td>Autoic Fusion Device</td>
<td>Posterior Approach, Posterior Column</td>
</tr>
<tr>
<td></td>
<td>Percutaneous Endoscopic</td>
<td>Synthetic Substitute</td>
<td>Anterior Column</td>
</tr>
<tr>
<td>Sacrococygeal Joint</td>
<td>Open</td>
<td>Nonautologous Tissue Substitute</td>
<td>No Device</td>
</tr>
<tr>
<td>Coccygeal Joint</td>
<td>Percutaneous</td>
<td>Autologous Tissue Substitute</td>
<td>No Qualifier</td>
</tr>
<tr>
<td>Sacroiliac Joint, Right</td>
<td>Percutaneous Endoscopic</td>
<td>Synthetic Substitute</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nonautologous Tissue Substitute</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>No Device</td>
<td></td>
</tr>
<tr>
<td>Hip Joint, Right</td>
<td>Open</td>
<td>Internal Fixation Device</td>
<td>No Qualifier</td>
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<tr>
<td></td>
<td>Percutaneous</td>
<td>Autologous Tissue Substitute</td>
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<tr>
<td></td>
<td>Percutaneous Endoscopic</td>
<td>Synthetic Substitute</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Nonautologous Tissue Substitute</td>
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<tr>
<td></td>
<td></td>
<td>No Device</td>
<td></td>
</tr>
</tbody>
</table>
What Can I Do?

• Step 1 – Examine Affect on Facility Departments
• Step 2 – Confirm Compliance with Contractors
• Step 3 – Train for ICD-10-CM
• Step 4 – Perform Internal Tests
• Step 5 – Implement ICD-10-CM

Coding and Documentation Improvement

• With complete information in the record, coders can effectively analyze, code, and report necessary information for claims and for quality measures
  • Physician review / sign all facility documentation
  • Make sure key elements are captured – query when needed
  • Ensure specificity of diagnosis documentation, including documentation for POA indicators

• Without such documentation, the application of all coding guidelines is a difficult, if not impossible, task – and accuracy of reimbursement is affected
Coding and Documentation Improvement

- Health care is increasingly data driven
- Cross functional skill sets support evolving activities
- Enhanced roles of HIM and Coding Department staff in ensuring quality of information
- Education and open communication are key
- Work Smart

Questions?
THANK YOU ALL FOR PARTICIPATING!

Presented by:
Sheila Sylvan
IMPACT!
Spring 2013

Hosted by:
DePuySynthes
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