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SIX MAJOR THINGS THAT TICK-OFF SPINE SURGEONS

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Today's business climate in the spine industry offers many challenges which can lead to frustration for the surgeons and their staff. Overall industry profitability is down; Physicians are being penalized. Most spine surgeons and hospitals are not getting paid for approximately 30% of the work they have performed. The following is a summary of some of the most common situations that spine specialists are faced with on a daily basis.

1. Preauthorization Requirements: Spine practices are riddled with presurgical denials. Carriers often change their requirements to provide an approval for fusion, decompression and other treatments. The preauthorization process has become so labor intensive that most practices move on to the next patient if there is a denial of care because the appeal and the peer-to-peer review is too time consuming and costly. Practices are compelled to look to the carrier website for the specific criteria that guarantees an approval. Most practices already have the information within the medical record, but do not include this information in the preauthorization documentation, thereby forcing them to reinvent the documentation process to support their requests.

2. Postsurgical Denials: There is nothing more infuriating than a denial of payment for services already approved because the carrier deems the case as not medically necessary. An aggressive appeals position must be undertaken which requires both time and staff energies to deal with an unjustified denial. The practice must take the responsibility of moving to an immediate peer-to-peer level which may be difficult, but pushing to that level as soon as possible may reduce the time it takes to right the wrong and force payment.

3. Changes in Minimal Decompression Coding and Reimbursement: The recent changes in the language for minimal decompression have left many a spine specialist confused about the coding that applies to the procedure. The language in the CPT coding descriptors allows for overlapping of procedure types. The minimally invasive procedure codes require explicit language that identifies open/direct visualization versus needle based versus non-needle based techniques which confuse the reimbursement reviewer and coder alike. The application of the new T-codes (0275T) and the often denied existing decompression codes (62287) leave the surgeon frustrated with the fact that unless the decompression is performed with the full open technique (63030), no payment will be forthcoming from the carrier. This is coupled with the continuous medical review process of claims submitted with the code representing open procedure. Quite often these claims are pulled and audited for extensive periods of time that does not seem to fit the simplicity of the decompression procedure. This review process is to ensure that an open procedure was performed before the carrier releases appropriate "reimbursement value" associated with the case.

4. Peer-to-Peer Reviews: Surgeons will find themselves arguing the case in a venue known as peer-to-peer review when there is a conflict in the reimbursement process that involves denials of codes or procedures based on medical necessity or failure to provide acceptable documentation. Most spine surgeons believe that an intellectual discussion with a peer will occur; a spine surgeon of equal talent, skill and training to debate the need for the surgery and patient outcome when going into this discussion with an insurance carrier. Unfortunately, many a spine surgeon is disappointed to find the "peer" is not a spine surgeon, but a medical practitioner of some type who has been hired to debate the need for such procedures or coding that has been denied by the carrier. In order for there to be a true debate or discussion, surgeons and their staff must demand a true peer, in both credentialing and experience, before agreeing to such a discussion. This may require a complaint to the carrier's executive office or a formal state complaint for the carrier to comply.

5. Bundling of Codes that Do Not Follow CPT Guidelines: While there are difficulties in all areas of reimbursement, spine procedures have been the victim of significant bundling applications that most other fields cannot appreciate. The bundling of codes has lead to the continuous decline in reimbursement for procedures that have been performed in good faith and should be considered for payment because they involve additional time, risk and skill.

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The following is a sample of the bundling that has lead to a great deal of discussion amongst spine surgeons in the country:

AMA CPT coding applications prohibit the coding of any instrumentation removal if there is an insertion of a new construct that involves any portion of the previously removed instrumentation. Therefore, the spine surgeon is not compensated for the work, risk or expertise needed to safely remove the instrumentation prior to inserting any new instrumentation, at any level. This is unfortunate as the removal of instrumentation can involve significant sweat factors, time and risk to complete this safely before moving onto the next procedure.

The AMA CPT book clearly stipulates that instrumentation coding may not be considered for cosurgeons. This is baffling as many large revisions and deformity procedures incorporate cosurgeon partnerships, including the fusion codes, decompression codes and some grafting codes. It is not clear as to why the instrumentation has been isolated from these procedures as not medically necessary for a cosurgeon when many a time cosurgeons work together on these procedures to reduce OR and anesthesia time to protect the patient. Fortunately most carriers have ignored this change and it would be in the best interest of both the patient and the surgeon for AMA CPT to reverse this rule.

Denials for Bone Grafting and Bone Marrow Aspirate Procedures have been considered incidental to the fusion procedure even though it requires additional work to perform these procedures. The ability to bundle procedures that seem minor when compared to the scale of the companion procedures detract from the risk and work involved. Most spine surgeons know that the reimbursement is minimal, but do expect to be compensated for their work, just as any craftsman would expect to be compensated for the necessary components to arrive at the final product. Denials for the grafting work are expanding to include the procedures that involve additional incisions, levels and require more time.

6. Appeals Ad Nauseam: Why is it that the appeals requirements have become so complicated? It's because it costs the practice money and saves the carrier money. The levels of appeal have gone from the first level, which is only a means to get to the second level (as all first level appeals are denied for the most part), the second level appeal is a way to get to the third level appeal (because submitting the second level appeal means that you were serious about the first level appeal) and the third level appeal is a means to force the carrier to reimbursement according to contract on occasion or to move to the executive level or state level appeal. These diversions are costly, time consuming, frustrating and unnecessary for an industry that moves money through the system in the trillions of dollars. Many denials are unjust, unnecessary and downright wrong but yet they continue, regardless of investigations, fines, and penalties. Will the only option be to bill the patient and force them to fight for proper coverage; let's hope not as the patient is doomed to failure if they are to go at this alone. The patient deserves better and so does the surgeon.

The spine revenue cycle can be daunting at times but with patience, education, and perseverance we can achieve our right and just reimbursement each and every time! If you have any questions, please contact us at 888-337-8220 option 7.

Coding Concierge

By: Barbara Cataletto

Question

I have a question regarding CPT codes 22556 and 63077. If a surgeon performed a T1-T2 anterior discectomy with interbody fusion, cage and instrumentation, can we report both CPT code 22556 and 63077 for the discectomy and fusion procedures. My notes state that we can only report one of the two codes if performed on the same interspace.

Answer

The thoracic anterior decompression has a code 63077 and can be used if there is a decompression in that interspace, and it is not solely for the preparation for the fusion and placement of the implant. Be sure to clearly identify the diagnosis that supports a decompression at that level, e.g. stenosis or herniated and that the operative note has full details on the procedure. Then continue to describe the interbody fusion procedure separately from the decompression.

BACK BREAKERS

1. How is Health Insurance just like a hospital gown?

2. How does the spinal cord hammer a nail into the wall?

3. Why does the spinal cord belong in the brass section of an orchestra?

4. Why didn't the skeleton cross the road?

ANSWERS

1. You only think you're covered. 2. With a series of spinal taps. 3. Because it has a dorsal and ventral horn. 4. Because he didn't have the guts!

Spine Reimbursement Sees a Major Impact

Bundling of procedures and assigning of "experimental" T codes can hamper provider reimbursement

Part 2 of 2-Part Series

Recent changes to CPT®spinal codes and coding guidelines have an important impact on reimbursement, new technologies, and the advancement of patient care. In this two part series, we'll review the changes you'll need to know in order to properly document and code these surgical cases. In the Spring Edition, we covered *63030 Not for Minimally Invasive Lumbar Decompressions and Minimally Invasive Fusions Now A Category III Procedure.* In this edition, we will cover *Understand the T Code Challenge* and *Don't Give Up A Reimbursement Without A Fight.*

Understand the T code Challenge

Category III CPT® codes, also called temporary codes or T codes, represent emerging medical technologies that have not yet been approved by the U.S. Food and Drug Administration (FDA). Unfortunately, payers often don't acknowledge T codes as a viable code set, claiming that the procedures are experimental and not covered. To make matters worse, T codes are not assigned relative value units (RVUs). The lack of RVUs is significant because it signals to payers that a procedure or service is experimental, non-conventional, and/or an unacceptable medical treatment. This could result in effective procedures and services assigned T code status to never "catch on" due to a lack of reimbursement.

As an example, there are difficulties using T codes for pre-authorization, submission, and payment for services going back to the development and implementation of artificial spinal disc surgery. The artificial disc coding and reimbursement example illustrates how T code status has nearly destroyed the artificial disc procedure as an adjunct procedure to the spine surgeons' repertoire.

In 2005, practices using unspecified procedure codes to report artificial disc procedures began using new Category III codes 0090T-0092T (total disc arthroplasty). Payers began treating these procedures as experimental. Years later, even now that CPT® directs coders to use 22856 (cervical) and 22857 (lumbar) to report artificial discs, many payers refuse to yield and pay for the procedures—for the most part due to past medical determinations.

In reviewing the CPT® changes, we see that several established spinal procedures have now been transferred to T codes. As mentioned, these include endoscopic discectomy lumbar, 0275T; as well as 0274T *Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic and facet fusion thoracic and lumber, 0220T-0222T*; as well as 0219T *Placement of a posterior intrafacet implant(s), unilateral or bilateral, including imaging and placement of bone graft(s) or synthetic device(s), single level; cervical*. Both endoscopic discectomy and facet fusion are widely accepted surgical procedures, with a significant history of success within the spine community. Surgeons performing these minimally invasive procedures (and facilities offering them) will likely feel a significant economic crunch with the shift from the traditional CPT® Category I code submission to T code submission.

Some payers understand the difficulties posed by T codes and have responded by providing coverage and reimbursement advisories on their websites, or may engage in "pre-surgical" discussions regarding coverage and reimbursement. Whenever there's doubt, it's best to be proactive and communicate directly with your payer representatives.

Proactive and cooperative communications will reduce post-surgical denials. Physicians will play a key role in educating and encouraging carriers to approve procedures if they can communicate effectively about the medical benefits to the patient.

Don't Give Up Reimbursement without a Fight

Practices and facilities will be required to authorize procedures that are now reported with a T code. Practices that do not confirm authorization may find themselves—as they have in the past with the artificial disc procedures—receiving denials for what are suddenly considered experimental or noncovered procedures.

Setting the standard for reimbursement if preauthorization is granted is a secondary challenge. Even with preauthorization and proven reimbursement history for endoscopic discectomy and minimally invasive facet fusion, the practice or facility will face challenges. T codes generally result in an immediate denial, regardless of approval status, and require in-depth appeals and audits on a regular basis. The ability to navigate these challenges requires continued communication via the appeals process. Practices will be forced to provide supportive documentation of the preauthorization, previous payment history for similar procedures, and a "stick to it" attitude toward an acceptable reimbursement solution.

One of the best defenses is a great offense. When dealing with T codes, pursue payer authorization in writing, inclusive of the CPT® codes and the patient's diagnosis and name, specific to the individual case. This basic document is often considered unnecessary until the denial is received, and getting it up front will save a great deal of effort.

Fortunately, in the case of endoscopic discectomy and/or minimally invasive facet fusion, a practice or facility may look to historic payments from codes 63030, 22610, and 22612 to support the reimbursement levels they expect for the T codes that now apply. Review practice reporting to identify payment trends (both highs and lows) to develop an acceptable fee range for these procedures in your geographic area. This will be helpful in formulating and supporting reimbursement appeals.

Industry is not likely to embrace technologies if surgeons, unsure of reimbursement, are hesitant to perform new procedures. This may hurt patients the most. Developing technologies should involve open discussions about medical necessity, CPT® applications, and reimbursement issues during the research and development phase to reduce the possibility of undesirable or unacceptable coding and reimbursement results. Sharing in new developments requires commitments from industry, physicians, patients, and insurers if we are to continue the process of improved medical treatments and medical successes.

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CODING UPDATE INSIDE

About Us

*Since its inception in 1998, **Business Dynamics** has emerged as a leading spine coding and medical reimbursement firm serving spine practices, spine product manufacturers and numerous organizations throughout the United States. Based in New York and Texas, **Business Dynamics** continues to successfully seek new ways to develop and expand knowledge within the spine industry to ensure maximum reimbursement for the spine specialist.*

*In order to fill the void in training and education for the spine professional, **Business Dynamics** developed **The Business of Spine**, our spine specific education and consulting company. With over 25 years of experience in the field of spine coding and reimbursement, **The Business of Spine** brings the business mindset into focus by combining many years of spine coding knowledge and experience to assist clients in maximizing reimbursement and increasing office efficiency.*

***The Business of Spine** provides a full range of spine-specialized consulting services performed by seasoned experts in Practice Management, Spine Coding & Billing, and Hospital Financial Management. This extensive list offered to spine specialists nationally includes **Claims Review and Audit Services, Comprehensive Billing Office Assessment, "The Spinal Cord"**, a hotline service offering real time coding advice, along with onsite educational **Lectures and Seminars** for Physicians, Facilities, and Manufacturers.*

***The Business of Spine's** Revenue Cycle Dynamics for the Spine Reimbursement Specialist certificate program provides the spine professionals with resources and tools needed to expand their knowledge of spine coding, collection, and appeals issues, allowing career advancements and providing stronger support to the spine business.*

*Our **Spinal Column Newsletter** and **Coding and Reimbursement Advisories** offer updates for our clients as changes occur in the realm of spine coding and reimbursement in response to state, federal, or insurance commission legislation.*

For more information, log onto www.thebusinessofspine.com or call us at 888-337-8220 #7