Transition to Practice
Lecture Series

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Fellowship Education Coalition

Coding and Billing

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The Transition to Practice Lectures Series is produced by the American Orthopaedic Association (AOA) in collaboration with the Fellowship Education Coalition comprised of the following orthopaedic societies: AOA/CORD, AAHKS, AANA, AAOS, ABOS, ACGME, AOFAS, AOSSM, ASES, NASS, OTA and POSNA.

Overview

- **Background**
- **Coding in the Office**
- **Coding in the Operating Room**
- **Additional Resources**
- **Fellow/Faculty Evaluation**
  - Use this survey to provide your feedback about this module.

Goals

- Understand the basic terminology and concepts involved in coding for evaluation/management (E/M) and surgery
- Understand the application to orthopaedic surgery
- Review general guidelines, pearls and pitfalls for code assignments

Language of Coding

- **CPT**: Current Procedural Terminology
  - Alphanumeric system that represents “all” physician services
- **RVU**: Relative Value Unit
  - Unit used as the basis for measuring the relative economic value of medical procedures. The units are applied across all of medicine.
- **ICD-10**: International Statistical Classification of Diseases
  - Medical diagnosis classification list developed by the World Health Organization

Language of Coding

- **CPT**: Current Procedural Terminology
  - First developed and published by the AMA in 1966
  - Meant to standardize physician services
  - No initial connection to reimbursement
  - In 1983, Centers for Medicare & Medicaid Services (CMS) mandated use of CPT for billing

- AMA is responsible for maintenance of and changes to CPT codes

Language of Coding

- **CPT:** Five-digit system
  - 10000 – 19999 Anesthesia
  - 20000 – 69999 Surgery
  - 70000 – 79999 Radiology
  - 80000 – 89999 Pathology
  - 90000 – 99999 Medicine
  - 99201 – 99499 Evaluation/Management

E/M: Evaluation and Management

- Key Components
  - History
  - Physical Examination
  - Medical Decision-Making (MDM)

- Contributory Factors
  - Nature of the presenting problem
  - Extent of counseling
  - Coordination of care
  - Time

E/M: Evaluation and Management

- New vs. Established
  - Three-year rule: New patients have not been seen by the treating orthopaedist or another provider in the same practice within the past 3 years

- Consultation
  - Must document request from another physician to either recommend care for a specific problem or determine whether transfer of care will be accepted
  - Medicare no longer accepts consultation codes as of 2010

E/M: New Patients (99201— 99205)

- Reimbursed based on the lowest level among **all three** key components
  - History
  - Physical Exam
  - Medical Decision-Making (MDM)

- Goal for new patient visits: at least **level 3**
  - History: always level 4
  - Physical Exam: at least level 3 (this is the rate-limiting key component)
  - MDM: at least level 3

E/M: History

- Goal: **level 4** history (equivalent to level 5)
  - Not difficult to achieve
  - Use patient intake forms!

History	Focused	Expanded	Detailed	Comprehensive	Comprehensive
Chief Complaint	1	1	1	1	1
History of Present Illness Location, Quality, Severity, Timing, Duration, Context, Modifying Factors, Associated Symptoms.	1	1	4	4	4
Review of Systems (14 systems) *Symptoms* NOT *Diseases*		1	2	10	10
Past, Family, and Social History 3 areas: **P**ast (illness, injury, meds, surgery, allergy) / **F**amily/ **S**ocial			1	3	3

E/M: History

- Chief Complaint
- History of Present Illness
  - Location, quality, severity, timing, duration, context, modifying factors, associated conditions
  - *Include 4 of the above*
- Past (illness, injury, surgery), Family, Social History (PFSH)
  - *Include all 3* for new patients
  - Do not necessarily need to include medications or allergies
- Review of Systems (ROS)
  - *Include at least 10 systems* for new patients

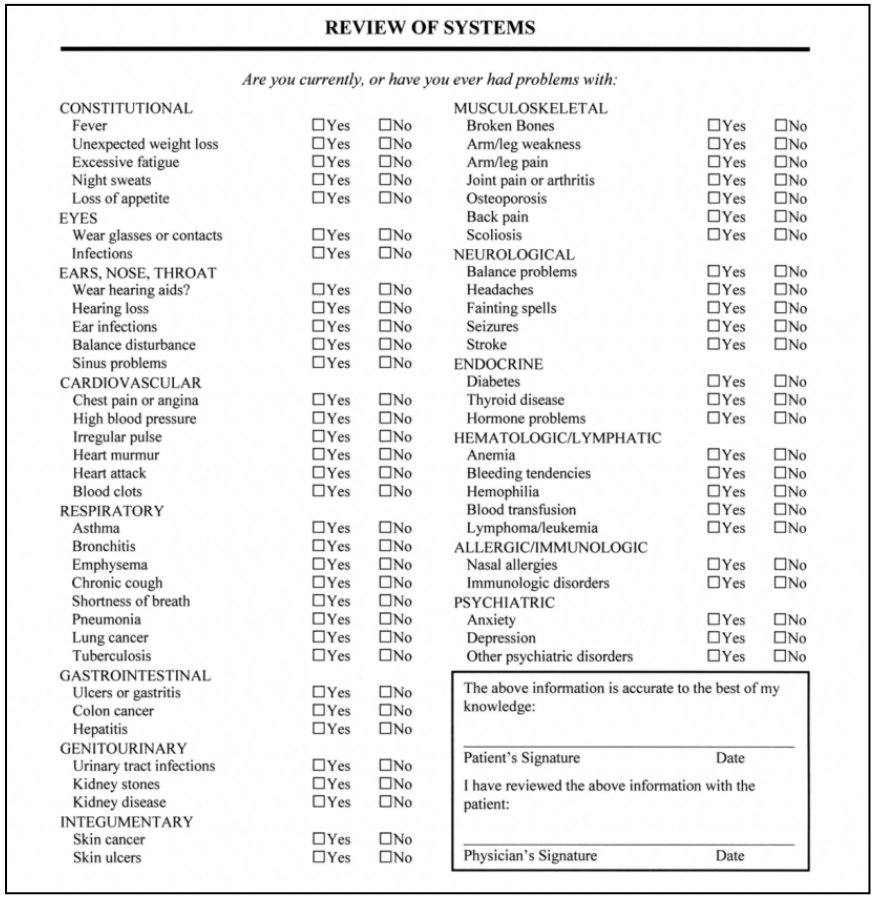
E/M: History of Present Illness

- History with 4 bullets is easily achieved in a standard orthopaedic evaluation
- Simple examples:
  - "The patient reports [symptom] in [location] for [duration]. The [symptom] is intermittent / constant [timing] and has been worsening / improving [context] since onset." – **4 bullets**
  - "The patient reports pain in [location] for [duration]. The pain is severe [severity] and does not radiate [quality]. The pain is worse with movement [modifying factors]. There is no associated numbness or tingling [associated conditions]." – **6 bullets**

E/M: PFSH + ROS

- **Use patient intake forms for PFSH, ROS**
  - Past Medical History “was reviewed with the patient and is documented on the patient intake form. Pertinent history includes…”
  - Family / Social History: “Non-contributory” not allowed. Include pertinent positives.
  - Review of Systems: similar statement

- For these statements to count, **you must sign and date the intake form and it has to be scanned into the chart.**



REVIEW OF SYSTEMS

Are you currently, or have you ever had problems with:

CONSTITUTIONAL			MUSCULOSKELETAL		
Fever	☐Yes	☐No	Broken Bones	☐Yes	☐No
Unexpected weight loss	☐Yes	☐No	Arm/leg weakness	☐Yes	☐No
Excessive fatigue	☐Yes	☐No	Arm/leg pain	☐Yes	☐No
Night sweats	☐Yes	☐No	Joint pain or arthritis	☐Yes	☐No
Loss of appetite	☐Yes	☐No	Osteoporosis	☐Yes	☐No
EYES			Back pain	☐Yes	☐No
Wear glasses or contacts	☐Yes	☐No	Scoliosis	☐Yes	☐No
Infections	☐Yes	☐No	NEUROLOGICAL		
EARS, NOSE, THROAT			Balance problems	☐Yes	☐No
Wear hearing aids?	☐Yes	☐No	Headaches	☐Yes	☐No
Hearing loss	☐Yes	☐No	Fainting spells	☐Yes	☐No
Ear infections	☐Yes	☐No	Seizures	☐Yes	☐No
Balance disturbance	☐Yes	☐No	Stroke	☐Yes	☐No
Sinus problems	☐Yes	☐No	ENDOCRINE		
CARDIOVASCULAR			Diabetes	☐Yes	☐No
Chest pain or angina	☐Yes	☐No	Thyroid disease	☐Yes	☐No
High blood pressure	☐Yes	☐No	Hormone problems	☐Yes	☐No
Irregular pulse	☐Yes	☐No	HEMATOLOGIC/LYMPHATIC		
Heart murmur	☐Yes	☐No	Anemia	☐Yes	☐No
Heart attack	☐Yes	☐No	Bleeding tendencies	☐Yes	☐No
Blood clots	☐Yes	☐No	Hemophilia	☐Yes	☐No
RESPIRATORY			Blood transfusion	☐Yes	☐No
Asthma	☐Yes	☐No	Lymphoma/leukemia	☐Yes	☐No
Bronchitis	☐Yes	☐No	ALLERGIC/IMMUNOLOGIC		
Emphysema	☐Yes	☐No	Nasal allergies	☐Yes	☐No
Chronic cough	☐Yes	☐No	Immunologic disorders	☐Yes	☐No
Shortness of breath	☐Yes	☐No	PSYCHIATRIC		
Pneumonia	☐Yes	☐No	Anxiety	☐Yes	☐No
Lung cancer	☐Yes	☐No	Depression	☐Yes	☐No
Tuberculosis	☐Yes	☐No	Other psychiatric disorders	☐Yes	☐No
GASTROINTESTINAL					
Ulcers or gastritis	☐Yes	☐No			
Colon cancer	☐Yes	☐No			
Hepatitis	☐Yes	☐No			
GENITOURINARY					
Urinary tract infections	☐Yes	☐No			
Kidney stones	☐Yes	☐No			
Kidney disease	☐Yes	☐No			
INTEGUMENTARY					
Skin cancer	☐Yes	☐No			
Skin ulcers	☐Yes	☐No			

The above information is accurate to the best of my knowledge:

Patient’s Signature Date

I have reviewed the above information with the patient:

Physician’s Signature Date

E/M: Physical Exam

- For **level 3**:
  - General: Well-appearing = 1
  - Mood: Normal mood and affect = 1
  - Gait: Ambulates [with normal gait / with assistive device] = 1
  - Body Areas: "TRIM + skin" x 2 body areas (neck, back, RUE, LUE, RLE, LLE) = 12
    - TRIM: **t**enderness, **r**ange of motion, **i**nstability, **m**uscle strength
  - Sensation = 1
  - Pulses = 1
  - **Total = 15 bullets** (only need 12)

Musculoskeletal Exam Bullet Counter				
Physical Exam Elements	Bullet count			
Vital Signs (at least 3: BP, T, P, R, Ht. Wt.)	1			
General Appearance	1			
Orientation X 3	1			
Mood and Affect	1			
Gait and Station	1			
BODY AREA (neck, back, RUE, LUE, RLE, LLE)	BA 1	BA 2	BA 3	BA 4
Inspection/Palpation	1	1	1	1
Range of Motion	1	1	1	1
Stability	1	1	1	1
Strength	1	1	1	1
Skin	1	1	1	1
CV (any 1: pulse, temp, edema, swelling, varicosities)	1			
Lymph (at least one area)	1			
Sensation	1			
DTR and Pathologic Reflexes	1			
Coordination and Balance	1			
Total	30			

Exam	Focused	Expanded	Detailed	Comprehensive	Comprehensive
Bullets (see bullet counter)	1	6	12	30	30

E/M: Medical Decision-Making

- For **level 3**: **2** points in **2** areas
- For **level 4**: **3** points in **2** areas

- **Data**
  - Order (1) + interpret (2) imaging = **3**

- **Diagnosis**
  - New problem, no work up = **3**
  - New problem + work up = 4

- **Plan/Risk**
  - OTC meds, PT, XR = 2
  - Order CT/MRI, aspirate/inject, treat fracture, discuss surgery (any one) = **3**

Medical Decision Making (2 out of 3 Data,Diagnosis,Risk)	**Straight Forward**	**Straight Forward**	**Low**	**Moderate**	**High**
Data add points (# points) (2) Interpret Imaging (2) Review/Summary record and/or curb–Side and/or Translator and/or History from other (1) Order imaging or review report (1) Order lab or review report (1) order tests (EMG, Vasc. Lab, PFT's etc.) or review report (1) Review with performing MD (1) Order old records	1	1	2	3	4
Diagnosis add points (# points) (1) Minor Problem (max of 2) (1) Established Problem—stable or better (each) (2) Estab. Prob.—worse (each) (3) New prob. no work up planned (max of 1) (4) New prob. work up planned (each)	1	1	2	3	4
Risk Management options selected, Diagnostic procedure ordered, ***Presenting problem***	Rest Ace Wrap Lab Test ***Minor (bug bite, cold)***	Rest Ace Wrap Lab Test ***Minor (bug bite, cold)***	OTC PT X-ray Arterial punt. Biopsy (superficial) ***1 problem***	Prescription Med Injection (script) Aspiration Surgery Fracture/Dislocation (no manipulation) Biopsy (deep) MRI, CT, BS X-ray 2 area ***exacerbation*** ***2 chronic probs***	Surgery with risk Emergency Surgery Fracture/Dislocation (with manipulation) Neuro Loss Discography Myelography Arthrogram Toxic Rx monitoring ***Life or limb***

E/M: Time

Time (minimum in minutes) Must document that face to face and > 50% counseling, and summarize the counseling provided.	N 10 C 15	N 25 C 30	N 30 C 40	N 45 C 60	N 60 C 80

E/M: Established Visits (99212 – 99215)

- Goal for established visits: **level 4** where appropriate
  - For established visits, lower component **of top 2** determines code
  - History: level 4
    - CC (1), HPI (4), **ROS** (2), **PFSH** (1 of 3)
  - Physical Exam: pass
  - Medical Decision-Making: level 4

- **Work backwards**
  - If you write a prescription/inject/schedule surgery, make sure to document history and MDM appropriately and charge for established level 4.

E/M: Established Visits

Code Need **2/3 key components** for Dictation. Lower component (of top 2) determines code. (**or Time**)	99212	99213	99214	99215

History	**Focused**	**Expanded**	**Detailed**	**Comprehensive**
Chief Complaint (CC on every note)	1	1	1	1
History of Present Illness Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated Symptoms	1	1	4	4
Review of Systems (14 systems) *Symptoms* NOT *Diseases*		1	2	10
Past, Family, and Social History 3 areas: **P**ast (illness, injury, surgery, meds, allergy) **F**amily/ **S**ocial			1	2

Exam	**Focused**	**Expanded**	**Detailed**	**Comprehensive**
Number of Bullets (see bullet counter)	1	6	12	30

E/M: Established Visits

- Medical Decision-Making uses an identical chart as for new patients
- For **level 4** visit, must obtain **3** bullets in **2 of 3** areas

  - **Data**
    - Order (1) + interpret (2) imaging = **3**
  - **Diagnosis** (pass)
    - Established problem, stable or better (each) = 1
    - Established problem, worse (each) = 2
  - **Plan/Risk**
    - OTC meds, PT, XR = 2
    - CT/MRI, aspiration/injection, fracture, discussion of surgery (any one) = **3**

E/M: Why is this relevant?

	Consult	New	Estab
Level 1	$50	$44	$21
Level 2	$94	$76	$45
Level 3	$129	**$111**	**$74**
Level 4	$188	**$170**	**$109**
Level 5	$231	$211	$147

250 patients/month x 12 months/year x $**74**/patient = $222,000
250 patients/month x 12 months/year x $**109**/patient = $327,000
Annual net increase for Level 4 established patients = $105,000

Based on 2014 CPT codes and Medicare payment information

E/M: Post-operative Visits

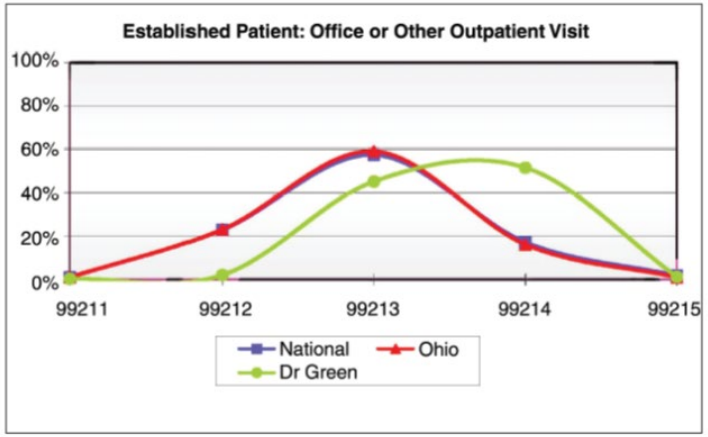
- Global Period
  - Starts with an index surgical procedure and ends at some defined interval thereafter
  - For major surgery, global period is **90 days**
  - Payment for index procedure covers all additional costs of management during this period
  - E/M code is 99024

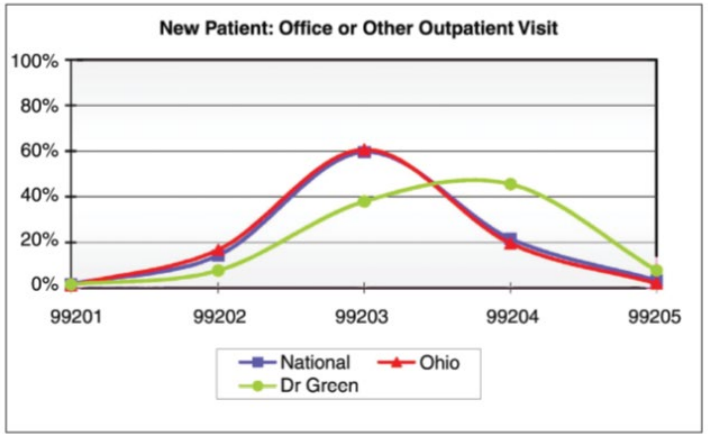
E/M: Modifiers

- -**24**: Unrelated problem treated within surgery global period
- -**25**: Unplanned injection on initial or follow-up evaluation
  - Cannot bill for E/M visit for *planned injections*
- -**57**: Decision for surgery

E/M: Pitfalls

- Medicare **audits** occur with:
  - Overbilling
  - Underbilling!
- Audit **red flags**:
  - New level 4 and 5 visits
  - Established level 5 visits
- Do not be an **outlier**!





E/M: Take Home Points

- Document and bill for **new** patient visits at **level 3** (at least) and **established** visits at **level 4** (as often as appropriate)
- Billing for level 4 is appropriate for:
  - Prescription, aspiration/injection, CT/MRI order, fracture/dislocation, surgery discussion
- Bill for consultations (when appropriate)
- Develop a new patient questionnaire to include PFSH and ROS
- Work backwards from MDM to determine level of service

E/M: Future Directions

- CMS to institute **significant changes** to E/M billing requirements in **2021**
  - History and physical exam **no longer** factors in determining level of service!
  - CPT code will be determined solely based on **Medical Decision-Making (MDM)** or **Time**
  - MDM calculation will be similar to the current MDM calculation
  - Time will be defined as total time spent, including non-face-to-face work done on that day, and will no longer require time to be dominated by counseling

- New system will be beneficial for orthopaedic surgeons
  - Majority of our time and effort is spent in Medical Decision-Making
  - 30-bullet physical exam no longer necessary to justify Level 4 new patient visit

Surgical Coding

- Surgical coding is generally more straightforward
- Each procedure is associated with a single CPT code
  - The CPT code(s) that are billed should reflect the procedure(s) performed as documented in the operative report

- AAOS Musculoskeletal Coding Guide and Web-Based Code-X
  - Definitive resources for orthopaedic surgical billing
- AAOS Complete Global Service Data
  - Bundling package lists every surgical procedure/CPT code and which codes can and cannot be listed for reimbursement in conjunction with that code

Surgical Coding: Bundling

- A bundling package defines which surgical CPT codes can be reimbursed either separately or in combination.
- For example, 29880 is the CPT code medial AND lateral meniscectomy. The following procedures are bundled with this code and cannot be billed separately:
    - 29881 – medial OR lateral meniscectomy: is obviously included with medial AND lateral.
    - 28982 – medial OR lateral meniscal repair: cannot be reimbursed when you have performed a meniscectomy
    - 28983 – medial AND lateral meniscal repair: cannot be reimbursed when you have performed a meniscectomy

Surgical Coding: Multiple Procedures

- General rules:
  - List the procedure with the highest number of RVUs in the first position
  - If secondary procedures are listed, a modifier may be indicated
  - Be cautious of bundling conflicts as discussed above
  - Check the AAOS Code-X!

Surgical Coding: Modifiers

- -**59** modifier: distinct procedural service
  - Most common
  - Modifier 59 is used to identify procedures or services that are not normally reported together but are appropriate under the circumstances.

- For example, multiple procedures during shoulder arthroscopy:
  - Arthroscopic rotator cuff repair – 29827
  - Arthroscopic biceps tenodesis – 29828, **59 modifier**
  - Arthroscopic distal clavicle resection – 29824, **59 modifier**

Additional Resources

1. AAOS Coding Resources
   - https://aaos.org/education/about-aaos-products/coding-resources/
2. AAOS Web-Based Orthopaedic Code-X
   - https://aaos.org/education/about-aaos-products/codex/
3. AAOS Musculoskeletal Coding Guide 2020
   - https://www5.aaos.org/store/product/?productId=17050727&_ga=2.209074962.1010128051.1585089347-607220517.1575954066
4. KarenZupko Coding Workshops
   - KZA and AAOS combine unparalleled expertise and experience to bring you and your practice valuable coding and reimbursement workshops.
   - https://www.karenzupko.com/orthopaedics/

Resources: Code-X

Resources: Coding Workshops

References

1. ”Using tables to determine E/M codes.” *AAOS Now*, May 2007. https://www.aaos.org/aaosnow/2007/may/managing7_link1/
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