Orthopedic Coding Update 2024

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Presented by:

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Disclaimer

The following information provided by DoctorsManagement is for general informational and educational purposes only, based on policies and guidance from CMS and the AMA that are in place and valid at the time of this live presentation on September 19, 2024. As guidance constantly changes, the accuracy of the information provided as part of this presentation should be validated at the time any changes are made.

In addition, this presentation is based on our audit experience and analysis of risk factors for compliance for billing E/M and orthopedic services.

Meet the Presenter

Scott G. Kraft

Scott manages client projects and deliverables for overall compliance management as well as chart auditing, provider and staff education and HIPAA compliance. He is a multi-specialty auditor who is passionate about physician education and finding ways for physician practices to operate more efficiently and successfully. He tries to relate coding and compliance information in a relatable, easy-to-understand way.

Scott is based in Vancouver, Washington. Scott is also a huge baseball fan and in his spare time trains to run marathons.

Today's Agenda

- E/M Services Overview
- Common Orthopedic Modifiers (25, 59, LT/RT)
- ICD-10-CM Coding Thoughts
- Coding for Physical Therapy Services
- Incident to/Split Shared Services
- In-Office Procedures (joint injections and fracture care)
- Small Joints (knees/shoulders/elbows)
- Major Joints (Hips)
- Spine Procedures

E/M Services

E/M Services Overview – History and Exam

- Significant Changes to the E/M Documentation Guidelines were implemented for Office Services codes 99202-99215 in 2021 and other E/M services types in 2023.

- Under these guidelines, history and exam are not ‘scored’ to determine the appropriate code for billing purposes.

- The provider is instructed to document a ‘medically appropriate’ history and exam based on the patient’s condition – from a coding perspective, what does that mean?

E/M Services Overview – History and Exam

- Medically appropriate doesn't mean 'NONE' – when there is no history or exam, the payer may determine that the visit itself is not medically necessary.

- History should explore the nature of the presenting problem(s) - exam should include examination of pertinent organ systems/body areas based on the presenting problem. Orthopedic cases would typically include a focused musculoskeletal exam on the problem areas.

- While it does not directly impact the code assignment, history and exam help establish and support the appropriate complexity of the presenting problem (i.e., level of exacerbation of the problem).

E/M Services Overview – History and Exam

- Many providers used documentation templates for the history and exam elements required under the previous guidelines – and many providers continue to use these templates.

- One area of focus when coding services is to look for areas of conflict or contradiction between what is in template documentation vs. what is created by the provider on this service date.

- It's very rare to not support a code under the current guidelines related to history and exam issues – but this documentation is a key part of assessing the correct code.

E/M Services Overview – Medical Decision Making

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed (*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.)	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  ▪ Review of prior external note(s) from each unique source*;
			  ▪ review of the result(s) of each unique test*;
			  ▪ ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 1 acute illness with systemic symptoms;
		or
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or Independent historian(s)
			• **Any combination of 3 from the following:**
			  ▪ Review of prior external note(s) from each unique source*;
			  ▪ Review of the result(s) of each unique test*;
			  ▪ Ordering of each unique test*;
			  ▪ Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High	**High**
		• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			
			Category 1: Tests, documents, or Independent historian(s)
			• **Any combination of 3 from the following:**
			  ▪ Review of prior external note(s) from each unique source*;
			  ▪ Review of the result(s) of each unique test*;
			  ▪ Ordering of each unique test*;
			  ▪ Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

E/M Services Overview – Medical Decision Making

Number and Complexity of Problems Addressed

- *A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter*

- *Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being 'addressed' or managed by the physician or other qualified health care professional reporting the service*

- *Referral without evaluation (by history, exam, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service*

E/M Services Overview – Medical Decision Making

EXAMPLE 1:

Left knee osteoarthritis – Discussed physical therapy, patient has some mobility concerns; discussed therapeutic injection and possibility of surgery.

Hypertension – managed by primary care

As documented, hypertension does not add to the complexity of the case or to the presenting problem in any way and wouldn't score under the guidelines.

EXAMPLE 2:

Left knee osteoarthritis – Discussed physical therapy, patient has some mobility concerns; discussed therapeutic injection and possibility of surgery.

Hypertension – the patient's uncontrolled hypertension and associated symptoms make the patient believe he cannot tolerate physical therapy at this time. As a result, we will manage the osteoarthritis with a therapeutic injection and initiate ibuprofen 800 mg. for to manage patient discomfort.

As documented in this case, the hypertension is a complication directly impacting the management of the osteoarthritis.

E/M Services Overview – Medical Decision Making

Stable, chronic illness (LOW COMPLEXITY):

Expected duration of at least a year or until the death of the patient.

Chronicity, conditions are treated as chronic whether stage or severity changes

'Stable' for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient that is not at their treatment goal is not stable, even if the condition has not changed and there is no short- term threat to life or function.

The risk of morbidity **without** treatment is significant.

- Documentation must establish chronicity for many orthopedic conditions.
- Osteoarthritis is a known chronic condition; back pain or shoulder pain has to be established as chronic per the documentation guidelines.
- When the condition is stated as stable or there is no clear status update, then the condition is considered stable

E/M Services Overview – Medical Decision Making

***Chronic illness with exacerbation, progression, or side effects of treatment (MODERATE)*:**

Chronic illness that is acutely worsening, poorly controlled or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects, but that does not require consideration of hospital level of care.

- When a condition is established as chronic, and stated as worsening, uncontrolled, unstable, etc., then it is exacerbated.
- Under the guidelines, a patient can be documented as improved but not at an established treatment goal and considered to be exacerbated.
- Provider should establish a treatment goal or plan to get credit for improved problems.
- Remember – we don't know the patient's baseline unless documented. Positive symptoms (pain, discomfort, etc.) do not automatically make a case exacerbated.

E/M Services Overview – Medical Decision Making

Chronic illness with severe exacerbation, progression, or side effects of treatment (HIGH):

The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care

- History is a key element to establish level of exacerbation
- The word ‘severe’ is subjective and would not automatically establish high complexity.
- Descriptors – inability to walk, or move, or work; severity/consistency of pain

E/M Services Overview – Medical Decision Making

Chronic illness that poses a threat to life or bodily function:

Chronic illness with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment.

- Again, history is a key area here to frame the severity
- What is the threat to life or bodily function? (Ex: limb in danger of amputation, complexity of fracture of hip/leg)
- Patient co-morbidities and how they impact the orthopedic injury
- Is the patient being sent to the hospital from the visit? Is there an elevation in the setting for a patient? (Ex: hospital inpatient to intensive care or to a different hospital due to condition).

E/M Services Overview – Medical Decision Making

Acute, uncomplicated illness or injury (LOW):

A recent or new short-term problem with low risk of morbidity for which treatment is considered.

There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected.

A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness.

- This could be a patient strain/sprain due to a sports injury or a patient working outside or gardening
- The injury would be expected to heal without complication
- High level of pain would not automatically elevate the condition absent other complications or documentation of expected long recovery.

E/M Services Overview – Medical Decision Making

Acute illness with systemic symptoms (MODERATE):

Systemic symptoms with high risk of morbidity without treatment

Systemic symptoms may not be general such as fever, body aches or fatigue in a minor illness

Symptoms may be single system

- Patient injury could be causing potential or active infection or carry heightened infection risk due to co-morbidities
- These would be symptoms caused by the injury or the case but not necessarily directly related to the specific injury site.

E/M Services Overview – Medical Decision Making

Acute illness that poses a threat to life or bodily function (HIGH):

Poses a threat to life or bodily function in the near term without treatment

- Similar to a chronic case, we would look to the history for documentation of the severity of the condition, potential immediate or near term impacts to the patient.
- This could be the severity of an injury caused by an accident or injury and require potential hospital level of care

E/M Services Overview – Medical Decision Making

Acute, complicated injury:

An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

- The discussion of treatment options must be documented by the provider and can't be inferred.
- Evaluation of other body systems must be medically necessary based on the injury and should not be credited based on a 95/97 guidelines exam.
- In both instances this should correlate to the risk to the patient from the presenting problem itself (i.e., deciding between ibuprofen and acetaminophen for a simple strain would not count).

E/M Services Overview – Medical Decision Making

Acute or chronic illness or injury that poses a threat to life or bodily function (HIGH):

Acute complicated injury that poses a threat to life or bodily function in the near term without treatment

- Similar to the previous presenting problem, but again here we look to the history and discussion of the case in the plan to level the threat to life.
- We would look for urgency of the need for treatment, the nature and risk of the treatment as it relates to the problem, potential elevation to the place of service.

E/M Services Overview – Medical Decision Making

Undiagnosed new problem with uncertain prognosis (MODERATE):

A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast.

- Key to remember is that the presenting problem(s) and symptom(s) should pose risk to the patient.
- A strain that could be a sprain but, even if it is a sprain would be uncomplicated would not fit this category.
- Likewise, a severe injury that poses an imminent threat to the patient but has uncertainty about prognosis would score in a higher category.

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

The patient complains of back pain of three days duration, at worst 4/10 on the pain scale. The injury happened when the patient was playing pickleball and is improved but not completely relieved by ibuprofen. How would you score this:

A. Acute, uncomplicated condition
B. Acute, complicated condition
C. Chronic stable condition
D. New diagnosis with uncertain prognosis

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

The patient complains of back pain of three days duration, at worst 4/10 on the pain scale. The injury happened when the patient was playing pickleball and is improved but not completely relieved by ibuprofen. How would you score this:

A. Acute, uncomplicated condition

B. Acute, complicated condition

C. Chronic stable condition

D. New diagnosis with uncertain prognosis

Duration does not establish chronicity and there are not substantive severity factors identified.

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

Established patient returns for management of longstanding right shoulder osteoarthritis. Patient has experienced recent worsening of pain when trying to lift his arm above his shoulder and is struggling to lift heavier items. How would you score this:

A. Chronic stable condition
B. Chronic exacerbated condition
C. Chronic condition with severe exacerbation
D. Acute condition that poses threat to life or bodily function

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

Established patient returns for management of longstanding right shoulder osteoarthritis. Patient has experienced recent worsening of pain when trying to lift his arm above his shoulder and is struggling to lift heavier items. How would you score this:

A. Chronic stable condition
B. Chronic exacerbated condition
C. Chronic condition with severe exacerbation
D. Acute condition that poses threat to life or bodily function

- While there are patient limitations, the documentation does not establish severity that would elevate to high complexity.
- Osteoarthritis is commonly regarded as chronic; longstanding, while imprecise, helps to identify a chronic case.

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

Patient presents for management of chronic ankle pain. The patient's condition is manageable, but worsens when the patient tries to play tennis and she would like to explore options to improve the pain. How would you score this:

A. Chronic stable condition
B. Chronic exacerbated condition
C. Chronic condition with severe exacerbation
D. Acute condition that poses threat to life or bodily function

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

Patient presents for management of chronic ankle pain. The patient's condition is manageable, but worsens when the patient tries to play tennis and she would like to explore options to improve the pain. How would you score this:

A. Chronic stable condition
B. Chronic exacerbated condition
C. Chronic condition with severe exacerbation
D. Acute condition that poses threat to life or bodily function

The provider should be educated to understand the definitions of chronic, but if the provider states a condition is chronic, we would consider it chronic absent a conflict (Ex: "chronic knee pain of three days duration") which should lead to a provider query.

Amount of Complexity of Data to be Reviewed and Analyzed

- There are 3 categories within this section that must be analyzed:
  - Category 1: Basic office visit “work”
    - Review of prior external notes
    - Review of testing results
    - Ordering test
    - Assessment requiring an independent historian
  - Category 2: Additional work
    - Independent interpretation of testing
  - Category 3: Further work
    - Discussion of management or test interpretation with another provider (MD/DO/NPP)

Amount of Complexity of Data to be Reviewed and Analyzed

Test: *Tests are imaging, laboratory, psychometric, or physiologic data*

External records: *Records, communications and/or test results are from an external physician, other qualified health care professional, facility or healthcare organization*

External physician or other qualified healthcare professional: *An external physician or other qualified health care professional is an individual who is not in the same group practice or is a different specialty or subspecialty. It includes licensed professionals that are practicing independently. It may also be a facility or organizational provider such as a hospital, nursing facility, or home health care agency.*

Independent historian(s): *An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian(s) is needed, the independent historian(s) requirement is met.*

Independent Interpretation: *The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.*

Amount of Complexity of Data to be Reviewed and Analyzed

Required Categories Per Level of Service			
Level of Service	Category 1	Category 2	Category 3
Straightforward 99202/99212	Minimal or None		
Low 99203/99213 **1 out of 2 Categories**	2 Elements		N/A
Moderate 99204/99214 **1 out of 3 categories**	3 Elements		
High 99205/99215 **2 out of 3 Categories**	3 Elements		

Amount of Complexity of Data to be Reviewed and Analyzed

Category 1 – tests and documents

- Work more common to the average encounter
  - Review of notes – remember only external notes count
  - Ordering tests – each individual test and lab or lab panel counts as one. If the provider is separately paid for the interpretation of imaging, then these tests CANNOT be counted toward the data component
  - Review of tests – remember only external tests count and each must be specifically referenced in the record
  - Assessment requiring a historian – remember that the documentation should specify the independent historian AND the reason why it was medically necessary to use the independent historian

Amount of Complexity of Data to be Reviewed and Analyzed

Category 2: Independent Interpretation of Tests

The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Amount of Complexity of Data to be Reviewed and Analyzed

Category 2: Independent Interpretation of Tests

Key orthopedic takeaways:

- Documentation must include the specific test interpreted and that it can be confirmed as external (different specialty group within one system or different clinic/health system).
- The provider must document his/her own interpretation – should not state “agree with radiology report.” This interpretation does not need to be a formal report.
- The AMA does permit a provider to order a radiology test that will be billed and interpreted by radiology, but if appropriate perform an independent interpretation of the test to facilitate expedited treatment or when the provider believes there is specific relevance to the independent read. This independent interpretation and reason must be part of the medical record.
- Independent interpretation is NOT credited for tests ordered and billed by another provider of the same specialty/group at a later date and is generally only credited ONCE and not for future encounters with the same provider.

Amount of Complexity of Data to be Reviewed and Analyzed

Category 3: Discussion of management or test interpretation

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (e.g, clinical staff or trainees).

Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange.

The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter.

It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Amount of Complexity of Data to be Reviewed and Analyzed

Category 3: Discussion of management or test interpretation

Some things to remember:

- The conversation must be with an external provider and not a colleague of the same specialty.
- When an inpatient is seen on a day-to-day basis, this aspect of the documentation should be updated by the provider.
- This conversation does not need to specifically be with a medical provider. When appropriate it can be credited for a mandatory community relator, mental health resources, etc. It should be with an entity involved in the care delivery with the patient and would not include, for example, other family members.

Risk of Complications of Morbidity and/or Mortality

The primary focus of column 3 is NOT the treatment plan

The primary focus of column 3 is RISK OF COMPLICATIONS of patient management of that treatment plan

- Have you changed the focus yet of how you document your treatment plans to accommodate this change in focus?
- Old guidelines focused on the management and treatment options “only”

Avoid the temptation to carry forward the presenting problem into the risk of the treatment plan. It’s up to the provider to document the specific risks as they relate to the medical decisions being made for the patient.

Risk of Complications of Morbidity and/or Mortality

How the AMA defines risk:

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration.

For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk.

Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty.

Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities).

For the purpose of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization.

The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter

Risk of Complications of Morbidity and/or Mortality

Straightforward/Minimal

Minimal Risk or “Negligible” risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established

Examples:

- Follow up PRN
- No plan
- Return as needed

Risk of Complications of Morbidity and/or Mortality

Low Risk

"Below average" risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.

- Examples ONLY:
  - Medications NOT requiring prescriptive authority
  - DME
  - Physical Therapy
  - Consult/Referral without elaboration

  Remember: If I can go buy it in the store, it is not prescription drug management (Ex: Voltaren gel, ibuprofen without dosing instructions).

Risk of Complications of Morbidity and/or Mortality

Moderate Risk

"Average" risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.

Examples Only:

Initiation, continuation, discontinuation, modification of a medication that requires prescriptive authority

- Decision or consideration of a minor* procedure with documented patient or procedure risk factors.
- Decision or consideration of a major* procedure without documented patient or procedure risk factors.
- Documentation indicates that the patients economic or social conditions impact appropriately treating or diagnosing the patient
- Documentation indicates a consult/referral is required for consideration of an average risk/moderate risk management option

*AMA: Minor and Major are at the discretion of the provider as documented

*CMS: Minor 0-10 global | Major 90 day global

Risk of Complications of Morbidity and/or Mortality

High Risk

"Above average" risk that illness, functional impairment, or organ damage will occur from the management options and/or treatment plan considered and/or established.

Examples ONLY:

- Long/short term intensive monitoring to prevent toxicity (NOT monitoring efficacy)
- Decision or consideration of a major* procedure with documented patient or procedure risk factors.
- Decision or consideration of an major* surgery performed with minimal delay/immediate
- Decision or consideration for hospitalization or alternative levels of care
- Documentation of election or consideration of DNR status and/or de-escalate due to a low chance of recovery
- Administration of controlled substance via IM, IV, or SubQ

*AMA: Minor and Major are at the discretion of the provider as documented

*CMS: Minor 0-10 global | Major 90 day global

Risk of Complications of Morbidity and/or Mortality

Key things to remember:

- Risk factors for minor and major procedures are intended to be specific, measurable risks related to the specific procedure and the specific patient. A set of risks that is not correlated to the procedure and is the set of risks equal to every patient is not intended to score in this area.
- Treatment options under consideration but not implemented after discussion with the provider CAN be credited under risk. This shouldn't be just a list of items but a discussion of specific treatments.
- When a schedule medication is credited as high risk for delivery other than oral, there should be a rationale for the delivery method documented and this must be part of the treatment plan and cannot be taken from the medication list.
- Emergency surgery is defined as the patient being put into surgery as soon as is practicable and can account for delays in surgical scheduling.
- A pre-operative clearance visit without management of an underlying condition or new medical decision making will not typically be supported if the decision for surgery has been made at a previous visit.
- The current guidelines bundle an E/M service into a minor procedure decision UNLESS there is discussion of multiple treatment options and/or management of other conditions.

Risk of Complications of Morbidity and/or Mortality

Key things to remember:

- REMEMBER: An in-office therapeutic intra-articular injection is considered a minor procedure and is LOW risk, not MODERATE risk unless specific risk factors are documented. The medication is considered part of the inherent risk of the in-office procedure payment. Noting that this can be done without an E/M visit as well means there is not a specific risk parameter outside of the medication management.

E/M Services – Medical Decision Making

- Final takeaways:
  - Medical decision-making is set based on the level of service (straightforward, low, moderate, high) established by two of the three categories of medical decision making.
  - When each of the three levels is different, the level in the middle is the level based on the assignment of the code.
  - The provider's documentation is what facilitates our coding of the encounter. We don't project our own thoughts on the documentation – even when things seem obvious – into the note.
  - My big saying: We just code it based on what the provider gives us – good communication between providers and coding/billing is the key to ensuring documentation and reimbursement is right.

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

The patient presents for management of a knee injury suffered skiing earlier in the week. The orthopedist reviews MRI images the patient brought from urgent care and diagnoses a ligament injury. How is this scored in the DATA category of E/M services?

A. Straightforward
B. Low
C. Moderate
D. High
E. No Credit

E/M Services Overview – Medical Decision Making

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A. Straightforward
B. Low
C. Moderate
D. High
E. No credit

This would be scored based on the documentation as independent interpretation of imaging

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

A patient presents to the office complaining of wrist soreness from playing tennis. The provider orders an X-ray, and bills for an E/M visit and bills for the in-office X-ray that identifies a slight wrist sprain. How is this credited in the DATA category?

A. Straightforward
B. Low
C. Moderate
D. High
E. No Credit

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A patient presents to the office complaining of wrist soreness from playing tennis. The provider orders an X-ray, and bills for an E/M visit and bills for the in-office X-ray that identifies a slight wrist sprain. How is this credited in the DATA category?

A. Straightforward
B. Low
C. Moderate
D. High
E. No Credit

Because the provider billed for the interpretation of the X-Ray, no credit is given for the test in the data component.

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

A patient presents to the hospital after a fall at home and is found to have a fractured hip. The patient will need hip surgery, and must hold her Eliquis for two days for the surgery. How is this scored in the RISK category?

A. Straightforward
B. Low
C. Moderate
D. High
E. No Credit

E/M Services Overview – Medical Decision Making

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A patient presents to the hospital after a fall at home and is found to have a fractured hip. The patient will need hip surgery, and must hold her Eliquis for two days for the surgery. How is this scored in the RISK category?

A. Straightforward
B. Low
C. Moderate
D. High
E. No Credit

This is considered high risk due to the risk factor of needing to hold the anti-coagulant and potentially would be emergency surgery based on the note.

Coding Services based on time

- Total time spent on the DATE of the encounter
  - Time spent on days prior to or post the date of the encounter do NOT count
  - That work can count toward the MDM of the encounter, just not for time-based guidelines
  - Clock time is NOT required
- Statement detailing the time
  - Qualification statement identifying the medical necessity of the time required
  - Carve out statement of separately identified services
  - Identify services performed by the provider of record as opposed to services that could have been performed by others, when appropriate
    - Example: hydration or infusion services

Coding Services based on time

- Total provider time does not include any time spent in the performance of other separately reported service(s)
- These would be services reported by a separate CPT
- Providers are strongly encouraged to include a “carve-out” statement in their documentation.
  - Example: The total patient time today included 45 minutes. Total time did not include any ancillary services or staff time
  - Provider does not have to break down time spent when other services are performed, just needs to document that the time he/she is counting toward the E/M service was not spent performing other, separately billable services.

Prolonged Service Billing – Office/Outpatient Billing

- Applies to use of 99205 (new patient visit) or 99215 (established patient visit). For 99205, visit must surpass typical service time range of 60-74 minutes. For 99215, must surpass typical service time of 40-54 minutes.

- If payer covers consultations, also applies to 99245 (typical service time range is 55-69 minutes.

- AMA position: Bill prolonged services with 99417 (15 minute increments) starting the first minute after the end of the code range
- CMS position: Bill prolonged services with G2212 (15 minute increments) starting the first minute after the end of 15 minutes following the code range.
- Result: CMS prolonged services units for Medicare are one unit behind CMS

Prolonged Service Billing – Office/Outpatient Setting

New Patient Time Range	Reported Code(s)
60-74 mins	99205
75-89 mins	99205 and 99417
90-104 mins	99205 and 99417 X 2
105-119 mins	99205 and 99417 X 3
120 mins or more	99205 and 99417 X 4 or more for each additional 15 minutes
Est Patient Time Range	**Reported Code(s)**
40-54 mins	99215
55-69 mins	99215 and 99417
70-84 mins	99215 and 99417 X 2
85-99 mins	99215 and 99417 X 3
100 mins or more	99215 and 99417 X 4 or more for each additional 15 minutes

Prolonged Service Billing – Office/Outpatient Setting

New Patient Time Range	Reported Code(s)
60-88 mins	99205
89-103 mins	99205 and G2212
104-118 mins	99205 and G2212 X 2
119-133 mins	99205 and G2212 X 3
134 mins or more	99205 and G2212 X 4 or more for each additional 15 minutes
Est Patient Time Range	**Reported Code(s)**
40-68 mins	99215
69-83 mins	99215 and G2212
84-98 mins	99215 and G2212 X 2
99-113 mins	99215 and G2212 X 3
114 mins or more	99215 and G2212 X 4 or more for each additional 15 minutes

Prolonged Service Billing – Inpatient Services

- Applies to the following codes:
  - Initial Inpatient Service 99223 (typical service time 75 minutes)
  - Subsequent Inpatient Service 99233 (typical service time 50 minutes)
  - Same Day Admission/Discharge 99236 (typical service time 85 minutes)
  - Initial Nursing Facility Visit 99306 (typical service time 45 minutes)
  - Subsequent Nursing Facility Visit 99310 (typical service time 45 minutes)
  - New Home Visit 99345 (typical service time 75 minutes)
  - Established Home Visit 99350 (typical service time 60 minutes)

Prolonged Service Billing – Inpatient Services

- AMA position: Bill prolonged services with 99418 (15 minute increments) starting the first minute after the end of the code range

- CMS position: Bill prolonged services with G0316 (hospital/observation), G0317 (nursing facility) or G0318 (home visit) in (15 minute increments) based on the typical service time as reported in AMA data for these codes.

- Result: CMS prolonged services units for Medicare are often very different and require much longer service times.

G2211

- Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition, or a complex condition

Intended for primary care but there are no specialty-specific restrictions on who can bill for this service.

G2211

- Best use scenarios for G2211 for orthopedics
  - Ongoing management of specialty-specific chronic disease
  - The provider will be the focal point of care on an ongoing basis for specific conditions – defined as the provider has seen the patient, will see the patient today and is expected to see the patient on an ongoing basis

- Scenarios where G2211 may not be appropriate
  - New or established patient treated for acute injury but not expected to return or treatment will follow defined course
  - Surgical patients who are not expected to be seen beyond the surgery.

Modifiers

Modifier Usage

- **The use of CPT/HCPCS codes are determined via code structures and hierarchal relationships among service types.**
- **These structures include instances where the work of one code is completely included in the work of more complex code (modifier 59 scenario) or where aspects of the typical pre- and post-procedure work are considered to be duplicated with the typical work of an E/M service (modifier 25 scenario).**
- **We must ALWAYS default to the belief that when a bundling relationship exists between two services, that is NOT appropriate to bill both services.**
- **The evidentiary burden of proof to support the use of multiple codes within a code bundle relationship rests entirely on the documentation created for that specific encounter.**

Modifier Usage

- **When we use a modifier, it is a signal on the claim that the documentation of the specific encounter supports severing the code bundle relationship between codes because, in the specific clinical circumstances of the note, there is a deviation from the standard clinical practice that caused the creation of the bundling relationship.**

- **While there are many code pairs where a modifier is used more often than they are considered to be bundled, the default should always be that the services are considered to be bundled unless the documentation shows otherwise.**

- **As coders, we may often code for the same providers rendering the same types of services – often with modifiers. We should always approach each encounter believing the modifier should not be supported until documentation proves it is appropriate.**

Modifier Usage

Modifier 24

- **DEFINITION: Unrelated evaluation and management service by the same physician or other qualified health professional during the global period.**

- **To use this modifier:**
  - **The patient must be in the global period for a minor procedure (10 days) or major procedure (90 days).**
  - **The rendering provider should be either the provider who performed the procedure/surgery OR a provider of the same specialty/Tax ID.**
  - **If a different provider is performing these services, refer to modifiers 54/55.**
  - **The visit is for services that are NOT included in the global billing period.**

Modifier Usage

Modifier 24

- **Before we consider documentation, we should first ask what is included in the global period and what is not included:**

- **Included in the global period:**
  - **Aftercare related to recovery from the procedure**
  - **Healing/non-healing from the procedure itself**
  - **Complications related to the procedure**

- **NOT Included in the global period:**
  - **Management of separate problems or conditions unrelated to the surgery**
  - **Management of underlying disease/diagnoses that the surgery may have been intended to address**

Modifier Usage

Modifier 25

- **DEFINITION: Significant, separately identifiable E/M service by the same provider on the same day as a procedure.**

- **To use this modifier:**
  - **The patient must have received an evaluation and management service AND a procedure on the same day.**
  - **The evaluation and management service should address diagnoses unrelated to the surgery AND/OR be an evaluation that results in the decision to perform a same day procedure following consideration of multiple treatment options.**
  - **A documented assessment and plan clearly meets the requirements of the above bullet (i.e., it cannot be inferred).**
  - **An edit pairing exists between the procedure/service and the E/M requiring a modifier. Some services can be billed without a modifier.**

Modifier Usage

Modifier 57

- **DEFINITION: Decision for major surgery**

- **To use this modifier:**
  - **The visit should result in the decision to perform a major surgery, typically defined as one with a 90-day global period.**
  - **The rendering provider should also be the surgeon (or another provider of the same group practice/TIN).**
  - **The surgery is performed on the same date as the visit or the following date.**

Modifier Usage

Modifier 59

- **DEFINITION: Distinct procedural service**

- **To use this modifier:**
  - **The patient must have a minimum of two billed procedures on the date of the service. Modifier 59 is not used with an E/M and one procedure (see modifier 25).**
  - **A payment edit must exist between the two procedures that the provider believes should be overridden due to the specific nature of these procedures.**
  - **Any other modifier is not applicable. Modifier 59 is a modifier of last resort – if a laterality modifier (LT, RT) or other modifier is more suitable to the code pair, that modifier should be used.**

Modifier Usage

Modifier 59

- **DEFINITION: Distinct procedural service**

- **Caveat:**
  - **We will discuss modifier 59 in place of the X modifiers, though when mandated by the payer or when most applicable, you can consider an X modifier.**
  - **XU – "Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service"**
  - **XS – "Separate Structure, a service that is distinct because it was performed on a separate organ/ structure"**
  - **XE – "Separate Encounter, a service that is distinct because it occurred during a separate encounter." Only use XE to describe separate encounters on the same date of service.**
  - **XP – Separate Practitioner, a service that is distinct because it was performed by a different practitioner**

Modifier Usage

Modifier 50/LT/RT

- **DEFINITION: Laterality/Bilaterality**

- **To use these modifiers:**
  - **Determine whether bilateral payment adjustment applies or whether the service can take place on either side of the body, but takes place on a specific side.**
  - **Will take precedent over modifier 59 for bilateral services.**
  - **Some payers want services coded as LT and RT on two lines; others will request modifier 50**
  - **Laterality should match assigned diagnosis coding and documentation based on side**
  - **Laterality must be documented in the note and cannot be inferred; query the provider as appropriate.**

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

A patient presents to the office for evaluation of knee pain. Following a evaluation and discussion of treatment options, a decision is made to perform a joint injection for pain relief. What modifier is assigned to the E/M code?

A. 24
B. 25
C. 57
D. 59
E. No modifier

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

A patient presents to the office for evaluation of knee pain. Following a evaluation and discussion of treatment options, a decision is made to perform a joint injection for pain relief. What modifier is assigned to the E/M code?

A. 24
B. 25
C. 57
D. 59
E. No modifier

The joint injection is a minor procedure so modifier 25 is appropriate.

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

A patient is evaluated in the hospital after presenting to the emergency department after a fall. The orthopedic surgeon decides the patient needs hip surgery which will be performed the next day. Which modifier is added to the E/M code?

A. 24
B. 25
C. 57
D. 59
E. No modifier

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

A patient is evaluated in the hospital after presenting to the emergency department after a fall. The orthopedic surgeon decides the patient needs hip surgery which will be performed the next day. Which modifier is added to the E/M code?

A. 24
B. 25
C. 57
D. 59
E. No modifier

This is a major surgery so modifier 57 would be appropriate if the surgery happens the same day or the next day.

ICD-10-CM Coding Thoughts

ICD-10-CM Overview

- Only confirmed diagnoses documented and managed in the note can be coded for outpatient and office services. These diagnosis codes must be identified and treated by the provider, who bears sole responsibility for the assignment of the diagnosis code.

- Others in the practice may assist, by educating the provider on the diagnosis codes managed most commonly or pointing out possible inconsistencies between the body of the documentation as it describes the patient's condition and the codes that were selected by the rendering provider.

- Only the rendering provider can describe the patient's condition in the documentation in a way that facilitates the assignment of the correct code.

ICD-10-CM Overview

- Probable/possible diagnoses should not be coded until they are stated to be a definitive diagnosis, signs/symptoms should instead be coded
- Coding a probable diagnosis would cause an ICD-10-CM code to be billed without supporting documentation confirmation of the patient having the condition
- From a documentation perspective, phrases like ‘suspected’, ‘likely’ or ‘probable’ are indications to coders that the condition is not a confirmed diagnosis. If a provider documents knee pain and states “likely osteoarthritis” then we would code the knee pain to the laterality in the note.

4. Signs and symptoms

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0 - R99) contains many, but not all, codes for symptoms.

See Section I.B.18 Use of Signs/Symptom/Unspecified Codes

5. Conditions that are an integral part of a disease process

Signs and symptoms that are associated routinely with a disease process should not be assigned as additional codes, unless otherwise instructed by the classification.

6. Conditions that are not an integral part of a disease process

Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

18. Use of Sign/Symptom/Unspecified Codes

Sign/symptom and “unspecified” codes have acceptable, even necessary, uses. While specific diagnosis codes should be reported when they are supported by the available medical record documentation and clinical knowledge of the patient’s health condition, there are instances when signs/symptoms or unspecified codes are the best choices for accurately reflecting the healthcare encounter. Each healthcare encounter should be coded to the level of certainty known for that encounter.

If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis. When sufficient clinical information isn’t known or available about a particular health condition to assign a more specific code, it is acceptable to report the appropriate “unspecified” code (e.g., a diagnosis of pneumonia has been determined, but not the specific type). Unspecified codes should be reported when they are the codes that most accurately reflect what is known about the patient’s condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation or conduct medically unnecessary diagnostic testing in order to determine a more specific code.

ICD-10-CM Overview – Conflicting Diagnoses

- This conflict may occur between the codes assigned by the rendering provider and the information within the body of the note, but there may also be contradictions between different aspects of the same note.
- In these instances, it is critical that the code support engage the provider to determine the most appropriate diagnosis based on the provider's knowledge of the encounter. It is not appropriate for the code support person who did not see the patient to assume that one diagnosis is more correct than the other.
- The totality of the information contained within the note may steer the code support person to favor one diagnosis over the other, but this should still be verified with the provider.

ICD-10-CM Overview – Laterality

- There is little excuse for laterality not to be captured as part of the provider's documentation – yet it happens with some frequency and can impact HCC weight adjustment, because the absence of laterality often forces the coder to assign an unspecified diagnosis code.
- An important distinction to make when assigning diagnosis codes when laterality is involved is to differentiate between circumstances when a code exists for a bilateral condition and when it does not. When there is not a bilateral code, don't default to an unspecified code but instead code both sides.
- Most musculoskeletal injury diagnosis codes have right and left side codes.

ICD-10-CM Overview – Excludes Notes

- *"a. Excludes1 A type 1 Excludes note is a pure excludes note. It means "**NOT CODED HERE**!" An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note.*
    - *An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition. ICD-10-CM Official Guidelines for Coding and Reporting FY 2022 Page 10 of 115*
    - *An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other. If it is not clear whether the two conditions involving an Excludes1 note are related or not, query the provider. For example, code F45.8, Other somatoform disorders, has an Excludes1 note for "sleep related teeth grinding (G47.63)," because "teeth grinding" is an inclusion term under F45.8. Only one of these two codes should be assigned for teeth grinding. However psychogenic dysmenorrhea is also an inclusion term under F45.8, and a patient could have both this condition and sleep related teeth grinding. In this case, the two conditions are clearly unrelated to each other, and so it would be appropriate to report F45.8 and G47.63 together.*
- *b. Excludes2 A type 2 Excludes note represents "**Not included here**." An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate."*

ICD-10-CM Overview – Seventh Character

- "A" – Initial Encounter is used while patient is receiving active treatment for the condition

- "D" – Subsequent Encounter is used for encounters after the patient has received active treatment of the condition, and is receiving routine care during the healing or recovery phase

- "S" – Sequela is used for complications or conditions that arise as a direct result of a condition

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

A patient returns in follow up for management of a fracture. The fracture is documented as healing according to schedule. The patient is told she can increase activity and should return in 4 weeks. What is the appropriate seventh character?

A. A
B. D
C. S

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

A patient returns in follow up for management of a fracture. The fracture is documented as healing according to schedule. The patient is told she can increase activity and should return in 4 weeks. What is the appropriate seventh character?

A. A
B. D
C. S

The patient is in the routine healing phase so the seventh character D is appropriate.

Coding for Physical Therapy/Occupational Therapy

Coding for Physical Therapy/Occupational Therapy

PT/OT services typically start with an evaluation of the patient prior to the specific episode of therapy care being provider. Depending on the patient's coverage or circumstances, a physician's order may be required.

Physical Therapy:

- 97161: Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
- 97162: Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.
- 97163: Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.

Coding for PT/OT

PT/OT services typically start with an evaluation of the patient prior to the specific episode of therapy care being provider. Depending on the patient's coverage or circumstances, a physician's order may be required.

Occupational Therapy:

- 97165: Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.
- 97166: Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.
- 97167: Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.

PT/OT Coding

Key things to remember for evaluations:

- The predominant factor for which PT code to assign is personal factors and/or comorbidities.
- Documentation should include a therapy plan of care for the ICD-10-CM codes outlined as needing coverage.
- For OT codes, the predominant factor is the number of documented performance deficits.
- These are NOT codes where documentation of time is required; when billing with timed codes, the time should be excluded but time to each therapy modality should be documented.
- Re-evaluations should be done only when there are new clinical findings, a significant change in the patient's condition, or failure to respond to the therapeutic interventions outlined in the plan of care.

PT/OT Coding

Key things to remember for evaluations:

- When a patient is pre-authorized for PT/OT for specific injuries but the therapeutic evaluation identifies additional conditions, revision of the pre-authorization or a physician query may be necessary.
- Re-evaluations for a change in condition should include documentation of the change in the condition.
- Re-evaluations have the same documentation requirement as evaluations.

PT/OT Coding – Time Based Coding

Examples of the most commonly used time-based codes:

- 97110: Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
- 97530: Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
- 97112: Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
- 97035: Application of a modality to 1 or more areas; ultrasound, each 15 minutes

PT/OT Coding – Time Based Coding

Things to remember with time-based codes:

- Time spent on each modality, along with the name of the modality and a description of the activities should be documented for EACH billed code.
- A minimum time threshold for each modality is 8 minutes for billing purposes
- Some payers (notably Medicare) follow the ‘rule of 8’ for the billing of the TOTAL units spent on all time-based activities. Others do not and each modality should be coded separately based on time.
- Not all payers cover all services. For example, Medicare always bundles 97010 for hot and cold packs. So it is important to consider payer coverage.
- Medicare typically covers G0283 under its policies for electrical stimulation; other payers cover 97014

PT/OT Coding – Medicare's 8-minute rule

- The eight-minute rule basically means that, for Medicare, the total amount of time spent on COVERED time-based services is subdivided into 15-minute units for the purposes of determining the total volume of units.
- This differs from other payers, who determine coding for each time-based code based on its own time, adding one unit every time the 8-minute threshold of the 15-minute unit time has been passed.
- How does this work?: Consider a claim with 8 minutes of therapeutic exercise (97110) and 8 minutes of manual therapy (97140).
- For most payers you would bill one unit of each code. Medicare would require you to sum this to a total therapy time of 16 minutes and pay for one unit of either 97110 or 97140, but not both.

PT/OT Coding – PTAs/OTAs

- Services by physical therapy and occupational therapy assistants are billable in some circumstances. Some things to remember:
  - The services must be done under the direct supervision of a therapist (in the building and immediately available to assist)
  - Services should be done under a plan of care created at the evaluation by the PT/OT
  - Assign modifier CQ (physical therapy) and CO (occupational therapy) for services performed in whole or in part by the PTA/OTA
  - These modifiers are appropriate when the PTA/OTA performs the entire service or when they perform part of the service. Under the 'de minimis' standard CMS applies, meaning that when a PTA/OTA performs more than 10 percent of the minutes of the service, it should be billed as a PTA/OTA service. This is the case UNLESS it is the final unit of a Medicare service and the PTA/OTA minutes can be subtracted to not comprise any part of that unit OR when there are two remaining units of the same service where the PT and PTA each provide between 9 and 14 minutes of the same service and the total time is between 23-28 minutes. In this instance one unit can be billed with the CQ/CO and one without.

Incident to/Split Shared Services

Incident to and Split Shared Services

- **When these visits are billed under the physician, reimbursement rate is based on 100 percent of the Medicare allowed charge.**

- **When billed under the NPP, the reimbursement rate is based on 85 percent of the Medicare allowed charge.**

- **These two visit types both carry high risk of error rates and should be reviewed and audited carefully.**

Incident to Services

- **Incident to services are billed in the following settings:**
  - **The office setting (POS 11)**
  - **The patient's home (unusual as typically it means both providers are present)**
  - **Space that is leased in a facility setting by the provider and is considered as part of the lease terms to be POS 11**

- **The service is rendered in its entirety by the NPP under 'direct' supervision of a physician in the same group. This means the physician is present in the office suite and immediately available to assist.**

Incident to Services

- **Incident to service notes do not need to be signed by the supervising physician, though there should be records available to prove/establish the presence of this provider.**

- **An incident to service is rendered under a plan of care created by a physician who has previously seen the patient. Under changes in 2022, the physician CANNOT be asked to come in a create a plan of care for a visit in which the remainder is done by the NPP. This is a split/shared visit and cannot be done in the office.**

- **Consequently, any time the patient is a new patient or presents with a new problem that is managed by the NPP, the visit is not eligible to be billed by the physician.**

Incident to Services

- **A physician is expected to remain "actively involved" in the care of the patient when the patient is being billed for incident to services on an ongoing basis.**

- **ANY change to the plan of care, including the placement of new orders, changes to medications (addition/subtraction/dosage) or the decision to perform a minor procedure is construed as a change to the plan of care and impacts the ability to bill incident to services.**

- **Practices planning to offer incident to services MUST have a mechanism or protocol for the rendering provider to alert that changes have occurred to the plan of care to ensure correct billing.**

Incident to Services

- **A physician is expected to remain “actively involved” in the care of the patient when the patient is being billed for incident to services on an ongoing basis.**

- **ANY change to the plan of care, including the placement of new orders, changes to medications (addition/subtraction/dosage) or the decision to perform a minor procedure is construed as a change to the plan of care and impacts the ability to bill incident to services.**

- **Practices planning to offer incident to services MUST have a mechanism or protocol for the rendering provider to alert that changes have occurred to the plan of care to ensure correct billing.**

- **As an auditor, one of the highest error rate service types I review are incident to Medicare services that are billed under a physician.**

- **The most common identified error is that a modest change has been made to the plan of care.**

Split Shared Services

- What is a split/shared service?
  - **A split (or shared) E/M visits is an E/M visit provided in the facility setting (i.e., hospital inpatient/observation, provider-based clinic) by a physician and an NPP in the same group. The visit is billed by the physician or practitioner who provides the substantive portion of the visit.**
  - **Substantive is defined currently as either the provider who performs the majority of the visit bills for it or the physician may bill the service if he/she documents sufficient medical decision making to support the code.**
  - **Physician documents sufficient plan of care or affirms the plan of care documented by the nurse practitioner. Attestation should specifically state that the physician has reviewed the assessment and plan and agrees with the diagnoses documented in the record and the treatment plan. NOTE: CPT states the physician should "take responsibility" for the plan of care. If this verbiage is not used, note that any attestation/signature and the visit being billed under the physician will make the physician responsible in the eyes of auditors/regulators.**
  - **The visit must be performed by a physician and non-physician practitioner (NPP) in the same group practice under the same TIN.**

Split Shared Services

- **CMS no longer permits split/shared visits to be done in the office (POS 11) setting. This means that a physician cannot create only the plan of care for a visit and claim it to be a split/shared visit. Incident to visit rules are place for POS 11.**
- **Provider-based settings are covered by the split/shared visit rules.**
- **Critical care visits and emergency department services may be billed as split/shared services under changes implemented in 2022.**
- **Split/shared visits MUST be coded with modifier FS to denote that it is a visit split among two providers.**

Split Shared Services

- **For a split/shared visit, the time of each provider is counted individually when the providers see the patient independently of each other.**

- **When the physician and the NP/PA see the patient together, the time spent may be counted only once (not for each provider) and may be credited to either provider (but not to both).**

- **Time based services such as critical care may only be billed based on which provider spends the most time as there is not a quantifiable medical decision making component.**

E/M Services Overview – Medical Decision Making

Let's look at some Quiz Examples:

A patient is seen in the inpatient hospital setting. The physician assistant documents 21 minutes of service time and the physician documents 15 minutes of service time. The physician does not document his own treatment plan. Who should bill the service?

A. Physician
B. Physician assistant
C. Either is fine

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In this scenario, the physician assistant has spent the most time and there is not specific medical decision making from the physician.

In Office Procedures (Joint Injections/Fracture Care)

In-Office Injections

- **For these services, documentation should always include:**
  - **Consent of the patient**
  - **The specific location of the injection (including the joint where the needle is placed)**
  - **If ultrasound guidance is used this should be documented with the reason and the images as part of the medical record.**
  - **For fluoroscopic guidance, the reason should be documented.**
  - **The specific volume of drug(s) injected should be documented. If the note is just for aspiration this should be part of the documentation.**
  - **Anesthetics are typically bundled into the injection services with rare, payer based exceptions.**
  - **Patient tolerance and aftercare instructions should be documented.**

In-Office Injections

- **Code selection is based on the joint or bursa being injected**
  - **Code 20600 for small joint or bursa (fingers, toes) without ultrasound guidance; Use 20604 for ultrasound guidance**
  - **Code 20605 for intermediate joint or bursa (temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa) without ultrasound guidance; Use 20606 for ultrasound guidance**
  - **Code 20610 for major joint or bursa (shoulder, hip, knee, subacromial bursa) without ultrasound guidance. Use 20611 for ultrasound guidance.**
  - **Ultrasound guidance code 76942 should NOT be billed with these services as it is addressed by 20604, 20606 and 20611.**
  - **Use modifiers LT/RT/50 based on laterality or bilateral injection.**

In-Office Injections – Other Injections

- **Code selection is based on location and muscle group**
  - **20550:** Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")
  - **20551:** Injection(s); single tendon origin/insertion
  - **20552:** Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
  - **20553:** Injection(s); single or multiple trigger point(s), 3 or more muscles

In-Office Injections – Other Injections

- **What to know when billing these codes**
  - **Documentation should be specific – instead of saying "knee injection" the provider should document the specific joint or point of entry.**
  - **Trigger point injections are determined by the muscle. The number of individual injections into one muscle group are not counted separately.**
  - **20550 is most commonly for plantar fasciitis or for injections to the flexor tendon with 20551 for injections to other tendon origin areas or both plantar fascia and the area around a calcaneal spur.**
  - **Use LT/RT or 50 as appropriate. For injections to fingers, use finger modifiers (left hand FA-F4, right hand F5-F9 moving from thumb to fifth digit).**
  - **Multiple units of these codes may be billed for multiple injection areas; use modifiers as appropriate.**

In-Office Injections – Other Injections

- **Important Considerations**
  - **An E/M service is not always supported and should not be supported for patients who are receiving scheduled injections or who return to request injections.**
  - **Documentation for the E/M service must show discussion of multiple treatment options resulting in the decision to perform an injection and not just show the injection itself.**
  - **Provider coding should be reviewed carefully in this area as the temptation is to always bill the E/M.**
  - **Some potential trigger phrases:**
    - **Patient requests additional injection**
    - **Patient here for injection**
    - **Previous injection has worn off, patient would like another.**

Fracture Care Coding

- **What to know when billing fracture care**
  - **These services have a 90-day global period, inclusive of the management of the fracture.**
  - **Only one provider may bill these codes – fracture care should not be coded unless it is the intent of the provider to manage the fracture. Urgent care, for example, should not typically bill fracture care.**
  - **Closed fracture care commonly done in the office includes applications of casts or splints (otherwise billed separately). Some supplies can be separately coded and billed as appropriate. Fracture care without manipulation typically involves delivery and application of a supply such as a cast or splint.**
  - **Items such as X-Rays and imaging are separately billable.**
  - **A separate E/M may be billed when the fracture care code is billed when documentation shows the workup to treat and diagnose the fracture, including multiple treatment options discussed as appropriate.**

Fracture Care Coding

- **What to know when billing fracture care**
  - **Manipulation is not required to bill fracture care but it should be coded when performed.**
  - **Open reduction is typically not done in the office as it is a surgical procedure and would be coded off of a surgical note. Closed reduction/manipulation is often a component of the E/M service note. Casting can (and often does) happen in either instance.**
  - **During the global period, supplies can be billed for things such as changes to the type of splint but applications are bundled into the global period.**
  - **Providers are not obligated to bill fracture care and can instead bill individual E/M services and cast applications as appropriate, but this decision should NOT be based solely on financial considerations.**

Surgical Documentation

Surgical Documentation – All Procedures

- Patient Name
- Date of Service
- Pre-operative diagnosis
- Post-operative diagnosis
- Surgeon's name
- Assistant surgeon/Co-surgeon
- Name of procedure(s)
- Indications for surgery
- Findings during surgery
- Specific details of the procedures performed

Every note stands alone this information must be present within the operative report and cannot be pulled from previously documented encounters without the provider referring to a specific document to reference

Surgical Documentation – All Procedures

NAME OF OPERATION:
1. POSTERIOR SPINAL FUSION OF T10, T11, T12, L1, L2, L3, L4, L5, S1.
2. PLACEMENT OF SEGMENTAL SPINAL INSTRUMENTATION IN THE FORM OF DEPUY EXPEDIUM 5.5 MM TITANIUM ROD COMPATIBLE POLYAXIAL SCREWS BILATERALLY AT T10, T11, T12, L1, L2.
3. LAMINECTOMY WITH COMPLETE SEGMENTAL DECOMPRESSION OF L2-L3, L3-4.
4. INCIDENTAL DUROTOMY WITH PROLENE AND DURAGEN PATCH REPAIR AT L4-L5.
5. PEDICLE SUBTRACTION OSTEOTOMY OF L3.
6. HARVEST, PROCESS AND APPLICATION OF FAT GRAFT TO THE DORSAL DURAL ELEMENTS FROM L2 TO L4.
7. USE OF BONE MORPHOGENIC PROTEIN AND LOCAL AUTOGRAFT FOR POSTEROLATERAL FUSION FROM T10 TO THE PELVIS.
8. USE OF INTRAOPERATIVE MONITORING.
9. USE OF INTRAOPERATIVE FLUOROSCOPY.

INDICATION FOR PROCEDURE:
Specific indications identified in detail.

PROCEDURE:
Specific procedures documented separately and in detail. Each procedure type should be documented in its own paragraph as it is easier to identify them separately.

Dictated by: Surgeon's Name, M.D.
Dict Date: X/XX/XXX Typed by: XXX
Trans Date: X/XX/XXX

Do not code from this header! Code from body of op report!

Code surgery from the body of the operative report

Surgical Documentation – Assistant at Surgery

- The surgeon is required to specify in the body of the operative report what the assistant actually does
- It is not sufficient evidence of participation to list the assistant's name in the heading of the operative report
- Modifiers
  - Use the "80" modifier when the assistant at surgery service was provided by a medical doctor (MD).
  - Use the "81" modifier to identify minimum surgical assistant services, and is only submitted with surgery codes.
  - Use the "82" modifier when the assistant at surgery service was provided by an MD and there was not a qualified resident available. Documentation must include information relating to the unavailability of a qualified resident in this situation.
  - Use the modifier "AS" for assistant at surgery services provided by a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS)

Surgical Documentation – Co-Surgery

- If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier “-62.”
    - Co-surgery is performed if the procedure(s) are part of and would be billed under the same surgical code
- If surgeons of different specialties are each performing a different procedure (with specific CPT codes), neither co-surgery nor multiple surgery rules apply (even if the procedures are performed through the same incision)
- Each surgeon must document his/her own note for co-surgery coding purposes that describes the specific surgeon’s work.

RESOURCES

A list of resources to consider when needing to research a new surgical procedure/specialty

1. **CPT and ICD-10 books** These are your primary sources, whether you use digital mediums or physical books

   They should always be the first source consulted and if unclear, go on to review other sources.

2. **National Correct Coding Initiative (NCCI)** edits and policy manual

   Updated quarterly and most auditors use software-based NCCI bundling checker (or web-based)

3. **Payer guidance: NCDs, LCDs**

4. **Coding reference books/Coding Software (Encoder)**

   Examples include CPT Assistant and various other sources offering clarification and in-depth explanation of CPT and other guidelines

   Not necessary as they are all based on the primary sources (CPT, CMS) but are time-savers if you can get them.

5. **The Internet (aka "just Google it")**

   Something of a last resort, but indisputably valuable

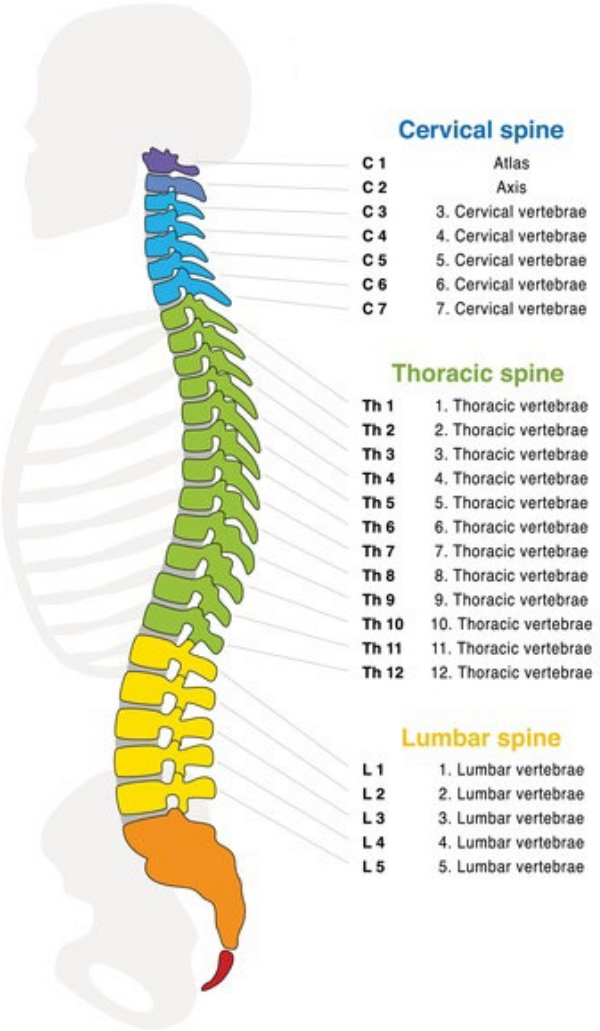
   Defer to online material from reputable and widely recognized organizations (e.g. AAPC, AMA, MGMA, specialty societies/academies, NAMAS etc.) ***and exercise caution when reading advice from "forums"***

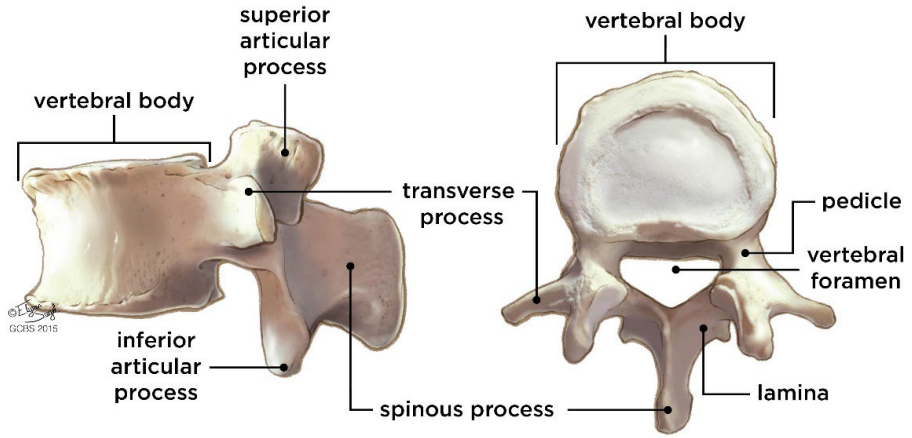
   *Great source anatomy and understanding procedures that are new to you

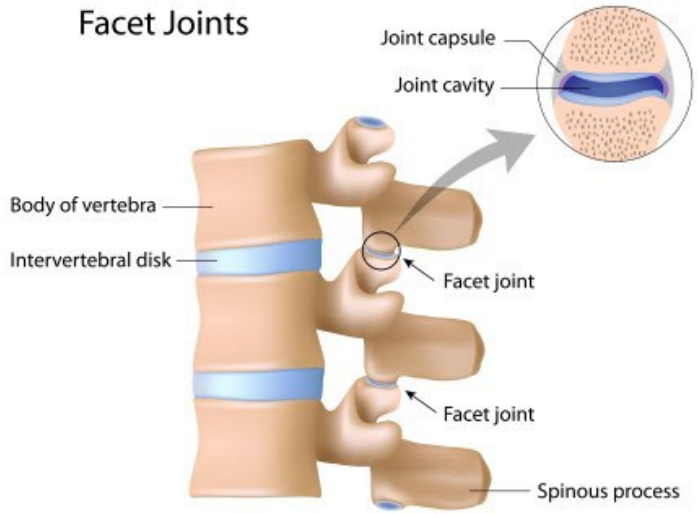
ANATOMY PHYSIOLOGY & TERMINOLOGY

- Coders and auditors are not clinicians, BUT it is important for us to understand the surgical procedures to help bridge the gap between the code descriptions and guidelines and what is required to be shown in the documentation
- Queries and conversations are more productive when there is a level of understanding before discussing with a surgeon

USING ANATOMY TO RESEARCH A SURGERY







WATCHING OUT FOR BUNDLING EDITS

- Given the massive amount of CCI edits affecting surgical procedures, doing a CCI “check” or validation should be part of any audit when multiple codes are being considered for proper billing
- If you use a CCI scrubber or validator (which most people do nowadays), do not allow software to override your knowledge, or to replace NCD/LCDs
- Only append unbundling modifiers (i.e. -59, XS) when they are appropriately supported (separate site, separate session, etc.)
- Never append these modifiers just to bypass insurance edits.
- Check payer LCDs for payer-specific guidance and examples on scenarios in which modifiers can be applied

FOLLOW THE OPERATIVE REPORT

- Verify the required contents of the operative report. Not all reports will follow this specific structure, but all must contain at least these elements:
- **Heading**
  - Name and hospital identification number of the patient;
  - Date and times of the surgery;
  - Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
  - Pre-operative and post-operative diagnosis;
  - Name of the specific surgical procedure(s) performed;
  - Type of anesthesia administered and whom it was administered by;
- **Body**
  - Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and
  - Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any
- **Findings**
  - A description of techniques, findings, and tissues removed or altered;
  - Any clinically significant observations made during the procedure;
  - Complications, if any; and,
  - Instructions for the patient's postoperative course and plan of care.

DISSECTING THE HEADING OF THE OP REPORT

- Remember we **do not** code from here, but we have to review and compare to see if anything is missing or a query is required
  - Date of surgery
  - Primary surgeon
  - Assistant surgeon
    - ***With identification of a resident/fellow***
    - ***Verify the assistant surgeon documentation requirements have been met***
  - Pre-op diagnosis
  - Post-op diagnosis
  - Name of procedure(s) performed
  - Indications for surgery

DETAILS IN THE BODY OF THE OPERATIVE REPORT

- The details of the performance must be noted
  - This is not a section of the note for a surgeon to just state what they did, the note must include specific detail to support the surgery rendered and how that correlates to the CPT code(s) they are reporting
- Complications
- Condition of patient after the surgery
- Surgeon's signature
- Attestation statement if scenario requires

PHYSICIAN QUERY

- **A query should be considered when the health record documentation**:
  - Is conflicting, **imprecise**, incomplete, illegible, ambiguous, or **inconsistent**
  - Describes or is associated with clinical indicators without a definitive relationship to an underlying diagnosis
  - Includes clinical indicators, diagnostic evaluation, and/or treatment not related to a specific condition or procedure
  - Provides a diagnosis without underlying clinical validation
  - Is unclear for present on admission indicator assignment

- **The main things to remember when querying are:**
  - Not to lead
  - Not to question the clinical judgment of the provider
  - Not to indicate the financial impact

SURGICAL MODIFIERS

- Modifier frequent fliers:

  - **Modifier 22** Increased procedural services
  - **Modifier 24** Unrelated E/M service by same physician during post-op period
  - **Modifier 25** Significant, separately identifiable E/M service, same physician, same day.
  - **Modifier 58** Staged or related procedure/service by same physician during postop period
  - **Modifier 59** Distinct procedural service (may also be replaced by the newer X modifiers)
  - **Modifiers 62 and 66** Two surgeons (62) and surgical team (66)
  - **Modifiers 78 and 79** Unplanned return to the OR (78) and unrelated procedure or service (79)
  - **Modifier 80 and AS** Assistant surgeon, MD (80) and assistant surgeon, NP/PA/CNS (AS)

Small Joints (shoulders/elbows/knees)

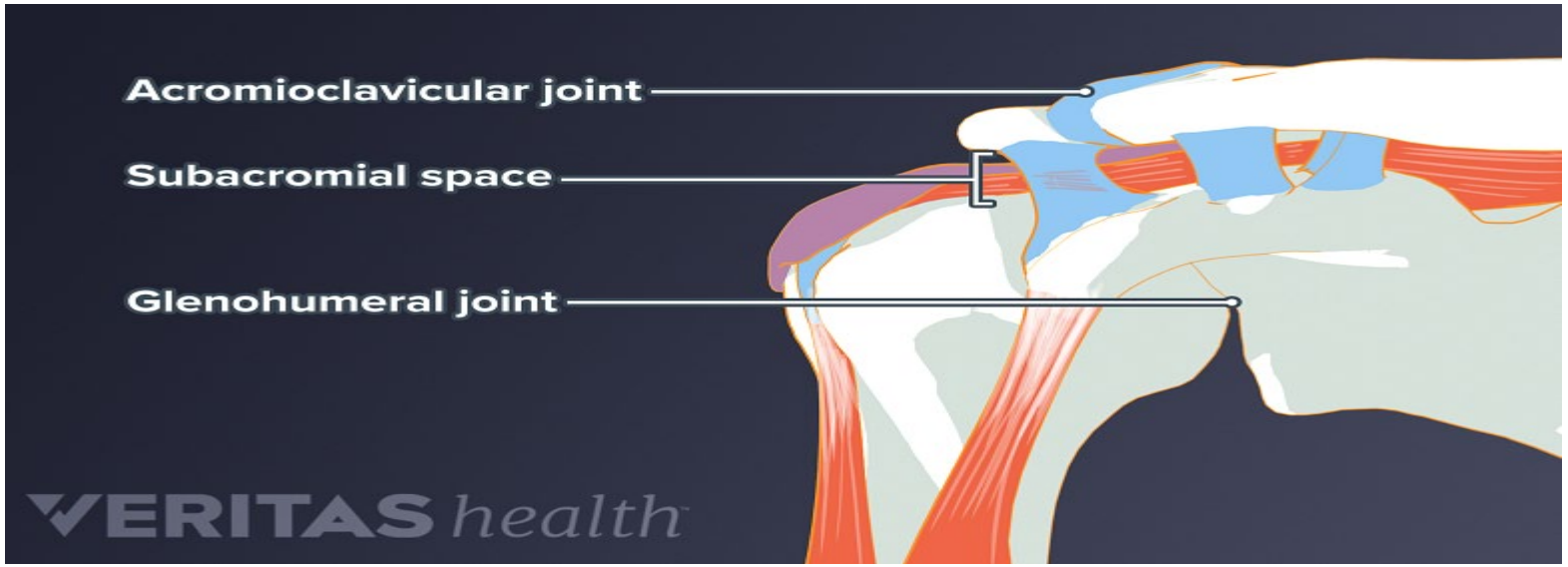
Arthroscopy

Basics of arthroscopy coding:

- **Arthroscopy is a minimally invasive surgery done using an arthroscope to limit the incision.**
- **Surgical arthroscopy includes diagnostic arthroscopy that is not separately reported. If a diagnostic arthroscopy results in the decision to perform surgical arthroscopy, only the surgical arthroscopy is reported.**
- **Diagnostic arthroscopy is billable when it results in the decision to perform an open procedure. Use modifier 58 when this is staged.**
- **If an arthroscopy converts to an open procedure, only the open procedure is reported.**

Arthroscopy -- shoulder

- **The shoulder is divided into three areas – the glenohumeral joint, the acromioclavicular joint and the subacromial bursal space.**
- **However, CMS recognizes the shoulder as a single anatomic structure so Medicare cases may only bypass coding edits when services are performed on separate shoulders.**



Arthroscopy -- shoulder

Debridement

- **29822**: Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])
- **29823**: Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])

NOTE: These services are bundled into other shoulder arthroscopy procedures, even if done in a different area of the same shoulder than the primary procedure. NCCI allows separate coding of extensive debridement with 29824, 29827 and 29828

Arthroscopy -- shoulder

Common arthroscopy

- **29824**: Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (Mumford procedure)
  - Lay term: The provider makes small incisions in the shoulder area. She inserts an arthroscope through one of the incisions and removes and reinserts the arthroscope through another incision and excises the distal portion of the clavicle, including its articular surface, where it is in contact with the joint. The provider then irrigates the area, checks for bleeding, removes any instruments, and closes the incision.
- **29825**: Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
  - Lay term: The provider makes an incision in the shoulder area. She inserts the arthroscope through the incision and into the shoulder joint and inserts additional instruments to free up and remove adhesions. She manipulates the joint as necessary.
- **29826** (add-on): Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed
  - Lay term: When the patient is appropriately prepped and anesthetized, the provider makes three small incisions in the shoulder area. He views the entire shoulder joint area using the camera of the scope. He then inserts additional instruments and performs repairs to the shoulder blade to decompress, or relieve pressure, on structures that rub together abnormally. He removes part of the coracoacromial ligament, if necessary.
- **29827:** Arthroscopy, shoulder, surgical; with rotator cuff repair
  - **Lay term:** The provider makes an incision in the shoulder area. She inserts the arthroscope through the incision and into the shoulder joint. She inserts additional instruments to repair tears to the soft tissues, remove bone spurs, and free up adhesions.

Arthroscopy -- shoulder

Labral tears (SLAP)

- **29806**: Arthroscopy, shoulder, surgical; capsulorrhaphy
  - Lay term: The provider makes three small incisions in the shoulder area. He inserts the arthroscope through one of the incisions into the shoulder joint. He then inserts additional instruments and repairs the torn joint capsule. He inspects the ligaments and other structures in the shoulder. The provider then irrigates the area, checks for bleeding, removes any instruments, and closes the incisions.
- **29807:** Arthroscopy, shoulder, surgical; repair of SLAP lesion
  - Lay term: The provider makes an incision in the shoulder area. She inspects the labrum, the biceps tendon, and the head of the humerus. She inserts instruments to excise the torn part of the labrum, stitching the area if necessary. The provider then irrigates the area, checks for bleeding, removes any instruments, and closes the incision.

NOTE: Work on the upper half of the labrum is generally supported with 29807, often identified by the 'clock' location of the suture placement (i.e, 10 o'clock and 1 o'clock).

Arthroplasty -- shoulder

- **23470**: Arthroplasty, glenohumeral joint; hemiarthroplasty
  - Lay term: The provider incises across the front of the shoulder from the middle of the collarbone to the middle of the arm bone. The provider continues to dissect down through subcutaneous tissue, or just under the skin, to access the joint. Next, he retracts the muscles, nerves, and blood vessels. He then incises the joint capsule and dislocates the glenohumeral joint to dislodge the head of humerus from the glenoid socket. He then removes all the loose bodies present in the cavity. Next, he incises the damaged head of the humerus using an osteotome and places a prosthetic humeral head implant stem into the humerus shaft by drilling into the medullary canal. Next, he places the prosthetic humerus head into correct alignment and reduces it into the glenoid cavity. He sutures the muscle around the joint to provide the appropriate stabilization.

Arthroplasty -- shoulder

- **23472**: Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))
  - Lay term: The provider incises across the front of the shoulder from the middle of the collarbone to the middle of the arm bone. The provider continues to dissect down through the subcutaneous tissue, or just under the skin, to access the joint. Next, he retracts the muscles, nerves, and blood vessels. He then incises the joint capsule and dislocates the glenohumeral joint to dislodge the head of the humerus from the glenoid socket. He then removes all the loose bodies present in the cavity. Next, he prepares the glenoid cavity for the artificial implant. He removes the articular cartilage from the glenoid cavity and uses a surgical instrument to shape it to receive the artificial glenoid component. He next fills the glenoid socket with bone cement and places the artificial glenoid component into place. He then incises the damaged head of the humerus using an osteotome and places a prosthetic humeral head implant stem into the humerus shaft by drilling into the medullary canal. Next, he places the prosthetic humerus head into correct alignment and reduces it into the glenoid component. He may also perform acromioplasty to decompress the soft tissue structures. He then sutures the muscles around the joint to provide the appropriate stabilization. He removes all the osteophytes around the joint.

Fracture -- shoulder

- **23616**: Open treatment of proximal humeral (surgical or anatomical neck) fracture, includes internal fixation, when performed, includes repair of tuberosity(s), when performed; with proximal humeral prosthetic replacement
- Lay term: The provider incises the skin over the fractured bone. He then dissects down through subcutaneous tissue, protecting the nerves and vessels. He retracts the muscles to have adequate exposure of the fracture. He then adjusts the bone to reduce, or realign, the fractured fragments. He may fix the fracture using implants such as screws, nails, or wires. He may also repair the tuberosity, or rounded projection, on the upper end of the humerus. In the case of a severe fracture, the provider replaces the upper end of the humerus bone with a synthetic humerus bone implant. For this, the provider clears the glenoid cavity and debrides it properly so that the humeral head can fit and rotate smoothly. Then he closes the wound by suturing the skin layers together.

Open Rotator Cuff -- shoulder

- **23410**: Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute
- **23412**: Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic

The provider dissects down through the subcutaneous tissue, or just under the skin, and retracts the muscles, blood vessels, and nerves. This exposes the subacromial space, a space between the acromion process of the shoulder blade and the head of the humerus bone. He now has access to the rotator cuff muscles and the rupture, or tear. The provider then assesses the shape of the tear and removes the frayed segments of the tendons. He then makes a trench in the humeral bone for the tendon to lie in and drills holes in the bone to attach the tendon. Next, he sutures the tear in the tendon and places bone anchors to fix the tendon to the bones.

NOTE: The primary difference here is the persistent nature of the injury as defined by the provider.

Arthroscopy -- elbow

Debridement

- **29837**: Arthroscopy, elbow, surgical; debridement, limited
- **29838**: Arthroscopy, elbow, surgical; debridement, extensive

NOTE: The distinction here is that limited occurs in either the anterior or posterior compartment of the elbow and extensive is in both areas. Bundling edits do not exist in the same way as they do with the shoulder and knee.

Arthroscopy -- elbow

- **29830**: Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)
  - Lay term: The provider makes a small incision in the elbow area. She views the entire joint area using the camera of the scope. She then inserts additional instruments to take a biopsy of the synovial tissue and submits it for analysis.
- **29834**: Arthroscopy, elbow, surgical; with removal of loose body or foreign body
  - Lay term: The provider makes an incision in the elbow area. She inspects the joint and uses instruments to secure and remove any loose or foreign bodies.
- **29835**: Arthroscopy, elbow, surgical; synovectomy, partial
  - Lay term: The provider makes small incisions in the elbow area. She views the entire elbow joint area using the camera of the scope. She then inserts additional instruments to excise the inflamed portion of synovial membrane.
- **29836**: Arthroscopy, elbow, surgical; synovectomy, complete
  - Lay term: The provider makes small incisions in the elbow area. She views the entire elbow joint area using the camera of the scope. She then inserts additional instruments to excise the entire synovial membrane.

Arthroplasty -- elbow

- **24363**: Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement (eg, total elbow)
  - Lay term: The provider makes a longitudinal curved incision over the protruded area, the medial condyle, toward the midline of the elbow. He exposes the ulnar nerve and elevates the triceps and extensor mechanism that helps in extension from the olecranon. The provider exposes the elbow joint and releases the synovium and capsule from the humerus. He cuts the proximal ulna and the distal humerus, and performs a total elbow arthroplasty. He positions the elbow prosthesis and inserts the final components using bone cement. After achieving hemostasis, he reattaches the triceps tendon to the proximal ulna and closes the area in layers.
- **24370**: Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component
- **24371**: Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component
  - Lay term: The provider makes an incision over the previous incision. She dissects down through the subcutaneous tissue just under the skin and moves the tendons and ligaments out of the way, taking care to avoid damage to nerves and blood vessels. She incises the joint capsule, exposes the joint, and removes any scar tissue. She removes the old cement, removes the failed components, and examines them for defects. She uses a rasp, a sanding instrument, to smooth the edges of the lower end of the humerus and the upper end of the ulna for good prosthetic fit. She may augment the bones with allograft. She applies fresh cement, flexes the elbow, and inserts the replacement components. She closes the tissues over the joint and inserts a drain.

Arthroscopy -- knee

Debridement

- **29877**: Arthroscopy, knee, surgical; debridement/shaving of articular cartilage (chondroplasty)
  - Lay term: The provider inspects the joint and uses instruments to reshape the cartilage lining of the joint surfaces by debriding and or shaving the surfaces.

NOTE: This is the basic diagnostic arthroscopy or procedure when there is not a known problem other than the need for debridement.

Medicare DOES allow debridement to be separately reported with meniscus repair in the same knee in a different compartment with G0289. However this must be part of a meniscus repair. Standalone debridement for Medicare is also 29877.

Arthroscopy -- knee

Menisectomy – when this service is performed, the surgeon removes either some or all of the meniscus. These codes include debridement or shaving of articular cartilage (chondroplasty) in the same or other compartments of the knee.

- **29880**: Arthroscopy, knee, surgical with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed
- **29881**: Arthroscopy, knee, surgical with meniscectomy (medial OR lateral, including any meniscal shaving) including debridement/shaving of articular cartilage (chondroplasty), same or separate compartment(s), when performed

NOTE: The difference between the codes is whether the service is performed in the medial compartment, the lateral compartment or both compartments and that is what you would look for in the documentation.

Arthroscopy -- knee

For these services, the meniscus (or torn part of the cartilage) would be repaired with instruments.

- **29882**: Arthroscopy, knee, surgical with meniscus repair (medial OR lateral)
- **29883**: Arthroscopy, knee, surgical with meniscus repair (medial AND lateral)

NOTE: Similar to 29880/29881, the difference between the codes is whether the service is performed in the medial compartment, the lateral compartment or both compartments and that is what you would look for in the documentation. Unlike those services, chondroplasty or debridement may be separately reported in a different compartment of the same knee.

Arthroplasty -- knee

Knee replacement partial or total

- **27446:** Arthroplasty, knee, condyle and plateau; medial OR lateral compartment
- **27447:** Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)

NOTE: Assign 27446 as a partial knee when documentation describes medial OR lateral; use 27447 when documentation shows both components.

- **27486:** Revision of total knee arthroplasty, with or without allograft; 1 component
- **27487:** Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component

NOTE: For revision, the 27486 is a partial revision to a total knee and 27487 is the total revision of both components (femoral and tibial).

Other Less Common Arthroplasty -- knee

- **27440:** Arthroplasty, knee, tibial plateau
  - This is a reconstruction of the tibial part of the knee only
- **27441:** Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy
  - This is similar to 27440 but with debridement and removal of some synovial tissue.
- **27442:** Arthroplasty, femoral condyles or tibial plateau(s), knee
  - This is similar to 27440 but would also reconstruction of defects in the femoral condyle.
- **27443:** Arthroplasty, femoral condyles or tibial plateau(s), knee; with debridement and partial synovectomy
  - This is similar to 27441 but includes the femoral condyle.
- **27445:** Arthroplasty, knee, hinge prosthesis (eg, Walldius type)
  - In this procedure there is a hinge prothesis involved as an artificial implant to replace a portion of the removed bone.

Major Joints (Hips)

Arthroplasty -- Hip

- **27130**: Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
  - Lay term: The provider makes an incision in the skin of the hip joint and dissects down through the subcutaneous tissue to reach the hip joint capsule. He identifies and protects the sciatic nerve and releases the soft tissue. He then manually dislocates the hip joint and separates the femoral component from the acetabulum. He then removes the femoral head from the end of the femur using a saw. Next, he uses a reamer, a type of surgical cutting tool, in the acetabulum to create a perfect hemispherical bone socket that matches the shape of the acetabular prosthesis. He then places the acetabular prosthetic component in the socket and secures it using bone cement and possibly a graft. He then prepares the femoral shaft canal using a reamer or rasp for inserting the femoral prosthetic component. He inserts the femoral prosthetic stem into the femoral shaft and affixes it using bone cement. Lastly, he reunites the two components using a graft, if appropriate, and cement and reduces the hip joint, restoring the normal alignment of the hip joint

Arthroplasty -- Hip

- **27125**: Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)
  - Lay term: The provider incises over the posterior aspect of the hip. He dissects all the muscles around the hip joint to expose the joint capsule. The provider then dissects the joint capsule to gain access to the femoral head and neck. He excises the neck and head of the femur of the bone and places the prosthesis through the femoral canal. The provider might use bone cement to hold the prosthesis in correct position. After the placement of the prosthesis, the provider evaluates the bone for both stability and mobility.

Arthroplasty Revision -- Hip

- **27134**: Revision of total hip arthroplasty; both components, with or without autograft or allograft
- **27137**: Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft
- **27138**: Revision of total hip arthroplasty; femoral component only, with or without allograft

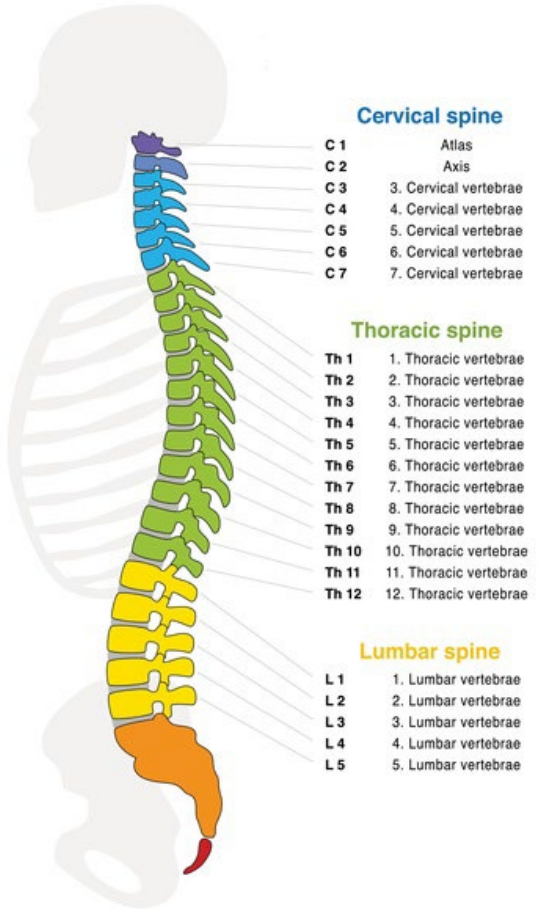
Note: We would look to the documentation as revision codes – as a result the patient must already have a previously implanted artificial hip. The question from a documentation perspective, based on the coding, is whether the note shows revision to one component or both components.

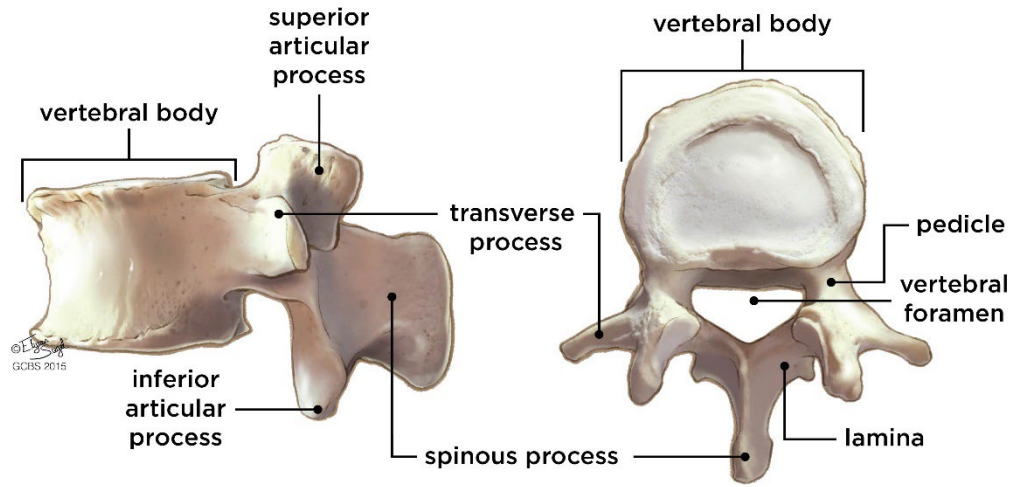
Fracture -- Hip

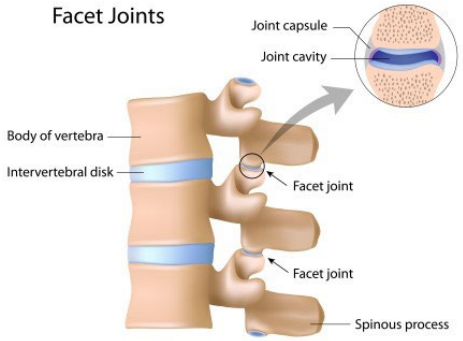
- **27236**: Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement
  - Lay term: The provider makes an incision in the skin over the fractured bone. He dissects down through subcutaneous tissue, protecting the nerves and vessels. He separates tissue and retracts the muscles to have adequate exposure of the neck of the femur. He adjusts the bone to reduce the fractured fragments. He fixes the fracture using implants like screws, nail, or wires. If the bone is too severely damaged or broken, the provider removes the fracture fragments and places an artificial implant as a replacement of the bone. In this situation, he reams out the femoral canal, inserts an appropriate size prosthesis, and moves it into the socket in the hipbone.

Spine Procedures

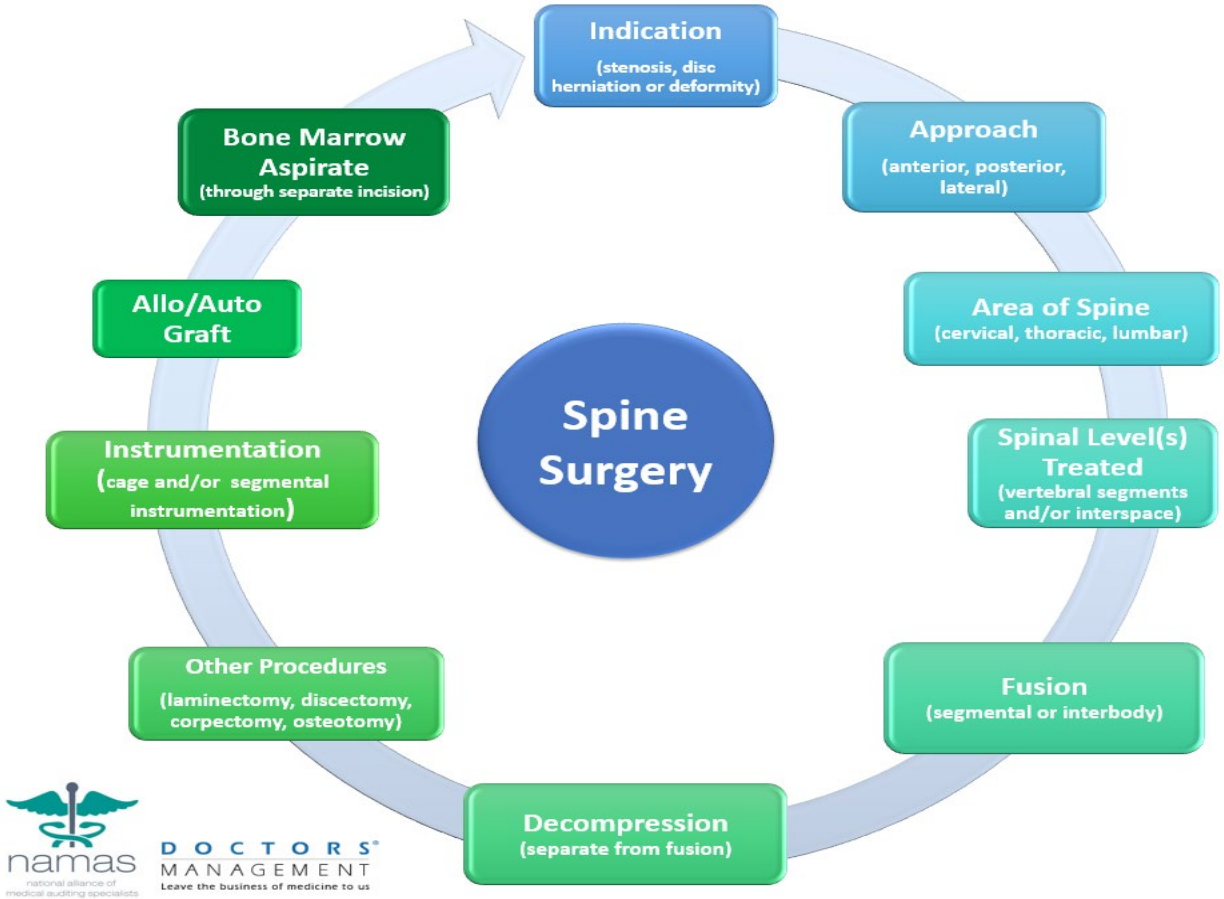
Spine Surgery







Spine Surgery



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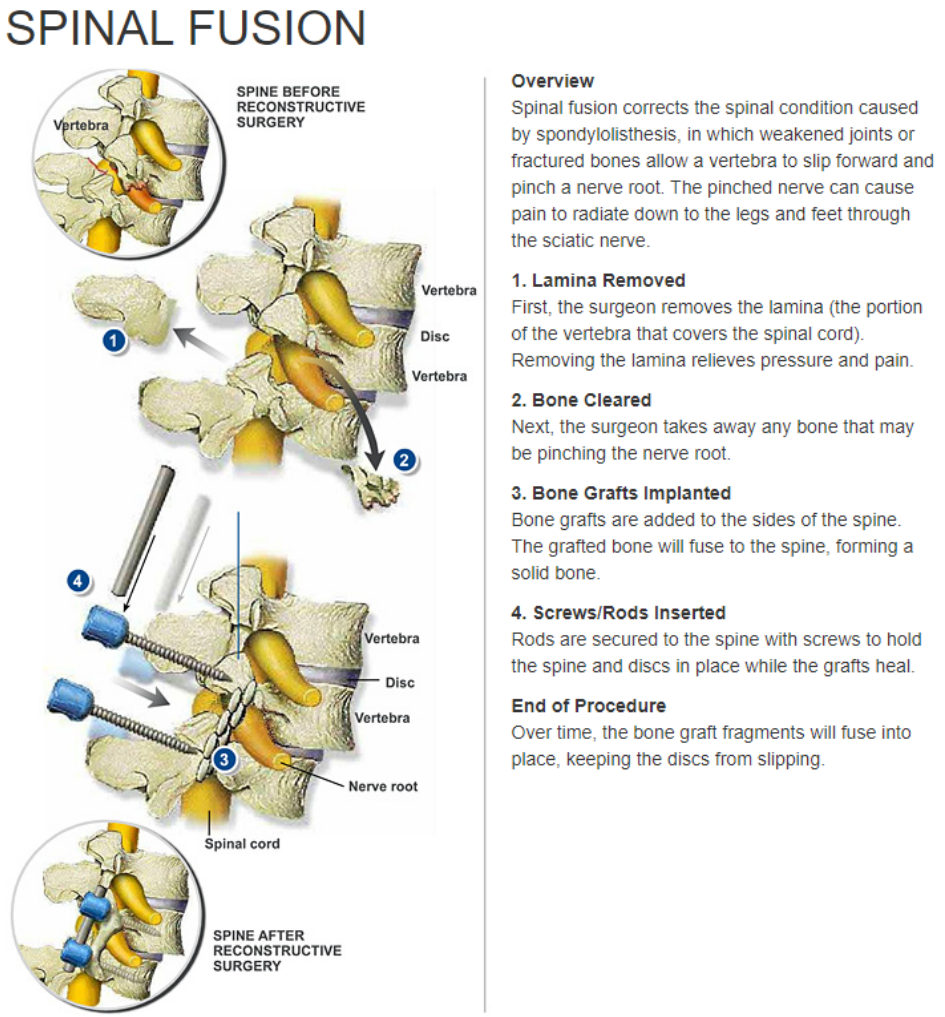
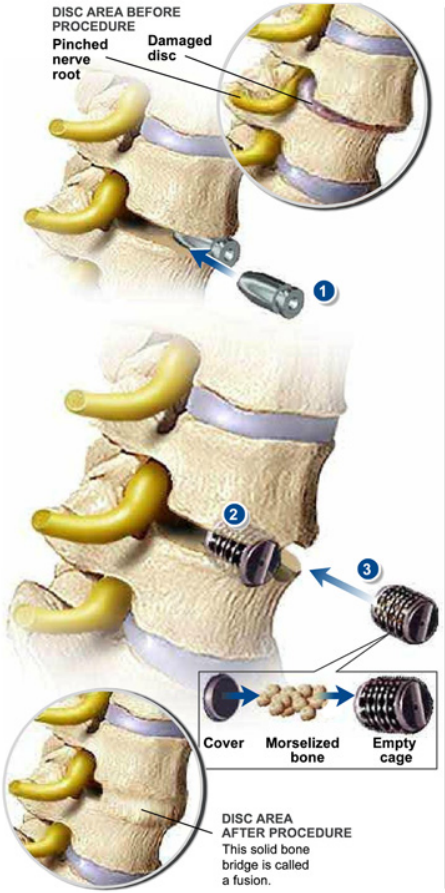
Spinal Fusion

- The surgeon strips the muscles from the spinous process and posterior lamina out to the mid portion of the facet joints and performs removal of lamina (the portion of the vertebra that covers the spinal cord) and cleans away any bone that may be pinching the nerve root
- The surgeon harvests small chips of bone (local grafts) from adjacent structures and applies them to the prepared bony surfaces at the back of the vertebrae, at the back and side, or at the side and across



Spine – lumbar fusion

LUMBAR INTER-BODY FUSION (IBF)



If you are suffering from back or leg pain, the source of that pain may be a damaged disc in your spine. In this procedure, your board certified spine surgeon replaces the disc with metal supports and bone grafts. As a result, vertebrae above and below the removed disc fuse together.

Lumbar inter-body fusion (IBF) is an effective treatment for degenerative disc disease. Because the surgeon makes a smaller incision and uses smaller tools, this procedure is considered minimally invasive surgery. This process avoids damaging your lower back muscles.

In an IBF, your surgeon completely removes the damaged disc and replaces it with material directly into the space left by the disc. The surrounding bone grows to fill in the space, creating a solid bridge that limits your movement.

Overview

Surgery is never the first choice at Southeastern Spine Institute. Fusing the spine is an extreme process because it limits your movement and cannot be reversed. IBT, a less invasive way to fuse your spine, treats severe back pain caused by degenerative disc disease. The procedure is detailed below. Talk to your surgeon about the risks and what to expect during your recovery.

1. Making the Incision

Your surgeon approaches the damaged disc through an incision in your abdomen. This procedure avoids cutting your back muscles. The surgeon then partially removes the disc.

2. Inserting Spacers

After removing the disc, the surgeon inserts temporary spacers into the empty space, as shown in illustration 1. This act realigns the vertebral bones and eliminates the pressure from your pinched nerve roots.

3. Creating the First Channel

The surgeon replaces the first spacer with a threaded metal cage (illustration 2). He creates a channel in the vertebral bones above and below the empty space to hold the cage. He screws in the cage, which is packed with bone graft, tightly into place.

4. Creating the Second Channel

Your surgeon then removes the other temporary spacer and creates the channel for the second cage. He screws the second cage tightly into place, as shown in illustration 3.

5. Recovering from the Procedure

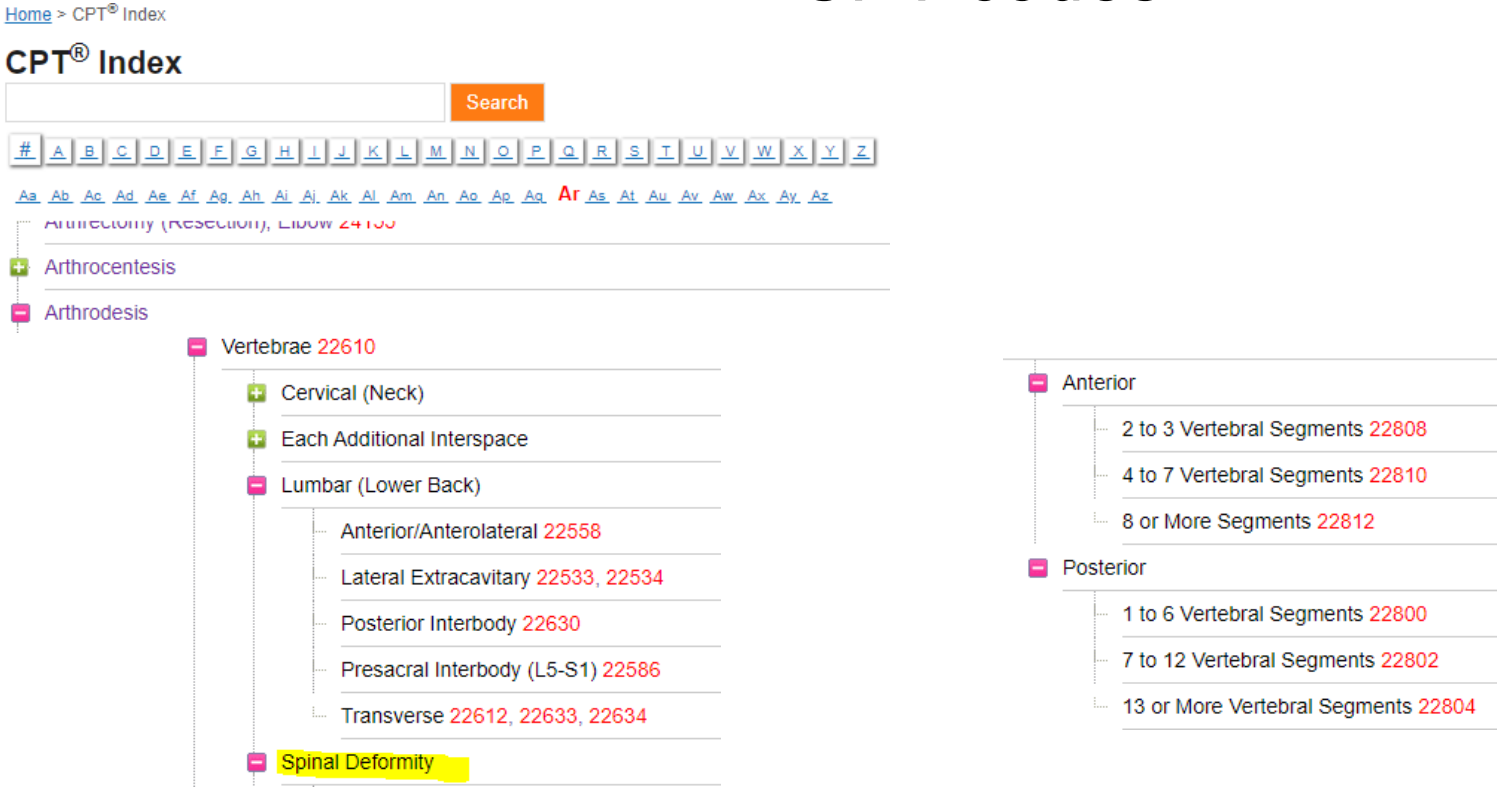
The morselized bone graft (illustration 3) eventually grows through and around the implants, forming a bone bridge that connects the vertebral bones of your spine. This solid bone bridge, shown in the bottom illustration, is called a fusion.

You must restrict your bending, twisting, lifting, and driving for up to six weeks after surgery. You may start physical therapy after that.

Arthrodesis Procedures

- Reason for surgery
  - Stenosis, spondylosis, etc.
  - Spinal Deformity
    - If the reason for the surgery is a deformity (scoliosis, kyphosis, etc.) a different set of codes is used
      - Codes for deformity are in category 22800- 22819
        - They are chosen based on approach anterior vs. posterior, then based on the total number of vertebral segments included in the spinal fusion
  - If multiple levels/segments are treated during one surgical session it is possible to have more than one indication (it is important that the surgeon reflect the indication for each procedure)
- Level Treated
  - If the surgery is for a reason other than deformity you will review documentation for the level of the spine treated
    - Cervical
    - Thoracic
    - Lumbar
- Approach
  - Anterior/Anterolateral
  - Posterior
  - Posterolateral
- Method
  - Segment and/or interspace (interbody)

CPT codes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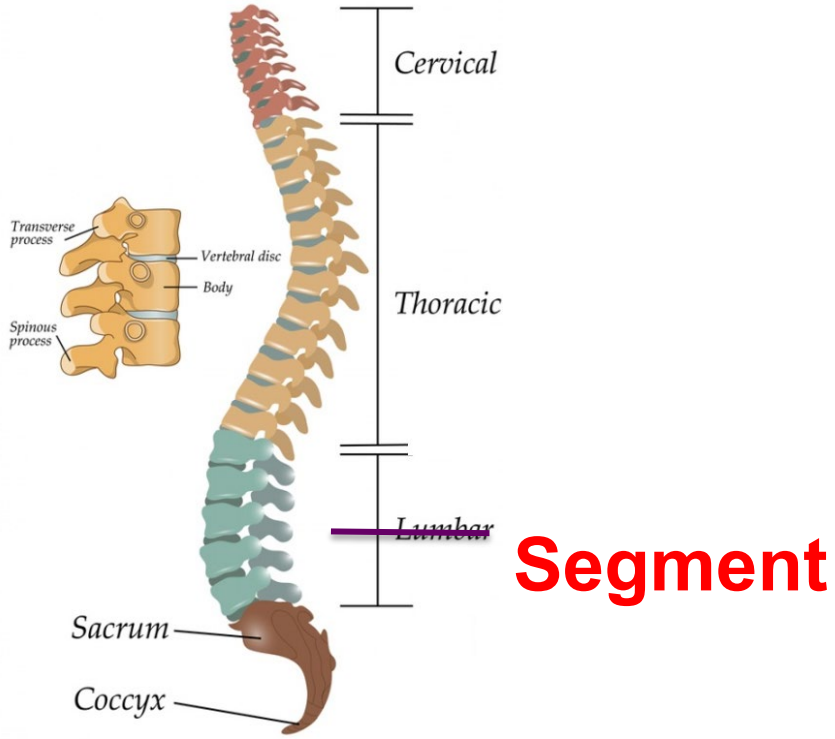
Arthrectomy (Resection), Elbow 24155
Arthrocentesis
Arthrodesis
Vertebrae 22610
Cervical (Neck)
Each Additional Interspace
Lumbar (Lower Back)
Anterior/Anterolateral 22558
Lateral Extracavitary 22533, 22534
Posterior Interbody 22630
Presacral Interbody (L5-S1) 22586
Transverse 22612, 22633, 22634
Spinal Deformity
Anterior
2 to 3 Vertebral Segments 22808
4 to 7 Vertebral Segments 22810
8 or More Segments 22812
Posterior
1 to 6 Vertebral Segments 22800
7 to 12 Vertebral Segments 22802
13 or More Vertebral Segments 22804

Fusion Procedures

Posterior Segmental Fusion L1-L4

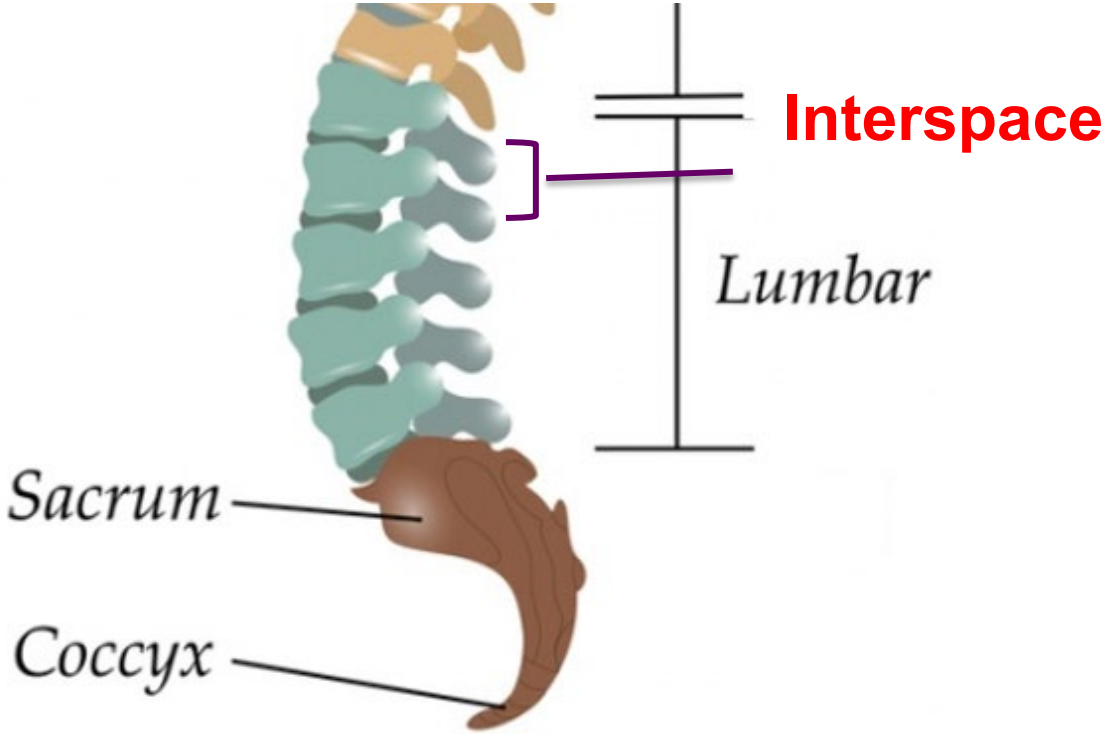
22612 qty 1 for L1 segment
+22614 qty 3 for L2 L3 L4



Segment

Posterior Interbody Fusion L1-L4

22630 qty 1 for L1-L2 interspace
+22632 qty 2 for L2-L3 L3-L4



Code Descriptors

22612 MIPS

Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)

View Code **Quick Links:** CPT® Assist | MCR CCI-Edits | MCD CCI-Edits | Fee Schedules/RVUs | Modifiers-P | Mod ASC & P | ICD-10-CM X | ICD-10-PCS X | Medically Unlikely Edits |

add a personal note ...

Add

22614 ✚

Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment (List separately in addition to code for primary procedure)

View Code **Quick Links:** CPT® Assist | MCR CCI-Edits | MCD CCI-Edits | Fee Schedules/RVUs | Modifiers-P | Mod ASC & P | ICD-10-CM X | ICD-10-PCS X | Medically Unlikely Edits |

add a personal note ...

Add

22630 MIPS

Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar

View Code **Quick Links:** CPT® Assist | MCR CCI-Edits | MCD CCI-Edits | Fee Schedules/RVUs | Modifiers-P | Mod ASC & P | ICD-10-CM X | ICD-10-PCS X | Medically Unlikely Edits |

add a personal note ...

Add

22632 ✚

Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure)

View Code **Quick Links:** CPT® Assist | MCR CCI-Edits | MCD CCI-Edits | Fee Schedules/RVUs | Modifiers-P | Mod ASC & P | ICD-10-CM X | ICD-10-PCS X | Medically Unlikely Edits |

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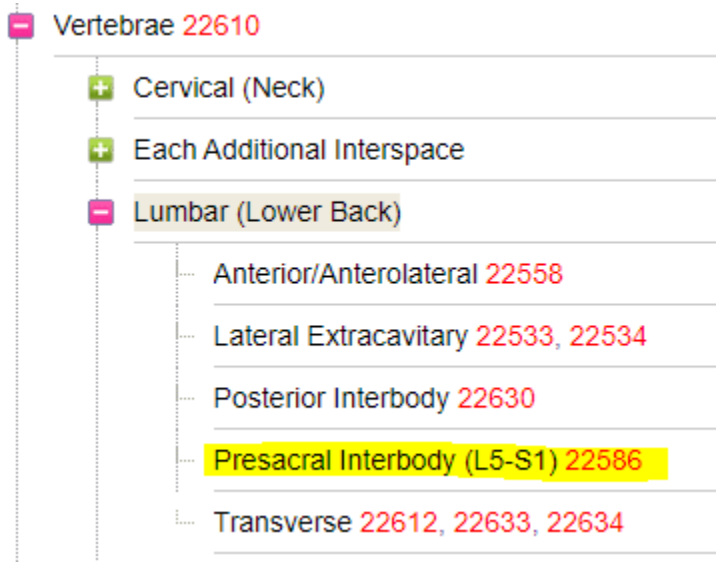
Pre-sacral Interbody Fusion

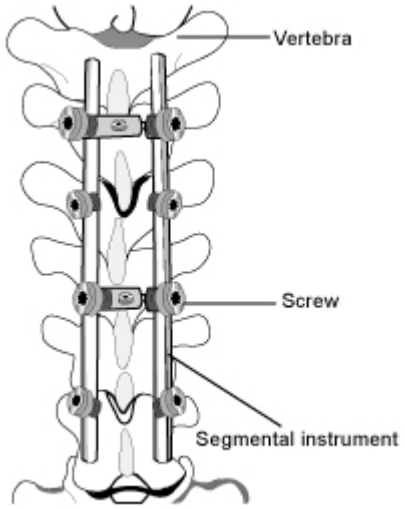
Interbody fusions done at the pre-sacral level L5-S1 use a different CPT 22586

- CPT 22586 includes posterior instrumentation

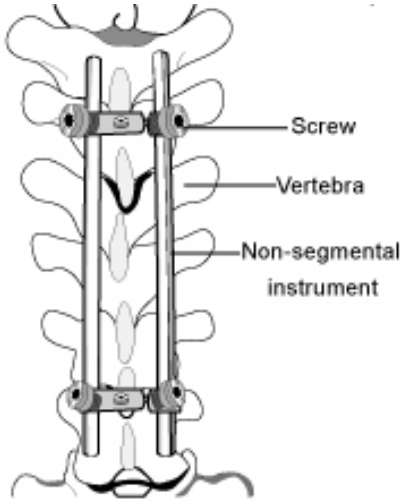


Posterior Non-Segmental/Segmental Instrumentation

- Segmental instrumentation is defined as fixation at each end of the construct and at least one additional interposed bony attachment.



- Non-segmental instrumentation is defined as fixation at each end of the construct and may span several vertebral segments without attachment to the intervening segments.



Interbody Biomechanical Device (cages)

- 22853 - in conjunction with interbody arthrodesis
- 22854 - in conjunction with vertebral corpectomy(ies) (vertebral body resection, partial or complete)

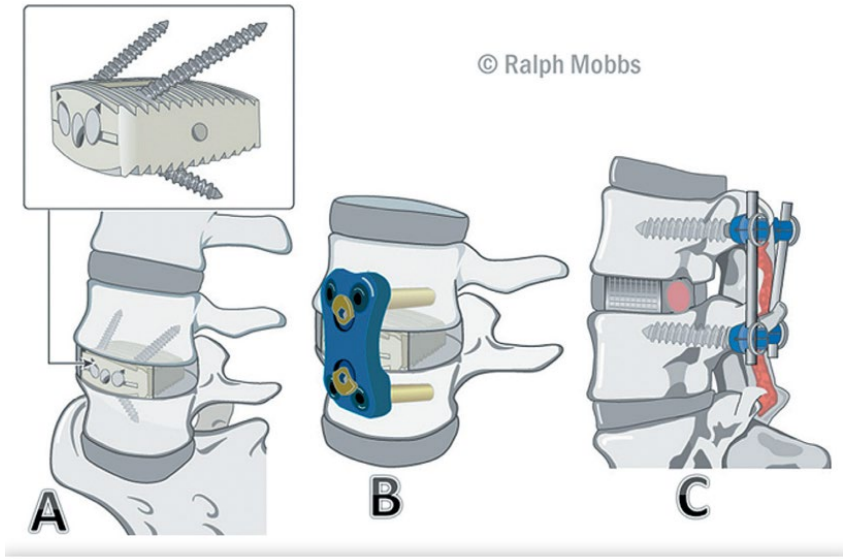


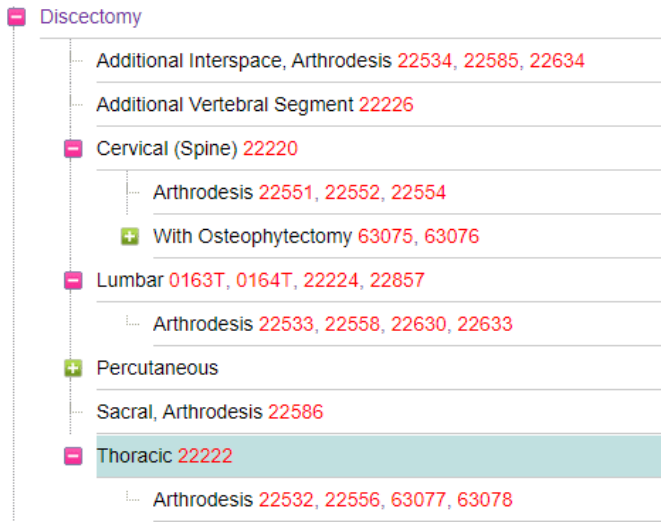
Fig. 2 (A) ALIF interbody device with integral fixation. (B) ALIF implant with anterior plate fixation. (C) ALIF implant with posterior instrumentation.

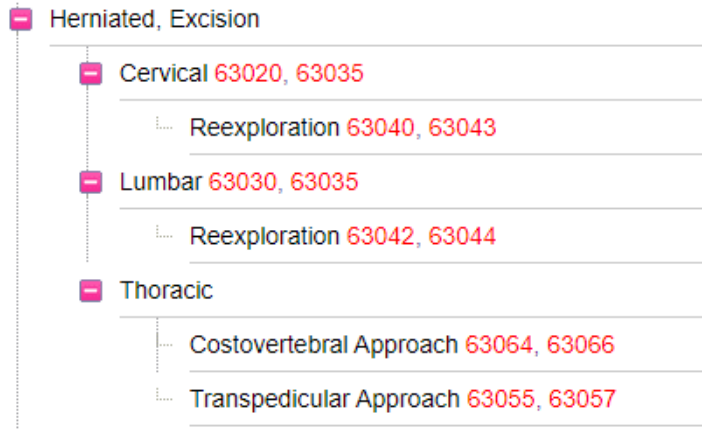
Review of Instrumentation Codes

- Insertion
  - Anterior 22845, 22846, 22847
  - Internal, Spinous Processes 22841, 22867, 22868, 22869, 22870
  - Intervertebral Biomechanical Device 22853, 22854, 22859
  - Pelvic 22848
  - Posterior 22842, 22843, 22844
  - Posterior Nonsegmental 22840
- Reinsertion 22849
- Removal
  - Anterior 22855
  - Posterior Nonsegmental 22850
  - Posterior Segmental 22852
- With Arthrodesis, Posterior Instrumentation 22586

Discectomy Procedures

- Indication for procedure will drive the code selection
- Documentation of specific detail is important to identify whether the discectomy was performed as a part of another procedure (i.e. laminotomy, arthrodesis, laminotomy with decompression)
  - **Is the disc removal done to prepare the interspace?**
  - **Is the disc removal done for the indication of herniated disc?**
- This is an example of when the surgeon needs to clearly show the separate indications





CCI Bundling

- Code all procedures supported within the operative report
- Run through CCI edit checker
- Review each procedure type, level treated and indications of procedures to determine if a -59 modifier is applicable

Thank You!

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