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From: Laura Caperton

Date: 8/15/05

Phone:

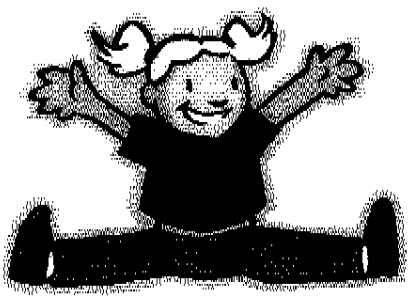
Pages: 2

Re: **Coding Correction Form**

CC:

Confidential

Comments:



Have a fabulous day!!

PREMIER
Orthopaedics & Sports Medicine, PLC

Coding Correction Form

Procedure:

1. The collector completes the routing of the Coding Correction Form, making coding suggestion(s), or asking the physician to choose the code.
2. The collector sends the Coding Correction Form to the appropriate physician.
3. The ***physician approves*** the diagnosis or CPT code/modifier change, ***or assigns*** a diagnosis or CPT code/modifier.
4. The physician signs and dates the Coding Correction Form. (Signature stamp is ***not*** acceptable.)
5. The first page of the Coding Correction Form is sent to the collector. The second page is stapled to the original fee ticket.
6. The first page, received by the collector and signed by the physician, is kept with the collector's batch in which the code change was made.

Patient's Name: _____ **Account #:** _____

Today's Date: _____ Collector: _____

Physician's Name: _____ Date of Service: _____

Code(s) to be Changed: ☐ CPT ☐ Diagnosis ☐ Modifier

Current Code(s) or Modifier(s) and the Definition: _____

Claim was denied because:

- ☐ The procedure or E/M is considered bundled into the primary procedure.
- ☐ The diagnosis does not support medical necessity.
- ☐ The diagnosis is incorrect or incomplete.
- ☐ Information is needed for adjudication (i.e. –RT and –LT on Synvisc claims, etc.).
- ☐ It is considered to be duplicate claim.
- ☐ Documentation is lacking to support the level and/or type of service billed.

Collector's recommendations: _____

Reason supporting recommendation:

- ☐ The procedure was during the post-op period of a related procedure, but is payable.
- ☐ The procedure was during the post-op period of an unrelated procedure, but is payable.
- ☐ The procedure was during the post-op period of another procedure (the patient was returned to the operating room because of a complication of the first surgery), but is payable.
- ☐ These procedures are usually bundled, however, they are not in this case.
- ☐ Payment will be allowed with a diagnosis that is justified by documentation and that supports the procedure or x-ray.
- ☐ Digit modifiers are needed for claim adjudication.
- ☐ Right or Left modifiers are needed for claim adjudication.
- ☐ The E/M was when the decision was made to perform major surgery.
- ☐ The E/M was during the post-op period of a procedure and is not related.
- ☐ The E/M is separately identifiable from a minor procedure(s) that was done on the same day.
- ☐ Documentation requirements were not met for the level and/or type of service that was billed. Suggested codes more accurately meet the requirements.
- ☐ An incorrect modifier was used.

Other: _____

Physician's suggested code change (if not suggested by the collector):

_____

_____

Physician's Signature (indicates approval of code change) ***Date***

Date collector made change(s) and refilled the claim: _____