Surgical Chart Auditing

Presented by: Rhonda Buckholtz, CPC, CPMA, CPC-I, CGSC, GENTC, COBGC, CPEDC



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Agenda

- Importance of documentation
- Global surgical packages
- CCI
- Modifiers
- Dissecting an operative report
- Step by step
- Common pitfalls



Overview

- Medical records are under increased scrutiny
- Role has changed
- Auditing requires more than just looking from a coding perspective



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Surgical Documentation

- Accurately translating is a challenge
 - Must have a good understanding of:
 - Diagnostic rules
 - Surgical terminology
 - Anatomy
 - Carrier rules
 - CCI editing
 - Coding



Surgical Documentation

- Surgery section is largest in CPT® manual
 - Divided into 16 subsections
 - Most based on anatomic site
 - Further divided into category
 - Guidelines in each section
 - Must follow notes



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Example

Surgical laparoscopy always includes diagnostic laparoscopy

To report a diagnostic laparoscopy (separate procedure), use 49320



Documentation

- Lack of complete documentation in patient medical records can result in errors in
 - reimbursement
 - statistics
 - financial planning
 - clinical data



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Benefits of Proper Documentation

- Improves compliance
- · Identifies revenue opportunities
- Improves patient care
- Improves clinical data for research and education
- Protects the legal interest of the patient, facility, and physician
- Achieves accurate case mix index by correctly coding from proper documentation



Risk Areas

- Many on the "risk areas" identified by the OIG depend on the level of documentation
 - Poor documentation doesn't meet medical necessity
 - Opens up audit areas



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Documentation Audits

- Analysis of documentation for content and validity/medical necessity relationship
- Analysis of documentation in relationship to coding and billing
- Identification of patterns and trends in documentation



Documentation Audits

- Identification of risk areas in documentation, i.e. illegibility or improper use of symbols and abbreviations
- Analysis of documentation for compliance issues
- Education and training on documentation improvement opportunities



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Medicare Integrity

 Section 1862(a)(1) states, no Medicare payment shall be made for expenses incurred for items or services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member"



Supporting Medical Necessity

- Justification of care depends on information found in the medical record
 - Diagnosis codes identify circumstances of patient encounter
 - Medical record documentation must be supportive



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What's in a Surgical Procedure?

Cleansing, shaving, and prepping of skin	Exploration of operative area	Insertion, removal of drains, suction devices, dressings, pumps into same site
Draping patient	Fulguration of bleeding points	Surgical closure
Positioning patient	Simple debridement of traumatized tissue	Application and removal of postoperative dressings, including analgesic devices
Insertion of IV for meds	Lysis of a moderate amount of adhesions	Applications of splints with musculoskeletal procedures
Administration of medications by physician doing procedure	Isolation of neurovascular tissue or muscular, bony, or other structure limiting access	Institution of patient controlled analgesia
Local infiltration of medication	Surgical cultures	Photographs, drawings, dictations, transcription
Surgical approach, including identification of landmarks	Wound irrigation	Surgical supplies

Global Surgical Package

- Subsequent to the decision for surgery, one E/M visit on the date immediately prior to, or on the date of, the procedure (including H&P)
- Local anesthesia, defined as local infiltration, metacarpal/digital block, or topical anesthesia
- The operation itself
- Immediate post operative care
- Writing orders
- Evaluation of patient in post anesthesia recovery
- Normal uncomplicated follow up care



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Global Surgery Package

- Third party payers have varying definitions
- Usually pre/post operative services are included
 - Check payer policies



Medicare Surgical Guidelines

- Minor surgical procedures
 - 0-10 day global
 - Include same day services
- Major surgical procedures
 - Preoperative beginning the day before, the day of surgery
 - 90 day global
 - Related post op
 - Post surgical pain management by surgeon
 - Any related supplies, services, or procedures



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Correct Coding Initiative

- National policy
 - Aimed at controlling improper or incorrect practices
- Third party payers
 - Most rely on them as well
 - Some make their own "twist"



Unbundling

- Similar to coding an incidental procedure
 - Usually involves less subtle fragmenting of a bill
 - Never divide components of a procedure when one code covers all
 - Can result from two problems
 - Unintentional
 - Intentional



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Unbundling Prevention Tips

- Use current code books
- Educate yourself on guidelines
- Use encounter forms wisely
- Code directly from the chart or operative note whenever possible
- Update codes annually
- Gather the most concise information
- Use correct modifiers
- · Watch integral procedures



- -22 Increased Procedural Services
 - Increased intensity
 - Technical difficulty of the procedure
 - Severity of the patient's condition
 - Physical and mental effort required



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Surgical Modifiers

- -50 Bilateral Procedures
 - Used when procedures are performed bilaterally at the same session



- -51 Multiple procedures
 - Used when multiple procedures are performed at the same session



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Surgical Modifiers

- -52 Reduced Services
 - A procedure is partially reduced or eliminated at the physicians discretion



- -53 Discontinued Procedure
 - Used for procedures that have been discontinued due to extenuating circumstances



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Surgical Modifiers

- -54 Surgical Care Only
- -55 Postoperative Management Only
- -56 Preoperative Management Only



- -57 Decision for Surgery
 - Appended to the appropriate E/M to denote the visit where the decision to perform surgery was made



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Surgical Modifiers

- -58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period
 - Used to indicate:
 - Procedure was planned prospectively at the time of the original surgery
 - Procedure was more extensive than the original procedure



- -59 Distinct Procedural Service
 - Used when two distinct and separately identifiable procedures are performed on the same day
 - Different session
 - Different procedure or surgery
 - Different site or organ system
 - Separate incision/excision
 - Separate lesion



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Surgical Modifiers

- -62 Two Surgeons
 - Used when a surgical procedure requires the skill of two surgeons



- -66 Surgical Team
 - When the skills of more than two physicians, as well as a team of highly skilled technical employees, are required



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Surgical Modifiers

- -78 Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period
 - Used to indicate that another procedure was performed during the postoperative period of the initial procedure



- -79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period
 - Used to indicate a separate procedure unrelated to the original during a postoperative period



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Surgical Modifier

- -80 Assistant Surgeon
 - Used when a surgeon is required to assist during a procedure



Dissecting the Note

- Reading the report is not enough
 - Must have a good understanding of the content, instruments, and terms
 - Focus on the body of the note
 - Find the missing pieces



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Dissecting the Note

- Highlight key words:
 - Locations and anatomical structures
 - Procedure method
 - Type
 - Size/Number
 - Surgical instruments/medical devices used



Case Dissection

Details of Procedure:

• With the patient in the left lateral position and after sedation using 6 mg of Versed and 100 mcg of Fentanyl, the Olympus adult colonoscope was inserted and advanced to the cecum. The ileocecal valve and appendiceal openings were normal. The scope was withdrawn with the viewing circumferentially the cecum, right colon, hepatic flexure, transverse colon, splenic flexure, left colon, and sigmoid. Diverticular opening noted. In the distal rectum, small polypoid elevations were cauterized and ablated. The scope was taken from the field and the patient taken to recovery in stable condition. The patient will undergo follow-up colonoscopy in 3 years.



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Informed Consent

- Requires more than just a signature on a form
 - Method of communication regarding condition
 - Results in the patients agreement or authorization to undergo treatment



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Informed Consent

- Should contain:
 - Patient's diagnosis (if known)
 - Nature and purpose of proposed treatment/procedure
 - Risks and benefits of proposed treatment/procedure
 - Alternatives
 - Risks and benefits of those alternatives
 - Risks and benefits of not receiving or undergoing treatment/procedure



Informed Consent

- Patient should have opportunity to ask questions
 - Informed decision
- Ethical and legal requirement
 - Required in all 50 states
- Documentation serves as evidence in a court of law
 - Good documentation can save you

AAPC Condending the Business Side of Medicine

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Informed Consent

- CMS examples of a well-designed Informed Consent process
 - Description of the surgery; including anesthesia
 - Indications
 - Material risks and benefits including likelihood of each (material risks could include risks with a high degree of likelihood but a low degree of severity, as well as with a very low degree of likelihood but high degree of severity)
 - Treatment alternatives
 - Who will conduct surgical intervention and administer anesthesia
 - Whether physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks

Surgical Audit Process

- Four steps in auditing a surgical chart
 - Determine what you are going to review
 Type of service
 Date of services



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Surgical Audit Process

- 2. Review operative note:
- ✓ Preoperative information
- ✓ Patient demographics
- ✓ Surgery date
- ✓ Preoperative anesthesia
- ✓ Indications for procedure
- ✓ Diagnostic reports
- ✓ Intraoperative information
- ✓ Preoperative diagnosis
- ✓ Postoperative diagnosis
- ✓ Surgeon/assistant surgeon/ cosurgeons
- ✓ Procedure title
- √ Findings

- ✓ Procedure details
- √ Tissue/organ removal
- ✓ Materials removed/inserted
- ✓ Closure information
- ✓ Blood loss/replacement
- ✓ Wound status
- ✓ Drainage
- ✓ Complications noted
- ✓ Postoperative condition of patient
- ✓ IV infusion record
- ✓ Signatures
- ✓ Legibility
- ✓ Supports procedure
- Supports medical necessity



Surgical Audit Process

Report your findingsComplete a detailed analysis and/or summary report for the practitioner



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Surgical Audit Process

4. Educate

Provide education on CCI edits, unbundling issues, problematic areas, and coding updates



Auditing the Surgical Medical Record

- Organize your tools
 - Audit tool
 - Charge ticket
 - CPT code book
 - ICD-9-CM code book
 - HCPCS level II code book
 - NCCI edits
 - Other pertinent coding publications
 - Detailed analysis
 - Summary analysis

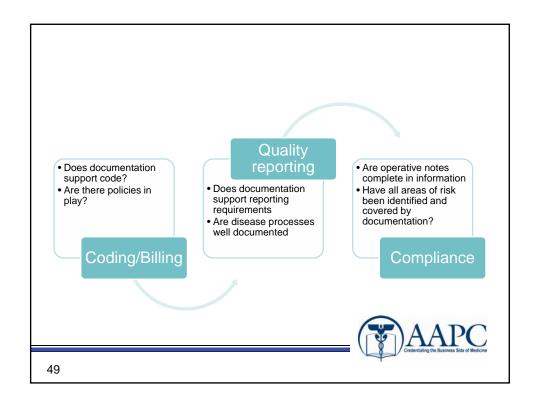


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Auditing the Surgical Medical Record

- Steps to take
 - Make a copy of the op note if possible
 - Underline/highlight important information
 - Use medical references for unfamiliar terms
 - Cross out non-code-related documentation
 - Check bundling issues
 - Verify code sequencing
 - Apply necessary modifiers





Context

- Look in all aspects of the medical record
 - How does documentation tie in?
 - Coding/billing
 - Quality reporting
 - Compliance



Reporting

- Always report your findings
 - Include errors, omissions, and risk areas
 - Offer suggestions for remedy
 - Provide education
 - Initiate follow up



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Common Pitfalls





Example: Missing Medical Necessity

PREOPERATIVE DIAGNOSIS: Infected Infusaport

POSTOPERATIVE DIAGNOSIS: Infected Infusaport

PROCEDURE: Removal of left subclavian Infusaport and placement of a right subclavian central venous catheter.

The patient was identified as John Books and taken to the procedure suite. He was placed in the supine position on the procedure table. Once adequate sedation was given, the right chest was prepped and draped in the standard surgical fashion.



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Using an 18-gauge needle, the right subclavian vein was cannulated. A guidewire was placed. Using a #11 blade, a small nick was made adjacent to the wire and a triple lumen catheter was then placed over the wire. This catheter was secured to the skin using 2-0 Silk suture.

Attention was then directed towards the left chest. The left chest was then prepped and draped in the standard surgical fashion. Using 1% Lidocaine a field block was created over the port site. Using a #15 blade, a linear incision was made. This incision was carried down through the subcutaneous tissue until the port was identified. The sutures connected to the port were divided and the port was removed from the patient. The catheter tract was then closed using 3-0 Vicryl suture and the skin incision was reapproximated using 3-0 nylon suture in an interrupted vertical mattress. Pressure dressing was then placed over this site.



Example Risky Consent

Assessment #1: 457,0 Lymphedema Syndrome Postmastectomy **Plan for #1:**

Follow-up: The swelling has not responded to conservative treatments with arm elevation, etc. At this point, I prescribed Jobst compression stockings in a 20-30 pressure gradient. Also, she no longer needs her Mediport according to oncology. She would like it removed. I explained the surgery in including the risks, benefits, and alternatives. Consent was obtained. We will schedule the surgery.



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Questions?



