Total Joint Coding and Documentation in Quality Programs

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Both the Comprehensive Care for Joint Replacement (CJR) and Bundled Payment for Care Improvement (BPCI) programs mandate increased alignment between hospitals and physicians. Historically, coding of the patient experience during the hospitalization has affected hospital reimbursement, but not physician reimbursement. With these new initiatives, physicians now have a stake in the game.

Under these new models, inaccurately describing or coding procedures or failing to document all comorbid conditions or complications will result in lost revenue to the physician. In the past, hospital coders have used information provided by physicians preoperatively, intraoperatively, and postoperatively to categorize patients within the musculoskeletal diagnosis-related group (MS-DRG) codes that are used for hospital reimbursement. Physicians must now play a more active role in this process.

Current process

Under the current process, when a patient undergoes a procedure in a hospital, the hospital coder reviews the surgeon’s operative report and identifies whether the patient is “exempt” from the CJR bundled payment. It is vitally important for the physicians to document all relevant medical comorbidities prior to the surgery and also in the H & P.

TJA revisions

ICD-10 and the definitions that accompany it have made the coding process much more complex for coding professionals and hospitals. When a primary replacement or a revision replacement occurs, the description of the event is vitally important to the coder.

Under ICD-10, replacement is defined as “putting in or on biologic or synthetic material that physically takes the place and/or function of all or a portion of a body part.” If the procedure involves removal or replacement of a device or component, the recommended code remains a replacement procedure and is then considered the root operation. Situations in which components are removed or replaced can be coded separately using a different designation.

According to ICD-10, “Revision should be reported when the objective of the procedure is to correct the position or function of a previously placed device without taking out and putting a whole new device in its place.” (Italics added.) Therefore, it is critical to document the failure mechanism that requires returning the patient to the operating room and to document completely, accurately, and specifically what happened during the procedure and what was removed. In effect, the current ICD-10 codes “unbundle” a joint revision procedure into a removal and an insertion.

When documenting the indications for surgery, orthopaedists must mention whether a fracture is present. If so, the documentation must specify the location of the fracture and how it affects the prosthesis. It is also important to mention whether a mechanical complication led to the patient’s return to the operating room. The presence of a malignant neoplasm and the date on which it was removed must also be documented.

Documenting whether a partial hip replacement or a resurfacing procedure was performed is important to the hospital coders. Surgeons should document removal of implanted devices and prostheses in both the procedure line and in the body of the note. This will help coders more accurately determine the appropriate hospital code. Because the transfer of a patient from one acute care facility to another can change coding at the hospital level, these situations need to be documented as clearly as possible.

If the documentation doesn’t support the accurate hospital code, patients’ episodes can be under-coded in some instances and not truly reflect patients’ SOI/ROM and resource complexity/consumption for those episodes. A records review of one national hospital chain participating in bundled care showed a small but significant number of revision cases that were coded under MS-DRG 470, “Lower Total Joint Replacement without a Major Complication or Co-morbid Condition (MCC).” Predictably, the costs of the acute hospitalization and the 90-day postoperative course were significantly higher in these cases and factored negatively in determining profit and loss.

A list of the complications and comorbid conditions that can alter hospital reimbursement (by changing the MS-DRG from 470 [without] to 469 [with]) is available as a PDF on the e-MedTools.com website under “medical coding” and “CC/MCC list.”

“CJR/BPCI payment.” The difference in reimbursement is substantial; see https://www.edifecs.com/downloads/0353_COCR_Map-CTA.pdf

Initiatives such as CJR and BPCI require hospitals and physicians to work together more closely. In many instances, this enhanced alignment has shown to be a cost-effective strategy and to improve patient care. Coding issues like those described in this article were not recognized previously by physicians due to the limited financial interest prior to CJR and BPCI.

Moving forward, increasing communication among hospitals, physicians, and staff can facilitate the accurate categorization of patients into appropriate DRGs, thereby limiting mistakes that may threaten financial success.

Hospitals that have a Clinical Documentation Integrity program can partner with the clinical documentation specialists to review patient records while the patients are still in the hospital. This ensures that documentation and specificity is as accurate as possible, resulting in correct code assignments, precise profiling (SOI/ROM), proper quality scores, and appropriate reimbursement.

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