SCIENTIFIC ARTICLE

Ethical and Educational Considerations in Coding Hand Surgeries

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Purpose To assess treatment coding knowledge and practices among residents, fellows, and attending hand surgeons.

Methods Through the use of 6 hypothetical cases, we developed a coding survey to assess coding knowledge and practices. We e-mailed this survey to residents, fellows, and attending hand surgeons. In additionally, we asked 2 professional coders to code these cases.

Results A total of 71 participants completed the survey out of 134 people to whom the survey was sent (response rate = 53%). We observed marked disparity in codes chosen among surgeons and among professional coders.

Conclusions Results of this study indicate that coding knowledge, not just its ethical application, had a major role in coding procedures accurately. Surgical coding is an essential part of a hand surgeon's practice and is not well learned during residency or fellowship. Whereas ethical issues such as deliberate unbundling and upcoding may have a role in inaccurate coding, lack of knowledge among surgeons and coders has a major role as well.

Clinical relevance Coding has a critical role in every hand surgery practice. Inconstancies among those polled in this study reveal that an increase in education on coding during training and improvement in the clarity and consistency of the Current Procedural Terminology coding rules themselves are needed. *(J Hand Surg Am. 2014;39(7):1370–1377.*

Key words Coding, ethics.

Coding for services provided to patients is an integral part of what hand surgeons do on a daily basis. Surgeons use Current Procedural Terminology codes (CPT), published by the American Medical Association, as a method to represent the care provided. The CPT codes are the most commonly used means to quantify the work of surgery for reimbursement. Despite the critical importance of coding and billing to maintain practice solvency, and thus to continue to provide care for patients, surgeons spend little time teaching or learning about billing either during training or after starting their practices.

Coding has become a major concern to payers and the public and has achieved national recognition as witnessed by many cases involving fraud. The Centers for Medicare and Medicaid Services (CMS), the largest health care payer in the United States, exacts monetary penalties for coding fraud under the Health Insurance Privacy and Accountability Act of 1996.[1] The Department of Health and Human Services (the department in which CMS exists) recovered over $400 million dollars in 2012 for disallowed services and restitution/damages for fraudulently billed services.[2]

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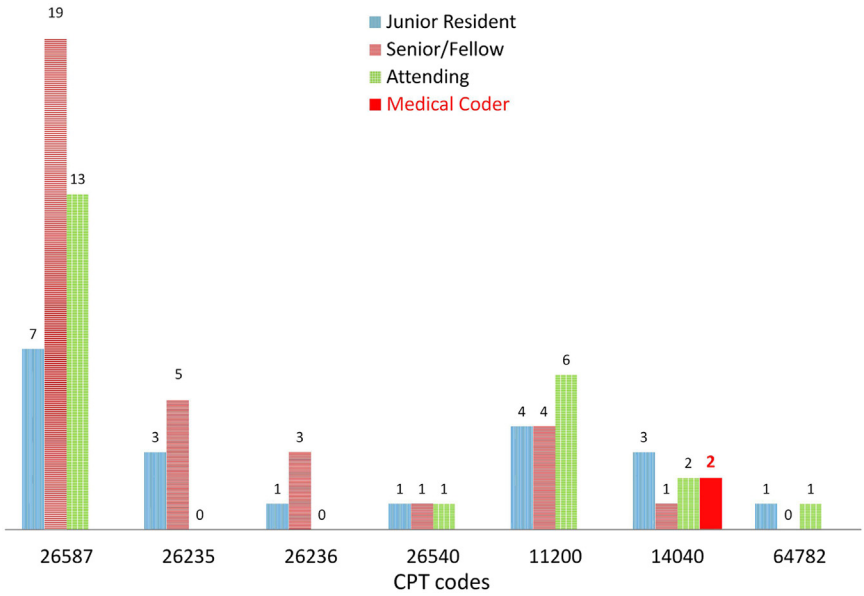

FIGURE 1: Graphic representation of the results of question 1: removal of a supernumerary digit with an identifiable digital nerve. CPT code descriptors: 26587—reconstruction of polydactylous digit; 26235—partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), proximal or middle phalanx of finger; 26236—partial excision (craterization, saucerization, or diaphysectomy) bone (eg, osteomyelitis), distal phalanx of finger; 26540—repair of collateral ligament, metacarpophalangeal or interphalangeal joint; 11200—removal of skin tags, fibrocutaneous tags, any area, up to and including 15 lesions; 14040—adjacent tissue transfer or rearrangement, forehead, chin, cheeks, mouth, neck, axillae, genitalia, hands and/or feet, defect 10 cm^2 or less; 64782—excision of neuroma hand or foot, except digital nerve.

In residency and fellowship, hand surgeons are required to log cases for the Accreditation Council for Graduate Medical Education as a means to document their training. These logs are assessed at the program level to determine whether a training program has provided sufficient education for its enrollees. Trainees rarely receive direct feedback on the accuracy of codes chosen. Terms such as "unbundling," "included services," and "modifiers" are discussed only in concept, if they are discussed at all. Fakhry and colleagues[3] reported that 85% of surgical residents in their survey rated themselves as novices with respect to coding for professional services.

Errors in coding, whether deliberate or unintentional, can have a major impact on our practices. In an effort to better understand hand surgeons' knowledge and attitudes toward coding practices, we created a survey in which fictional but representative cases were sent to participants, who were then asked to code them.

MATERIALS AND METHODS

We created 6 cases across the spectrum of hand surgery. We deliberately chose cases in which there might be a question as to which code might be appropriate and whether additional code(s) might also be appropriate. Respondents were allowed to select from multiple potential codes for each case and were allowed to select multiple codes if they felt it was appropriate. They were allowed to use any sources of information they desired to select their responses. The case scenarios presented in the survey were as follows:

1. You remove bilateral ulnar-sided supernumerary digits on a 1-year-old. The digits had 2 phalanges each and a nail plate. There was no bony connection to the true little finger. You remove the extra digits including identification and division of the digital nerve and artery to the extra digit.
2. You perform a fasciectomy on a ring and little finger for Dupuytren disease. Tissue was removed from the ring and little finger and palm. The small finger proximal interphalangeal joint was able to be nearly fully extended with passive manipulation. On the ring finger, you also opened the flexor sheath and released the proximal and lateral attachments of the proximal interphalangeal joint volar plate to achieve maximal extension. You perform local tissue rearrangements for both fingers. A small skin graft was needed to fully cover the little finger.
3. You release the first dorsal compartment of a patient with de Quervain tenosynovitis. At surgery, a