Introduction

The dwindling reimbursement witnessed by all surgical subspecialties, has been predicated on more stringent regulatory language and requirements by all consenting payors and sureties. The escalating amount of submission data and appeals have personified the practice of surgical medicine, accompanied by an entire teams of coding and billing experts, most of whom attend biannual meetings offered by the AANS as method of contemporaneous education and resolve. Medicare reimbursement data are fundamentally flawed in determining healthcare expenditure as it shows a bias toward delivery of care in specific patient demographics. However, neurosurgeons, not just policy makers, must take ownership to analyze, investigate, and interpret these data as it will affect healthcare reimbursement and delivery moving forward.

Methods

In a neurosurgical practice, represented by eight contributing surgeons, a retrospective review assessed the number of times that ‘coding errors’ resulted in either failure or approval, appeals and peer to peer phone recourse or reimbursement discrepancies. The complex spinal practice numbering a case load of thousand plus was analyzed and reported in these categories for trends and patterns.

Results

A two year analysis realized a doubling in the number of rejections of surgical case submissions and appeals coupled with a near thirty percent decrease in both DRG remuneration and reimbursement compared to a like coding and billing practice from ten years previous.

Contribitional Data

- Comparison of per procedure reimbursement for common spinal operations. Spinal surgeons performing cervical fusions in the West Region received less reimbursement than those surgeons in other parts of the country; and this was found to be statistically significant (P = 0.015). Surgeons in the West were reimbursed on average $849 for CPT code 22551 while those in the Midwest received $1,475 per procedure. No statistically significant difference was found on the reimbursement of standard laminectomy (P = 0.5), lumbar fusion (P = 0.4), or additional laminectomy (P = 0.403) based on geographic location.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4568303/

Conclusions

- The ubiquitous nature and acceptance of both regional and national scrutiny has transformed nearly all surgical practices and implemented necessary time allotment for further substantiation of diagnosis and treatment.

References