Cost management

Tips on coding and billing for spinal cases

With its high costs and thousands of components, spinal surgery is a financial challenge. Close attention to documentation and coding can help ensure your facility is billing properly and receiving the appropriate reimbursement.

These are tips from Lisa Courneya, RHIT, CCS, data analyst for orthopedic implant registries for the HealthEast Care System in St Paul, Minn.

Dictation is key

“The coders must go by the surgeon’s dictated reports,” says Courneya. If the dictation is incomplete, or there is an error in transcription, the procedure may not be coded correctly.

“If I see hardware was used for a given patient, but it was coded as a discectomy or a decompression, I know there is something amiss,” she says. She pulls the chart and if an error is found, sends an e-mail to the coding supervisor.

Such coding errors can cost money. The difference in the national average Medicare payment between a spinal decompression (DRG 499) and a spinal fusion (DRG 497) is $8,698.

Make sure co-morbidities are recorded

Co-morbidities can result in higher reimbursement, but they must be recorded in the surgeon’s dictation so the appropriate code can be assigned. If a patient has congestive heart failure (CHF), for example, it is sufficient for the surgeon to dictate that CHF is “possible” or “probable.” But coders are not allowed to deduct co-morbidities from signs and symptoms.

Document use of BMP correctly

Medicare provides a new-technology add-on payment for bone morphogenic protein (BMP) but only if stringent criteria are met. (The only current brand is Infuse from Medtronic Sofamor Danek.)

The add-on payment applies only for single-level procedures that comply with on-label use. Medicare defines on-label use as Infuse applied through use of an absorbable sponge and an LT-Cage/ Lumbar Tapered Fusion Device placed at the fusion site. Cases must be assigned to DRG 497 or 498, lumbar spinal fusion, with a combination of ICD-9-CM procedure codes 84.51 and 84.52.

Some examples of off-label use include anterior cervical spinal fusion or lumbar or thoracic spinal fusion without a cage.

Document 360-degree fusions correctly

Higher reimbursement is available for an anterior-posterior (360-degree) fusion than for an anterior or posterior procedure alone, but correct information must be provided for coding.

Higher payment is available even if the patient has the anterior surgery on one day and the posterior procedure on another day during the same inpatient hospitalization.

Make sure multiple procedures are coded

It may seem elementary, but if a patient has more than one procedure during the same inpatient hospitalization, make sure all of the procedures are coded.

Consider the treatment setting for kyphoplasty and vertebroplasty

In determining where to perform these procedures for treating osteoporotic fractures, be aware that Medicare reimburses more when these cases are performed on an inpatient rather than outpatient basis.

Consider coding advice from vendors

Spinal implant companies can offer guidance on coding for spinal procedures, but their information is not official. The official source is Coding Clinic for ICD-9-CM, a quarterly publication from the American Hospital Association (www.ahaonlinestore.com). The publication includes information from the Centers for Medicare and Medicaid Services (CMS).

Monitor vendors’ invoices

HealthEast’s implant database enables it to hold sales reps accountable for their billing. When an invoice is received, an accounts payable clerk checks the invoice against the implant database to see what was actually used on the case. Discrepancies are reviewed. For example, the invoice lists a package of 10 bone screws when only 2 were used. Or the company bills for an item that a sales rep gave a surgeon as a free sample. Or the invoice includes a shipping charge that should not be billed.

Spot opportunities to improve coding accuracy

Some examples of opportunities Courneya found in her reviews:

• Based on implant usage, a procedure originally assigned to DRG 233 (other musculoskeletal and connective tissue OR procedures with cc) was corrected to DRG 519 (cervical spinal fusion with cc), with a reimbursement difference of $1,862.

• A procedure originally assigned to DRG 234 (other musculoskeletal and connective tissue OR procedures without cc) should have been assigned to DRG 497 (spinal fusion with cc), with a reimbursement difference of $9,552. In this case, the dictated term “a fusion” was incorrectly transcribed as “effusion.” But the implant database showed a number of parts had been used, so Courneya suspected it was a fusion. She also suspected it should have been coded for a co-morbidity for anemia due to blood loss.

Negotiate better contracts with vendors

With an accurate database, HealthEast was able to negotiate a better contract with a major spinal implant vendor because it had documentation of its implant usage.

HealthEast uses Spinal Metrics software from Mendenhall Associates, Ann Arbor, Mich (www.orthopedicnet-worknews.com), which collects the patient’s demographic data and implant part numbers and produces reports for analyzing implant usage. Other OR information systems also have implant tracking components.

But the software is just a tool. The real key to financial management of spinal surgery is for departments to work together to ensure documentation and coding are accurate and to monitor and manage implant usage, costs, and reimbursement. Administrators must be willing to provide enough resources, both in personnel and information technology, to carry out these activities effectively. ❖