



New Mexico Orthopaedics Coding Study

EXECUTIVE SUMMARY:

*By using ProVation® MD software for documentation and coding compliance, New Mexico Orthopaedics demonstrated a **117% improvement in overall documentation and coding accuracy**, with a **53% decrease in professional documentation and coding errors** and a **42% decrease in facility documentation and coding errors**. We estimate the combined annual facility and professional coding revenue lost to undercoding to be \$596,000. These issues were addressed through the use of ProVation® software.*

ORTHOPAEDIC CODING – COMPLEX AND COMPREHENSIVE

In today's scrutinized, cost-constrained health care market, the financial success of a facility or practice depends on accurate, complete coding. Every procedure must be fully documented, both to ensure proper reimbursement and to meet the changing demands of regulatory bodies such as AAAHC, CMS, OIG and Joint Commission.

Unfortunately, the traditional process of dictation, transcription, and coding of procedure notes is slow, error-prone, and often incomplete. It makes poor use of physicians' time, adds costly overhead to the billing process, and can lead to underbilling, underpayment, compliance issues, or rejection of bills by third-party payers.

The problem is particularly severe in orthopaedic documentation and coding, which can involve over 1000 CPT codes in the musculoskeletal surgery subsection alone. Small oversights can result in big losses. For example, bone grafts must be specified as either autograft or allograft, as the two are coded differently and reimbursed at different rates. A surgeon performing two procedures in separate compartments of the knee can code, charge and be reimbursed for both – yet without the “59” modifier, the procedures are automatically bundled and reimbursed at a lower rate. Quite simply, incomplete information usually means lost revenue.

CASE STUDY

NEW MEXICO ORTHOPAEDICS CODING STUDY

A LEADER IN ORTHOPAEDIC CARE: NEW MEXICO ORTHOPAEDICS

New Mexico Orthopaedics knows all too well the vagaries of orthopaedic coding and reimbursement.

The largest orthopaedic group physician practice in the state of New Mexico, New Mexico

Orthopaedics addresses a wide variety of orthopaedic injury and disease, including knee arthroscopy, anterior cruciate ligament reconstructions, meniscal transplants, hip arthroscopy, chronic pain control, foot and ankle surgery, podiatry, rotator cuff repairs and instability reconstructions of the shoulder.

Opened in February 2000 as a joint venture between physicians and United Surgical Partners International (USPI), New Mexico Orthopaedics boasts 6 operating rooms and a physician practice that includes 16 orthopaedic surgeons and 3 physiatrists, as well as non-partner physicians who perform surgeries at the site.

New Mexico Orthopaedics faced the difficult challenge of navigating ever-changing orthopaedic coding and documentation rules that affect

ambulatory surgery centers and hospitals. Like many facilities, their coding tended to err on the conservative side – the best way to avoid audits and fines that come from accidental overbilling, but still a drain on revenues. As a cutting edge, forward-looking surgical facility, New Mexico Orthopaedics looked to technology for a solution.

Procedure documentation supports 70 to 90 percent of an MD's professional fee payment and 30 to 60 percent of a facility's revenue stream, depending on specialty area.

"The 'good news' is that this site was billing quite conservatively. At the other end of the spectrum, we find clients who are overcoding and overbilling. Those sites are at far greater risk of audits and fines."

SOLUTION: PROVATION® MD SOFTWARE

New Mexico Orthopaedics replaced physician procedure dictation with ProVation® MD software in October 2004. Designed by an in-house team of physicians and coders, ProVation® MD allows clinicians to quickly, completely and compliantly document clinical procedures. Physicians make selections from a series of medical content-driven menus that emulate typical procedural workflow and follow logical paths, automatically adapting to each piece of information that is selected. These selections then create detailed operative notes, complete with diagrams, which read just as if they were dictated. The software's coding engine applies appropriate CPT and ICD codes, as well as CCI edits – all driven by the medical content of the note. Since implementing ProVation®, New Mexico Orthopaedics has generated an average of 4,300 procedure notes annually with the software.

MEASURING RESULTS

In order to study the financial impacts of ProVation® software on New Mexico Orthopaedics' documentation and coding, ProVation® developed an initial postimplementation study approach consisting of five steps:

- 1) Initial client interviews
- 2) Data gathering of pre- and post-ProVation® procedure reports and billing codes
- 3) On-site interviews and workflow analysis
- 4) Off-site data analysis to independently review and confirm results
- 5) Final report preparation by ProVation® Medical based on independent analysis

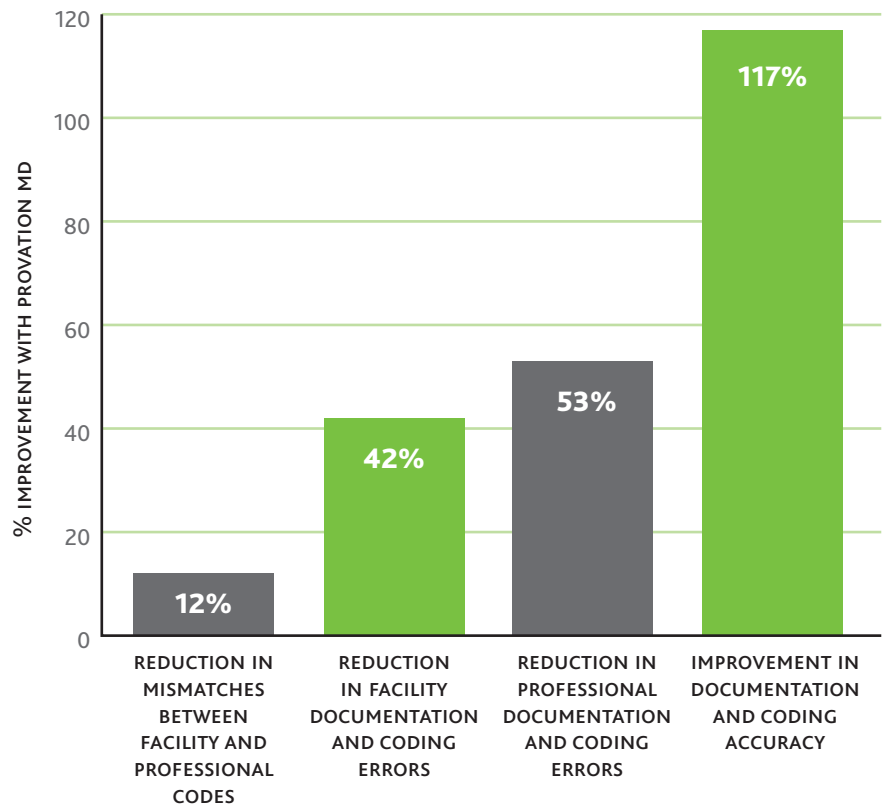
For the pre-ProVation® sample, 41 procedure records with facility codes and professional codes were randomly selected from a group of outpatient records. For the Post-ProVation® sample, 44 procedure records with facility and professional codes were randomly selected from a group of outpatient records. The majority of issues identified centered around undercoding on both the professional side and the facility side.

"We do pre/post-ProVation® coding studies routinely, and these results are the norm rather than the exception," said Allison Erickson, Compliance Director, ProVation® Medical. "Orthopaedic documentation and coding is extremely complex, constantly changing, and very tough for most sites to monitor."

RESULTS

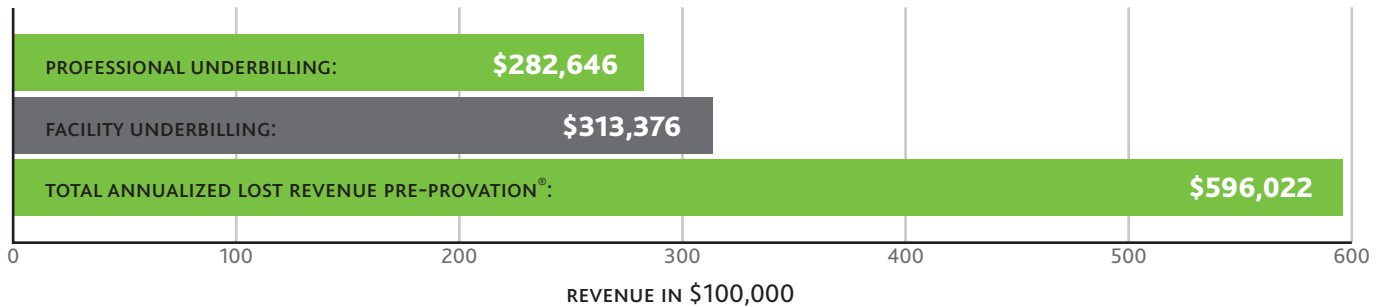
Based on the selected cases, comparison of the Pre-ProVation® sample to the Post-ProVation® reports showed the following:

- 117% overall improvement in documentation and coding accuracy
- 53% decrease in professional documentation and coding errors
- 42% decrease in facility documentation and coding errors
- 12% decrease in mismatches between facility and professional codes



Indeed, almost all the records in the Pre-ProVation® sample showed significant undercoding (and therefore underbilling). The amount of lost revenue from the sample selection, applied to an annual average caseload of 4,300 procedures, indicated the following annual impact:

PRE-PROVATION: REVENUE LOST DUE TO UNDERCODING



SUMMARY: CONFIDENCE AND COMPLIANCE THROUGH ELECTRONIC PROCEDURE DOCUMENTATION

In today's scrutinized, cost-constrained health care market, the financial success of a facility or practice depends on accurate, complete documentation and coding. Every procedure must be fully documented, both to ensure proper reimbursement and to meet the changing demands of regulatory bodies. Sites like New Mexico Orthopaedics are ahead of the rest of the pack in addressing these issues. By implementing ProVation® MD software, they're able to generate coder-ready procedure documentation that delivers compliance and proper, timely reimbursement.

Tina Allen, Administrator at New Mexico Orthopaedics, was impressed by the study results. "Complete and accurate coding ensures that we are reimbursed in full for the procedures we perform, which is critical to our financial health" she said. "With dictation, there are too many delays and items that can get missed, which has an impact on overall revenue and can slow down the coding and billing processes.

"Using the ProVation® system, we have a far greater confidence in our procedure documentation," she continued. "We know that all aspects of the procedure are captured, and the documentation supports the billing codes. We are able to process and drop bills faster, with the added comfort of knowing that we'll be properly reimbursed for the procedures we've performed."