Coding and Billing

Representing multiple orthopaedic subspecialty societies, the following members of the Fellowship Education Coalition authored this lecture:

A. Lee Osterman, MD, FAOA
Lutul D. Farrow, MD, FAOA
Laurence B. Kempton, MD
Albert Lin, MD
Praveen G. Murthy, MD
E. Peter Sabonghy, MD, FAOA
Jacob R. Worsham, MD
Overview

• Background
• Coding in the Office
• Coding in the Operating Room
• Additional Resources
• Fellow/Faculty Evaluation
  o 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!

<table>
<thead>
<tr>
<th>History</th>
<th>Focused</th>
<th>Expanded</th>
<th>Detailed</th>
<th>Comprehensive</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Complaint</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>History of Present Illness</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Location, Quality, Severity, Timing, Duration, Context, Modifying Factors, Associated Symptoms.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of Systems (14 systems) Symptoms NOT Diseases</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Past, Family, and Social History 3 areas: Past (illness, injury, meds, surgery, allergy) / Family/ Social</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>
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.
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: tenderness, range of motion, instability, muscle strength
  - Sensation = 1
  - Pulses = 1
  - **Total = 15 bullets** (only need 12)
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
### 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 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15</td>
<td>30</td>
<td>40</td>
<td>60</td>
<td>80</td>
</tr>
</tbody>
</table>
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

**Table:**

<table>
<thead>
<tr>
<th>Code</th>
<th>99212</th>
<th>99213</th>
<th>99214</th>
<th>99215</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Code</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Need 2/3 key components for Dictation. Lower component (of top 2) determines code. (or Time)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>History</th>
<th>Focused</th>
<th>Expanded</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Complaint (CC on every note)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>History of Present Illness</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated Symptoms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of Systems (14 systems)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptoms NOT Diseases</td>
<td>1</td>
<td>2</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Past, Family, and Social History</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 areas: Past (illness, injury, surgery, meds, allergy) Family/ Social</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exam</th>
<th>Focused</th>
<th>Expanded</th>
<th>Detailed</th>
<th>Comprehensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Bullets (see bullet counter)</td>
<td>1</td>
<td>6</td>
<td>12</td>
<td>30</td>
</tr>
</tbody>
</table>
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?**

<table>
<thead>
<tr>
<th>Level</th>
<th>Consult</th>
<th>New</th>
<th>Estab</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>$50</td>
<td>$44</td>
<td>$21</td>
</tr>
<tr>
<td>Level 2</td>
<td>$94</td>
<td>$76</td>
<td>$45</td>
</tr>
<tr>
<td>Level 3</td>
<td>$129</td>
<td>$111</td>
<td>$74</td>
</tr>
<tr>
<td>Level 4</td>
<td>$188</td>
<td>$170</td>
<td>$109</td>
</tr>
<tr>
<td>Level 5</td>
<td>$231</td>
<td>$211</td>
<td>$147</td>
</tr>
</tbody>
</table>

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

2020 coding & revenue cycle workshops

Transition to Practice Lecture Series

©2020 The American Orthopaedic Association
References

https://www.aaos.org/aaosnow/2007/may/managing7_link1/


https://www.aaos.org/articlelink/?id=30085
Please help us improve our support of best practices in education: Use this survey to provide your feedback about this module.

Submit questions or comments about the Transition to Practice Lecture Series to cord@aoassn.org