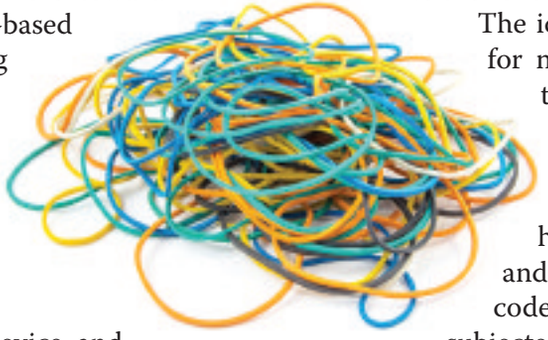
CODE
CLINICAL OUTCOMES AND DOCUMENTATION EDUCATION

PDAC and O&P: A Tangled Tale

By Molly McCoy, CPO/L

You may wonder why using the billing code or codes recommended by the manufacturer could be a problem for practitioners when submitting claims. For many products, the manufacturer-suggested coding is appropriate. However, there are cases when manufacturer-recommended coding leans more toward profit margin and less toward feature-based coding. With our claims and coding under increased scrutiny from all third-party payers, it's worth revisiting coding recommendations and the effects they could have on your practice.



Scenario 1:

You, as a practitioner, purchase a device and use the manufacturer-recommended code or set of codes when submitting the claim. Often, a product launch results in an increase in sales and a resultant increase in billing for the related codes. The Centers for Medicare and Medicaid Services (CMS)—and possibly private insurers—notices an up-tick in use of the codes and begins to examine them more closely by doing prepayment reviews and/or asking for additional documentation. You now must explain why you chose those codes for that device and for that patient. If you can make a strong argument, you're in a good position to have that claim paid. If you chose the codes without fully understanding them and/or the device, you run the risk of having your claim denied and being subjected to increased claim reviews.

Scenario 2:

You, as a practitioner, do not agree with the code or set of codes chosen by the manufacturer for a particular product. You do the research and discover a code that, in your professional and educated opinion, is more appropriate. Since you are the one on the hook for the coding decision and your practice would suffer if the decision is wrong, you submit the claim with the code you decided is correct instead of following the manufacturer's recommendation. In this case, you might be left in the lurch because the code you feel is more appropriate does not pay a high enough reimbursement to cover the cost of the item, let alone enough to cover your expenses. Now, what happens when a patient who would benefit from this device comes to you and you have chosen not to fit the device for any patient due to the low reimbursement? Do you let that patient go to your competitor and let your practice become known for not doing the high-tech stuff?

Neither of these scenarios are good options. The ideal remedy for these situations is for manufacturers to submit products to the Pricing, Data Analysis and Coding (PDAC) Contractor for code assignment and set the price afterward. The PDAC Contractor has the authority to assign codes, and if a product has a PDAC-assigned code or set of codes, the risk of being subjected to an audit when you submit a claim for that device using the PDAC-assigned codes potentially decreases. This would also potentially limit the amount of detailed explanation a practitioner must provide to get that claim paid because CMS is familiar with the product after the PDAC review has been completed. The dilemma for manufacturers is that sometimes codes they think are not appropriate are assigned to the product by the PDAC Contractor. Why take the chance of getting a "bad code" when it's a voluntary process anyway?

It's difficult to say with certainty that getting PDAC-approved codes for all new products would decrease audits for practitioners, but we do know it would not hurt. Hopefully there is a balance that can be struck so everyone shares the burden of reimbursement regulation equally.

SPS' Clinical Education Manager, Molly McCoy, CPO/L, has more than 20 years of professional and academic experience in the O&P profession. Molly provides documentation support for O&P clinicians with SPS' Clinical Outcomes and Documentation Education (CODE) program.

For more information, contact Molly at code@spsco.com or 800.767.7776 ext. 5. To see educational videos and additional resources on clinical O&P documentation, visit www.spsco.com/code.