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REIMBURSEMENT, DOCUMENTATION AND COMPLIANCE TIPS
Practical Suggestions for your Practice

ahs BILLING TECHNOLOGY RESULTS

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Introduction

The following notes are provided as general suggestions based on recent AHS work with clients. We are confident that the “tips” described will lead to more accurate reimbursement and more compliant documentation, coding and billing. However, these notes are not official coding guidelines.

In all cases, the notes are intended to highlight areas where appropriate documentation in the clinical record will result in more accurate coding and billing.
Anesthesia

**Controlled Hypotension:** Documentation for coding and payment of controlled hypotension is necessary on the anesthesia record, even if it is indicated on the billing sheet. If documentation is missing, it could result in loss of payment.

**Position:** Documentation on the anesthesia record of any position other than supine or lithotomy could result in additional payment. This applies to shoulders, elbows, heels, etc.

**Surgical Arthroscopy:** Shoulder, elbow, and knee arthroscopies that are surgically performed for more than diagnostic purposes result in payment of higher base units. A single, descriptive word is sufficient, such as synovectomy, debridement, menisectomy. The term “Knee Scope” is considered diagnostic in nature and is paid less.

**Back Procedures:** Laminectomy, Diskectomy, and Fusion are considered “extensive” if the procedure was done on more than one spinal level. Documentation of levels on the anesthesia record and billing sheet will increase the base units billed by as much as “5” units depending on the procedure.

**Cystourethroscopy:** When this procedure involves the distal 1/3 of the ureter or the upper 2/3 of the ureter or kidney, the result could be higher payment for additional base units. This information must appear on the anesthesia record and/or billing sheet.

**Acute vs. Chronic for Orthopedics:** This information determines the correct code, billing and payment.

**MAC (Monitored Anesthesia Care):** Documentation of all diagnoses that qualify the medical necessity of MAC is necessary for payment.

**Complex vs. Simple:** Specific information of complex vs. simple procedures will aid the coding and billing process. Without this information, the claim is delayed for further research.

**Compression Fracture:** Indicate if compression fracture is acute or pathological for accurate coding, billing and payment.

**TEE (Transesophageal echocardiography):** If used for monitoring purposes, TEE is included in the charge for the anesthesia. If TEE is used for diagnostic purposes, it is billed separately. Documentation of purpose is necessary for coding and billing. Coverage varies by State and Medicare Carrier.

**ASA Physical Status:** The diagnosis supporting ASA PS 3,4,5 is required for billing and additional payment.

**Incomplete Documentation:** Listing “Knee Arthroscopy” or “Laryngoscopy” without mention of other procedures performed will result in a loss of payment for higher base units. Documentation of “Post-Op Complications” aids in coding, billing, and payment.
OB Anesthesia

**Delivery Time:** Documentation of delivery time on the anesthesia record will prevent a delay in coding and billing. This is necessary to determine time billed to the insurance company and also to coordinate billing with subsequent C-Sections.

**Placement of Catheters and Lines / Blocks**

**CVP + Swan Ganz Catheter:** When a “double stick” occurs, documentation is necessary for appropriate coding, billing, and payment.

**Ultrasound or Fluoroscopic Guidance:** This procedure is separately billable to some payers IF it is documented on the anesthesia record. There must be a hard copy of the film in the patient’s chart in addition to documentation of anatomical findings, needle placement, etc. If used for needle placement, documentation must include a permanently recorded image showing the needle in close proximity to the nerve AND a statement of the process indicating the ultrasound was used for needle positioning in close proximity to the nerve blocked.

**Post-Operative Pain:** Documentation must clearly indicate “Requested by Surgeon.” This is separately billable from anesthesia if the block serves the purpose of post-op pain control and there was a different primary form of anesthesia. Documentation is necessary on all records including the Post Anesthesia Care and Post-Op Pain forms.

**Daily Management:** Documentation indicating the level of service provided is required for coding and billing for continuous Post-op Pain services such as daily management of brachial, femoral or sciatic catheters. These levels are based on the same criteria for determining the level of Evaluation & Management visits. This does not apply to daily management of epidural or subarachnoid continuous drug administration.
Chronic Pain

**Trigger Points:** The names of the muscles are necessary for accurate and compliant coding, billing, and payment from all payers.

**Paravertebral Facet / Transforaminal Injections:** The names of the levels are necessary for accurate and compliant coding, billing, and payment.

**Vertebroplasty / Kyphoplasty:** Noridian (Medicare carrier for Arizona, Montana, Wyoming, North Dakota, South Dakota, and Utah) has published a draft policy of NO PAYMENT for these procedures.

**Ultrasound Guidance:** Billed currently with Category III (temporary) codes for paravertebral facet injections and transforaminal injections. Eligible for payment by some payers. If used for needle placement, documentation must include a permanently recorded image showing the needle in close proximity to the nerve AND a statement of the process indicating the ultrasound was used for needle positioning in close proximity to the nerve blocked.

Ambulatory Surgery Centers

**Colonoscopy Documentation includes:**
- Distinguish between “Surveillance” and “Screening”
  - Surveillance involves monitoring the patients’ condition
  - Screening is a method used to determine disease or potential for developing disease
- Each method of polyp removal
- History of polyps (adenomatous or other) in self or family
  - Low Risk = payment every 10 years
  - High Risk = payment every 2 years
  - List relationship to family member
    ✓ Medicare only pays for parent or sibling

**Urology Services:** Document kind of interpretation for retrogrades in body of Operative Report or on a separate report.

**Orthopedics / Abrasion Arthroplasty:** Document a microfracture technique or bleeding bone achieved. Units of service billed will depend on the number of knee compartments involved. Shave/debridement of cartilage is billed as one unit of service regardless of the number of compartments.

**Injectable Medications:** Document the dosage/amount used and the contrast material in the Operative Report.