Is Your Documentation Up to Par?

Requirements for reporting the arthroscopic removal of loose or foreign bodies

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It may be hard to imagine that payers really read the operative notes. To make sure the documentation supports the work performed, but the reality is that when services reported don’t match the codes submitted, payers pay attention.

A recent case filed in a United States District Court is just one example. In addition to multiple coding and documentation issues, the federal government identified that CPT codes and charges were inappropriately being submitted for the arthroscopic removal of loose bodies. They found that the documentation either did not support the size of the loose bodies (smaller than required to report the code) or did not indicate that the loose bodies were ever removed.

Seven CPT codes cover the arthroscopic removal of loose or foreign bodies in various joints (Table 1).

Documentation requirements

Documentation requirements for arthroscopic removal of loose or foreign bodies differ, depending on whether the procedure is performed by itself or in conjunction with another arthroscopic surgical procedure in the affected joint.

If the only procedure performed is the arthroscopic removal of a loose or foreign body, the documentation must show that the actual work was performed and the procedure was supported by medical necessity.

If the arthroscopic removal of loose or foreign bodies is performed in addition to other arthroscopic surgical procedures in the same joint, the following documentation must exist to support reporting the appropriate CPT codes for both the removal of loose or foreign bodies and the other arthroscopic procedures:

- The loose or foreign body (bodies) must be larger than 5 mm in diameter
- A separate incision was required to remove the loose or foreign body (bodies)
- If the patient is a Medicare beneficiary and another arthroscopic procedure is being performed in the knee along with the removal of a loose or foreign body, Medicare requires the loose or foreign body to be in a different compartment than the other arthroscopic procedure, as stated in the definition of the G code.

In the following situations, the arthroscopic removal of loose or foreign bodies is not reportable according to CPT rules:

- Size is not documented as larger than 5 mm
- Documentation does not state a separate new incision or new portal was created to remove the loose body.
- Multiple loose bodies are "washed out" without documentation of size or separate incision/portal
- A chondroplasty is performed in the same compartment.
- If the rules for reporting are not met, the removal of the loose or foreign body (bodies) is not separately reportable. Payers are paying attention to this issue, and so should you.

Check your documentation

If you’re not sure your documentation is 100 percent “up to snuff,” take the following steps:

- Run a CPT frequency report and determine the frequency of those codes reported as a solitary code (uncommon) and those reported in conjunction with other arthroscopic procedures.
- Audit a sample of charts to ensure the documentation requirements are being met.
- Ensure medical necessity (eg, correct diagnosis is linked to the appropriate CPT code).
- Close any coding or documentation gaps you may find in your documentation.

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Four Steps to Improve Your Bottom Line

Howard Mevis

Sometimes, taking simple steps can result in big payoffs—particularly when it comes to the bottom line. The following tips can help improve cash flow, reduce expenses, and keep your practice Health Insurance Portability and Accountability Act (HIPAA)-compliant.

Know what you’re owed. Patients’ out-of-pocket costs are increasing. Your staff should know each patient’s payment responsibilities before the patient checks in.

Collect copayments at the time of service. The costs of billing and collecting relatively small copayment amounts can be substantial, particularly when you consider the charges for printing invoices and envelopes, postage, and staff time for calculating the bill, inserting the invoice into the envelope, and following up on payment. Alternatively, outsourcing this work to a service bureau also incurs an expense.

Orthopaedic surgeons may be surprised at the total costs of mailing invoices to patients to gain payment. Invoicing patients, rather than collecting copayments at the time of service, also results in payment delays and may have an impact on the practice’s cash flow.

One solution might be to use an online portal to collect patient payments. Mobile devices using “bank apps” can expedite funds transfer without the cost of credit card processing charges.

Reduce credit card processing fees. More patients are making payments by credit card, and credit card processing costs can add up. But no two processing services charge the same. One vendor may offer a low rate but charge more for service items, while another may charge for administration and setup but waive other fees. If a substantial number of patients in a practice pay using credit cards, processing fees can be substantial. Negotiate for savings or find another processing service. Using the AAOS Revenue Management Program (www.gatewayedi.com/aaos) can also help reduce credit card processing fees.

Stay HIPAA-compliant. HIPAA covers payments from payers, too. A practice that receives paper documents and remittances with patient documentation from payers may have a patient privacy issue to resolve. Find out whether payers support the new HIPAA operating rules for standardized electronic funds transfer and electronic remittance advice transactions.

Practices should also be prepared to receive electronic fund transfers. This can have a positive impact on cash flow by reducing the time frame before funds can be accessed and used.

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