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Leading the Way in Procedure Documentation and Coding

Orthopedics

## AUTOMATED ORTHOPEDICS PROCEDURE DOCUMENTATION INCREASES EFFICIENCY, REVENUE RECOVERY AND CODING COMPLIANCE

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*The traditional process of dictation, transcription and coding of clinical 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 solution is an electronic documentation system that replaces the dictation/transcription process, allowing physicians to create multi-media procedure notes with compliant codes at the point of care.*

### BACKGROUND

The practice of medicine has always been subject to scrutiny, but never more so than today. Patients, third-party payers and regulators all have interest in diagnoses, procedures and outcomes. As technology becomes increasingly complex, so do cost controls. In short, doctors must do more, for lower fees, than ever before. And they must document their work more thoroughly in order to be fully reimbursed and to protect their practices from penalty or censure by regulatory bodies.

### WHAT'S AT STAKE?

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 JCAHO, OIG, CMS, and AAAHC. According to Centers for Medicare and Medicaid Services (CMS), ***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.*** It is also the number one source of claims and coding problems. CMS estimates that 45 percent of all payment errors are due to inadequate or missing documentation. The result is lost revenue, delayed payment and non-compliance.

### THE TRADITIONAL PROCESS

Historically, doctors have dictated notes and checked off CPT procedure codes and ICD-9 diagnostic codes on charge sheets after completing one or more procedures. This information

## CUTTING COSTS, INCREASING REVENUE

*Reductions in physician fees have drastically changed the economics of running a practice. Doctors must maximize their productivity, hospitals and clinics have to cut costs, and business offices must ensure that every reimbursable service is submitted and paid. A procedure documentation and coding compliance system helps achieve all of these objectives. By automating the process of entering procedure notes, the system reduces demands on physicians' time, potentially allowing them to perform more procedures. It increases the accuracy and completeness of notes, ensuring the inclusion of all billable services. It can completely eliminate the need for transcription and reduce costs and delays incurred when coders have to seek clarification or additional information. It eliminates potentially costly key-entry errors and reduces the number of steps in bill handling by up to two-thirds. And it reduces or eliminates the rejection of bills by ensuring that submissions are timely, complete and compliant. Between increased revenue and reduced costs, complete payback of the cost of a system can take as little as 12 months.*

must then be transcribed at a per-line cost of between 12 and 18 cents or an annual salary of between \$30,000 - 45,000. Transcriptionists and coders often have to contact the doctor for clarification of notes, which are then handled by both the medical records and billing offices in a slow, costly process that can entail literally dozens of steps. Even if the bill reaches the payer without error or ambiguity, the process can take weeks to complete and cost hours of valuable personnel time.

### SOURCES OF ERROR

Unfortunately, despite multiple reviews by multiple parties, many bills are still submitted with uncorrected errors, omissions and ambiguities. These typically originate with the physician, who may fail to note individual steps in a complex procedure, may be too busy to add necessary detail or may not

even know that specific services are reimbursable.

The problem is particularly severe in orthopedics. Orthopedic coding can involve over 1000 CPT codes in the musculoskeletal surgery subsection alone, with hundreds more from sections like radiology and integumentary and nervous systems. With so many potential variations in procedures, coders need as much supporting procedure documentation as they can get in order to code correctly and ensure full and timely reimbursement. Documentation of arthroscopic, fluoroscopic and x-ray images is equally important for full reimbursement.

Small oversights can result in big losses. 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. The same is true of surgery involving separate levels of the spine. When a spine surgeon describes a procedure using generic terms like “L4-5 decompression,” the coder is left to wonder which specific surgical maneuvers were performed: laminotomy, laminectomy w/ foraminotomy and facetectomy, or laminectomy without foraminotomy or facetectomy. A correct code (or codes) cannot be assigned without this level of specificity, and proper reimbursement is harder to obtain. Quite simply, incomplete information usually means lost revenue.

The need to go to a phone or dictation room contributes to the gaps in dictated notes. Depending on the environment, doctors may not dictate their notes for hours, days or even weeks after a procedure. And, with a busy schedule of procedures, physicians may rush through dictation. In some cases, coders may spot potential gaps and follow up to get the necessary information. In other cases they may not. The ability for doctors or their assistants to document quickly and completely in or near the procedure room increases accuracy, cuts the need for rework, lowers administrative costs, reduces expensive handling of paperwork and eliminates loss of legitimate revenue. Adding to the complication, separate teams of coders review documentation and assign coding that is used to generate two separate bills – one for professional fees, which determine physician reimbursement, and one for facility fees, which

determine the amount the medical facility will be reimbursed for the procedure. Very rarely do professional and facility coders work in conjunction – although the two bills are both sent to third party payers, they are done so separately and without internal reconciliation beforehand. Ambiguous or incomplete documentation is often interpreted, and therefore coded, differently by these two teams – and if the physician bills for services that vary from those submitted by the facility, this could raise a red flag with payers. According to the Office of Inspector General (OIG), 23 percent of all claims do not match between the facility and the professional components.

***At best, rejected bills will require costly handling before resubmission. At worst, they can lead to permanent loss of revenue.*** In the future, there will be even more pressure, as the

OIG, acting under the Fraud and Abuse Act, begins checking for discrepancies between professional fees and facility fees. Recent record-breaking fines for construed overbilling have reached the millions.

### **PLUGGING LEAKS IN THE PROCESS**

The physician must accurately and completely document everything that occurred during the procedure if it is to be coded correctly and ultimately reach the payer for full reimbursement. Unfortunately, most physicians are unaware of the extent to which their input determines the amount paid for their services. Even those who recognize the impact can't be expected to know what a coder knows. Their focus is where it should be – on patient care, not the ever-changing lists of services and modifiers used to calculate reimbursement. As a result, the coder is often left with a note that must

### **PROVATION® MD**

*ProVation® MD Orthopedics is a powerful software system that simplifies procedure documentation and coding. Designed by an in-house team of physicians and coders, it includes features like the Anticipatory Interface™, a series of medical content-driven menus that emulate typical procedural workflow, automatically adapting to each piece of information that is selected. As a physician completes all of the documentation for a procedure and incorporates and labels images, the software maps clinical content directly to billing codes to ensure proper reimbursement. The system interfaces with scopes and monitors, automatically recording and matching images with entered data for thorough documentation of procedures. The robust coding engine generates correct CPT and ICD-9 codes, as well as, CCI edits. Coding and content updates are delivered quarterly. The system automatically generates coding, data, pathology follow-up reports, follow-up letters to patients and referring MDs, post-op orders and patient instructions, all populated from the procedure note.*

either be under coded due to missing or inadequate documentation or sent back to the physician for clarification.

The solution is an electronic documentation system residing on workstations in or near the procedure room. The physician enters data from a series of menus immediately following a procedure. Interactive software follows the logical flow of a procedure, presenting all relevant

options that may impact clinical care or correct coding at each step, then expanding the physician's selections into detailed clinical notes. The system attaches images from scopes and data from vitals monitors to the note to present a thoroughly documented description of the procedure. The "Preferences" feature allows surgeons to save menus of selections for commonly performed procedures for faster documentation.

A physician's own preferences contain pre-populated information, built to accommodate his/her personal documentation style, but allow patient specific documentation as well. If appropriate, the physician can include free-text for information included in the menus. The result is compliant, fully documented submissions, which can be reimbursed without lingering as receivables.

## I.T. INTERFACE

*From patient to physician to administration to third-party payers, health care runs on information. To be effective, specialized systems have to be both accessible to users and architecturally open to other systems. A software driven, coding compliance system must:*

- *Use industry-standard interfaces in compliance with HL7, DICOM, etc.*
- *Support standard hardware and operating systems*
- *Integrate effortlessly with enterprise-wide information systems and applications*
- *Leverage and feed existing IT infrastructure*
- *Interface with the full range of monitoring and imaging devices*
- *Have a rapid implementation cycle*
- *Provide customer-driven software maintenance, content and coding updates, and 24-hour, rapid-response client service*

*System operation in a changing regulatory environment depends on regular updates of software and databases. Vendors must demonstrate the ability to keep coding data up-to-date and regularly upgrade software. In addition, it is imperative that they provide thorough training, readily available software support and reliable system maintenance and service.*