CMS has started a pilot program that involves auditing Spine Practice Staple; Spine Fusion. DRG 460 represents a spine fusion, not including cervical, and is characteristically the basic code utilized for spinal fusion for our patient base that does not involve large deformity corrections, tumors or major fracture repair. The impact of this auditing program is that it will affect the revenue stream of both the practice and the facility if the CMS audit denies payment based on the medical necessity component.

CMS has put this auditing system in place in a few states within the country as a pilot program to analyze the cases by way of reviewing the medical record to support the medical necessity of the procedure. The audit consists of reviewing the facility chart exclusively to determine if the record supports the need. If the chart does not, the case is denied for both the practice and the facility and the appeal process begins. Anyone involved in CMS audits knows how cumbersome and costly this process is; not to mention cost prohibitive considering the manpower and the lack of reimbursement for the services already provided to the patient.

In order to reduce the likelihood of a denial of your fusion services, it is recommended that the practice and facility collaborate efforts and ensure that the facility chart has the information required to support the procedure in the medical chart. This can be accomplished easily by providing the necessary information contained in the physician chart in a format that can be included in the facility medical record. The only requirement is to organize a way to transmit or transfer this information.

The information presented in this article below clearly details the medical necessity requirement that CMS is assessing. As you will see in the information below; the key point to reversing the denials is to have the pertinent pre-surgical information available at the time of the audit to ward of the denials. Some practices may need to tweak their record keeping conforming to CMS’ expectations, but that should involve only minor changes. For the most part, this information is readily available in the patient’s medical record, so there is no need to reinvent the process.

Communicate with your staff to see if you have been subject to such audits already. If so, evaluate the steps taken in the appeals process and the adjustments your practice or facility has put in place to reduce these denials. If you have not been audited, try a proactive stance and look to partner with your practice or facility to ensure that all the required documentation is readily available for an auditor if requested.

The information present below is directly from the Trailblazers’ inquiries involving CMS audits of DRG 460. Use this information as a tool to assemble your processes to reduce or eliminate denials for the spine fusions performed in good faith and for the appropriate reasons.
“The goal of providing feedback and education is to ensure proper billing practices so your claims will be paid correctly. Ongoing education and appropriate billing are your responsibility. You must ensure that your records support the service:

- Is the service medically necessary? This means there is sufficient evidence to support the service being billed.
- Meets Medicare coverage criteria and coding rules.
- Is the service documented in the beneficiary’s medical records? This means there is sufficient information in the medical record to give a clear picture of the beneficiary’s condition, including any conservative treatment.

TrailBlazer has been reviewing claims billed with Medical Severity Diagnosis-Related Group (MS-DRG) 460 (spinal fusion, except cervical, without major complication or comorbidities). By far, the most common reason for denial has been a lack of specific information about conservative care before the surgical intervention. Through previous experience, we presume that in many cases this missing information may have existed in the outpatient records of the surgeon, primary care physician or other practitioner.

**Sample Documentation List**

This list contains examples of documentation that, if clearly documented, may help support payment for spinal fusion-related hospital care.

- Previous non-surgical treatment, including, but not limited to:
  - Physical therapy
  - Occupational therapy
  - Joint injections
  - Analgesia
  - Assistive devices
- Physical examination clearly documenting the progression of any:
  - Neurological deficits
  - Upper or lower extremity strength
  - Activity modification
  - Pain levels
- Diagnostic test results and interpretations, such as Magnetic Resonance Imaging (MRI)
Strategies to Improve Documentation

The following strategies could reduce audit errors caused solely by information missing from the hospital record:

- Hospitals may proactively obtain previous diagnostic and therapeutic records from the surgeon and other practitioners. These records may include pertinent:
  - Physical assessment of condition, including pain level.
    - Physician history and physical.
      - Progress notes.
      - “Consultations.”
    - Physical and occupational therapist evaluations and therapy notes.
      - Radiology reports.
      - Therapeutic procedure notes, such as joint injections.

- Practitioners should either create clinically meaningful inpatient records or supply the hospital with relevant documents from their outpatient records.

Documentation Example

Including adequate history of the presenting illness in the hospital record will improve the likelihood of Medicare payment of the hospital claim. It will also substantiate medical necessity for the payment of physician services performed in conjunction with the hospital stay. Please note that statements such as "Failed outpatient therapy, admit for spinal fusion", are simply not sufficient evidence of medical necessity for the admission or the surgery.
Please consider the following as an example of helpful documentation:

### MS-DRG 460 Example Documentation

- **Date:** 12/15/11
- **Chief complaint:** Low back pain radiating down legs.
- **History:** Patient has spondylolisthesis, gradually progressing with increased spinal stenosis over the past 5-7 years. Most recent MRI (11/2/11) shows spondylolisthesis at L3-L4 and L4-L5 with moderately severe stenosis at both levels. She has been treated as follows: Ibuprofen 400 mg QID since January (allergic to codeine); PT 3 x week from 6/15/11 to 9/30/11. Epidural steroid injections in October and facet joint injections in November gave only minor temporary improvement. Pain is now constant at level 5/10 when sitting, but 9/10 on rising or ambulation and radiates down both legs. Is slightly better with water therapy. The pain keeps her awake at night with severe stabbing, throbbing and aching.

- **Physical exam:** Patient has limited lumbar range of motion and severe pain on palpation. Knee and ankle reflexes are reduced to 1+ (they were 2+ in October). She has diminished sensation in lower legs, but strength and pulses are within normal limits. The patient has positive sitting root and leg raises bilaterally. Faber Four is negative bilaterally.

- **Impression:** Worsening pain, deteriorating reflexes and significant interference with function. Current therapy ineffective. Lumbar fusion is only option for pain control.

- **Orders:** Admit to inpatient care for L3-L4 and L4-L5 lumbar fusion.

As in all Medicare audits, the quality of the information in a document is often more important than the volume of information. Including all of the needed information in the record is crucial. The more types of supporting records Medicare receives, the clearer the clinical picture will be. The more complete the record, the less likely Medicare will deny services or recoup money."