CODING FOR SUCCESS IN 2019

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California Orthopaedic Association

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California Orthopaedic Association

CODING FOR SUCCESS 2019

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About This Manual

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CPT codes used in this manual are excerpts from the current edition of the CPT (Current Procedural Terminology) book, are not intended to be used to code from and are for instructional purposes only. It is strongly advised that all providers purchase and maintain up to date copies of CPT. CPT is copyrighted property of the American Medical Association.

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Today's Topics:

- E/M Categories; when do you use what
- Medical Necessity
- E/M Levels of Service; documentation to support
- Physician Assistant/APP Billing in Orthopaedics
- Payor Policies & Denials; documentation and diagnosis
- Global Surgical Package; components and modifiers
- Lunch (*yes*)
- Fracture Care
- Key Surgical Modifiers in Orthopaedics; all of them
- Office Injections
- Medicare Update – 2019 & beyond

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• NEW VS ESTABLISHED PATIENT
• CONSULTATIONS
• ER VISITS
E/M Categories & When to use Which
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OFFICE OR OTHER OUTPATIENT SERVICE

New Patient 99201 – 99205

Established Patient 99211 – 99215

- Document & Code Correctly
- New = 3/3 components;
  Established = 2/3 components

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New vs. Established

- New vs. Established Patient
  - Current Procedural Terminology (CPT) – those patients who have not received any professional services from any physician "of the **exact same specialty and subspecialty** who belongs to the same group practice, within the past three years
  - Centers for Medicare & Medicaid Services (CMS) – a patient who has not received any professional services, i.e., evaluation & management service or other face-to-face service . . . From the physician or physician group practice (same physician specialty) within the previous three years."
  - Workers' Compensation – definition of new and established patient relates to whether the provider has previously treated the patient's workers' comp injury or illness (DWC Physician Fee Schedule Regulations)
    - "(1) A "new patient" is one who is new to the physician or medical group or an established patient with a new industrial injury or illness. Only one new patient visit is reimbursable to a single physician or medical group per specialty for evaluation of the same patient relating to the same incident, injury, or illness
    - (2) An "established patient" is a patient who has been seen previously for the same industrial injury or illness by the physician or medical group."
    - Absent a new injury, the patient is considered "established" for the purposes of workers' comp – there's no time limitation like the three years cited by CMS or CPT

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Office/Outpatient Service	CPT	History	Exam	MD	Time
New Patient – Level I	99201	PF	PF	SF	10
New Patient – Level II	99202	EPF	EPF	SF	20
New Patient – Level III	99203	D	D	L	30
New Patient – Level IV	99204	C	C	M	45
New Patient – Level V	99205	C	C	H	60
Established Patient – Level I	99211	N/A	N/A	N/A	5
Established Patient – Level II	99212	PF	PF	SF	10
Established Patient – Level III	99213	EPF	EPF	L	15
Established Patient – Level IV	99214	D	D	M	25
Established Patient – Level V	99215	C	C	H	40

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CONSULTATIONS

Office/Outpatient 99241 – 99245

Inpatient - Initial 99251 – 99255

- Physician Initiated
- Must State in Record "Consult“
- Document the Three “R”s - Request, Reason, Report
- Follow Up Management of Condition – Not a Consult
- One Initial Inpatient Consult/Admission/Physician

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Elements of Consultation 3 R rule

- **Request & Reason; by the patient's attending physician or other appropriate source such as an insurance company and the need documented.**

  Your dictation should read:

  "Thank you for your request to render an evaluation of [patient's name] for [patient's condition]"

  Never use the word "referral" this word is interpreted as transfer of care.
- **Render:** In your conclusion state: **"My recommendation(s):**

  CONSULT MEANS: TELLING, NOT DOING

  Does not involve active management of the patient problem although diagnostic test may be ordered to help you render an opinion.
- **Report: a formal report containing the opinion or advice back to the requesting party. A cover letter is suggested.**

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CONSULTATION VS TRANSFER OF CARE

- In addition to meeting the previous criteria, there would have to be NO intent to transfer care by the original physician. For instance, a knee specialist has been treating a patient for ACL injury. During the visit, the patient complains of wrist pain that the knee specialist determines to be carpal tunnel syndrome. He suggests that the patient make an appointment to see the hand specialist in the same practice for treatment.

This type of scenario, which is common in orthopedic practices, would not be a consultation but would be transfer of care, because one orthopedist would be skilled in an area the other is not. The codes for the hand specialist would be from the established patient series (99212-99215) since the patient not qualify for a consultation or new patient codes.

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Emergency Department Service

New and Established Patients 99281 – 99284

- All Physicians May Use
- Critical Care Codes Should be Used if Appropriate
- New/Established Patients Coded Similarly
- Specialist Referral by ER Physician not Considered Consults

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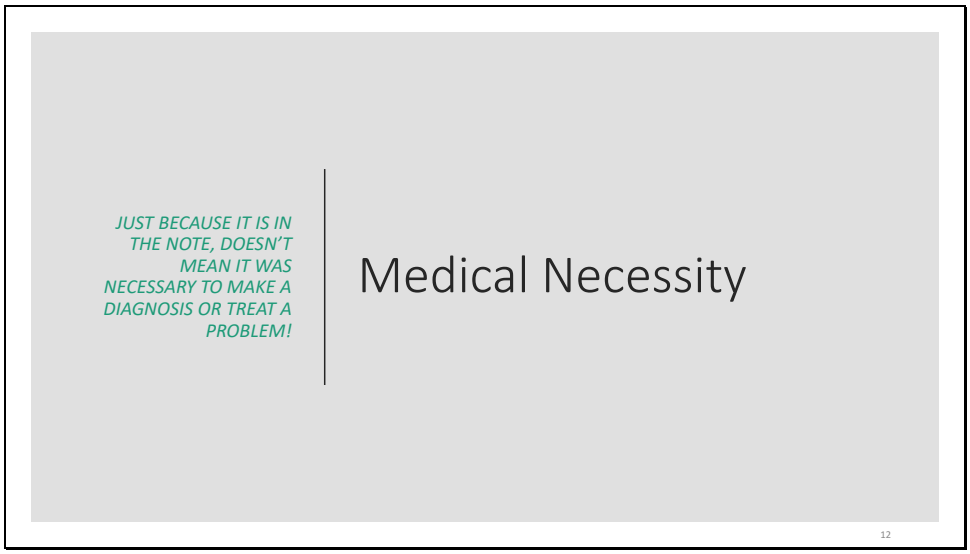
JUST BECAUSE IT IS IN THE NOTE, DOESN'T MEAN IT WAS NECESSARY TO MAKE A DIAGNOSIS OR TREAT A PROBLEM!
Medical Necessity
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Essentials of Medical Necessity

- EVERYBODY (CMS, Commercial Payers, WC) has their **OWN** definition
  - It is a coverage and payment concern, not necessarily a clinical or patient care description
- CMS – any expenses incurred for items or services, which are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member
  - NCD and LCD for some diagnostic & therapeutic services outline when or if a test or service is covered. Often provide specific criteria, including diagnoses that support coverage
- Commercial – coverage policies are available on their website. Provider contracts with payers also include coverage policies – review those.
- Workers' Comp – medical treatment & supplies that are reasonably required to cure or relieve the injured worker from the effect of his or her injury. Means treatment that is based upon the guidelines adopted by the administrative director pursuant to Section 5307.27

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Key Points

- The overreaching criteria for code selection must be medical necessity
- Medical necessity is best supported in MDM (Medical Decision Making) documentation
- Thorough documentation of a “thought process,” including the issues ruled out, will support medical necessity
- While established office visits and subsequent hospital visits require only two of three key components, it’s vital that medical necessity be supported in the MDM. MDM should be one of the two key components to support the level of service.

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What Does This Mean for Providers?

1. Must document more than just a diagnosis code
2. Act and Think as if you are still documenting on paper
3. Document
    1. Problems addressed
    2. Comorbidities that affect treatment
    3. For new issues, the concerns (if any) related to the presenting condition
    4. Documentation of the thought process supports the acuity of care and ultimately the medical necessity of service billed
4. Once thought process is determined, focus on tying the assessment and plan (MDM) to the subjective/objective (history/exam).
    1. Key is to document questions asked and/or what was examined that enabled the provider to make the assessment and create a plan

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Overview of E/M Section

E/M Guidelines

- There are two guidelines that may be utilized, 1995 or 1997
  - Providers/Coders may use either guideline
  - Whichever is most advantageous to the provider
  - Must follow one guideline per patient encounter
  - Cannot mix and match

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E/M Services

Remember, documentation must support the medical necessity and the level of service billed. The Level of Service is based on the documentation of the 3 Key Components and the Contributing Factors:

- **3 Key Components**
  - History
  - Examination
  - Medical Decision Making
- **Contributing Factors**
  - Nature of Presenting Problem
  - Time
    - Outpatient Setting (Counseling by Provider face-to-face)
    - Inpatient Setting (Counseling by Provider face-to-face and/or Coordination of Care)

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E/M – History Component

History levels are determined by the following 4 elements

1. Chief Complaint (CC)
2. History of Present Illness (HPI)
3. Review of Systems (ROS)
4. Past, Family, and/or Social History (PFSH)

- **The extent of the history is dependent upon clinical judgment and on the nature of the presenting problem (s)**
- **Not all histories will have or need all elements**

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E/M – History Component

The Four Elements of History

1. Chief Complaint (CC)
   - A concise statement describing the symptom, problem, condition, diagnosis, or other factor as the reason for the encounter.
2. History of Present Illness (HPI)
   - Describes the patient's developing condition/problem from the first sign and/or symptom or from the previous encounter to the present **or** the status of three chronic or inactive conditions
3. Review of Systems (ROS)
   - An inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms the patient may be experiencing or has experienced
4. Past, Family, and Social History (PFSH)
   - Review of the patient's past history, family history, and social history

E/M – History Component

- Chief Complaint

The reason for seeking medical care should be recorded in the patient's own words

"Patient complains of left foot pain due to fall last month."

E/M – History Component

- The History of Present Illness (HPI)

Two types

1. **Brief HPI**
   - ❖1 to 3 HPI Elements

2. **Extended HPI**
   - ❖4 or more HPI Elements **or** the status of at least 3 chronic or inactive conditions

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E/M – History Component

The HPI Elements

- Location – Where the symptom or problem is occurring
  - Abdomen, chest, leg, arm, head
- Severity - A rating or description of severity of the symptom or pain
  - Bad, intolerable, minimal, slight
- Timing – When symptom or pain occurs
  - Before bed, upon waking, two hours after taking medicine, continuous
- Quality – The character of the sign or symptom
  - Burning, dull, puffy, puss-filled, red, itchy, chronic, debilitating

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The HPI Elements

- Duration – How long a pain or symptom lasts, has been present, or persisted
  - For two months, following slip and fall at home
- Associated signs/symptoms – Any organ system or body area complaints associated with the chief complaint
  - Rash with blistering, nausea and vomiting, abdominal pain
- Context – Instances or items that can be associated with the chief complaint
  - When walking, in company of smokers, at work
- Modifying factors – Actions taken or things done to effect the symptom or pain, making it better or worse
  - Improves when lying down, worse after eating

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Review of Systems (ROS)

- ROS includes 14 systems
  - Constitutional symptoms (fever, weight loss, etc.)
  - Eyes
  - Ears, nose, mouth, throat
  - Cardiovascular
  - Respiratory
  - Gastrointestinal
  - Genitourinary
  - Musculoskeletal
  - Integumentary (skin and/or breast)
  - Neurological
  - Psychiatric
  - Endocrine
  - Hematologic/Lymphatic
  - Allergic/Immunologic

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E/M – History Component

The Past, Family, and Social History (PFSH)

- Past History
  - The patient's past experience with illnesses, operations, injuries and treatments
- Family History
  - A review of medical events in the patient's family, including diseases that may be hereditary or place the patient at risk
- Social History
  - Age appropriate review of past and current activities

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E/M – History Component

Example Outpatient Grid

HPI Location Severity Timing Modifying Factors Quality Duration Context Associated Signs & Symptoms	Brief 1-3			
ROS Constitutional Ears, Nose Throat, Mouth Skin/breast Endo Hem/Lymph Eyes Card/Vasc GI Neuro Allergy/Immune Resp Musculo GU Psych All Others Neg	None	Pertinent to Problem 1	Extended 2-9	Complete
PFSH Past Medical History Family History Social History Established Patient: only need 2 to be considered "Complete" New Patient: Requires all 3 to be considered "Complete"	None		Pertinent	Complete
OVERALL HISTORY LEVEL	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive

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Overall History Component

(example)

Each history element must be met or exceeded to determine an overall history level

- *Let's look at an example*
  - CC
    - Must be present in patient's medical record
  - HPI
    - Extended
  - ROS
    - Complete
  - PSFH
    - Pertinent
  - Overall History level = Detailed

E/M History

- *Caveat*
  - **Patient is unable to speak**
  - **Physician must document this**
    - **"Patient intubated, unable to obtain History"**
  - **Provider gets credit for a complete History!**

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E/M – Examination Component

Now let's look at the Examination

- Four Levels
  - Problem Focused
  - Expanded Problem Focused
  - Detailed
  - Comprehensive

- 2 Types
  - Multi-system
  - Single Organ System

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Exam - 1995 vs. 1997

Examination	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
1995	1 Body Area or Organ System	Limited Exam 2-4 Body Areas or Organ Systems	Extended Exam 5-7 Body Areas or Organ Systems	8 Organ Systems or a Comprehensive Single Organ System Exam
1997	Any 1-5 Bullets	Any 6+ Bullets	**General**: 2 bullets from 6 or more organ systems/body areas **or** 12 bullets from 2 or more organ systems/body areas **Eye/Psych:** 9+ bullets **All Others:** 12+ bullets	**General:** Perform all, document 2 bullets from 9 Organ Systems/body areas **All Others:** Perform all, document all elements in each bolded box and 1 element in each un-bolded box

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Medical Decision Making Component

Now let's look at the Medical Decision Making

Four Levels

1. Straightforward
2. Low Complexity
3. Moderate Complexity
4. High Complexity

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Medical Decision Making

- To determine the level of Medical Decision Making, two of the three following Elements must meet or exceed

Elements

- Number of Diagnoses or Treatment Options
- Amount and/or Complexity of Data to be Reviewed
- Risk of Complication and/or Morbidity/Mortality

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Medical Decision Making Component

Number of Diagnoses or Treatment Options
3 Categories

1. Self-limited or minor
   stable, improved or worse

2. Established problem
   stable, improved, worsening

3. New problem to examiner
   no additional work up planned
   additional work-up planned

Medical Decision Making Component

- **Self-limited or minor (stable, improved or worse)**
  - Sore throat
  - Earache (simple)
  - Simple laceration

  This category does not indicate that the problem is new or established
    - American Medical Association (AMA)

    "A problem that runs a definitive and prescribed course, is transient in nature, and is not likely to permanently alter health status or has a good prognosis with management/compliance."

Medical Decision Making Component

- **Established problem; stable, improved**

  For this provider/specialty group – usually diagnosis and treatment has already been started

- **Established problem; worsening**

  Must be documented or CLEARLY implied, (pain has increased, etc.)

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Medical Decision Making Component

New problem to examiner; no additional work- up planned

- New problem to examiner; additional work-up Planned
  - Starting treatment does not constitute “additional work-up”.
  - Any diagnostic study or plan to help find a definitive diagnosis.

Example:

- Radiology
- Laboratory
- Consultation with another physician

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NUMBER OF DIAGNOSES AND/OR TREATMENT			
A	B □ C		= D
Problem (s) status	Number	Points	Result
Self–limited or minor (stable, improved or worse)	max=2	1	
Est. problem; stable, improved		1	
Est. problem; worsening		2	
New problem; no additional workup planned	max=1	3	
New Problem; additional workup planned		4	
		Total	

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Medical Decision Making Component

- **Amount and/or Complexity of Data to be Reviewed**
  - Review &/or order of clinical lab tests
  - Review &/or order in the radiology section of the CPT
  - Review &/or order of tests in the medicine section
  - Discussion of test results with performing physician
  - Decision to obtain old records &/or history from someone other than patient
  - Review and summarization of old records &/or obtaining history from someone other than patient &/or discussion of case with another health care provider
  - Independent visualization of image, tracing or specimen itself (not simple review of report)

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Medical Decision Making Component

- Review &/or order of clinical lab tests
  - Any documentation of the review of tests previously ordered

    Example (s):
    - Test results documented in notes
    - Documentation that Provider reviewed results
  - Documentation that indicates tests are ordered

Medical Decision Making

- Review &/or order in the radiology section of the CPT
  - Review of Report not actual film

Example (s):

- Documentation of review of x-ray report
- Documentation that a x-ray was ordered

- No review of actual film

Medical Decision Making

- Review &/or order of tests in the medicine Section
  - Report (s) is reviewed or ordered

Example (s):

- EKG Report
- Stress Test
- EMG
- Documentation that a medicine test was ordered

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Medical Decision Making

- Discussion of test results with performing physician
  - Discussion = verbal communication and NOT a report or letter

Example:

- Pathologist viewing specimen then pages ordering MD to discuss results
- PCP MD pages MD Specialist to discuss test results

Medical Decision Making

- Review and summarization of old records &/or obtaining history from someone other than patient &/or discussion of case with another health care provider
  - Summarize the review of old record or history and document how it pertains to the patients current problem – it must be additional/relevant information
  - Does not include Parents of Pediatric Patients

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Medical Decision Making

- Independent visualization of image, tracing or specimen itself (not simple review of written report)
  - **Does not include:**
    - Rapid Strep Test
    - Urine Pregnancy Test
  - **Does include:**
    - Reviewing x-ray image (can be in electronic system)
    - EKG Strip

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AMOUNT AND/OR COMPLEXITY OF DATA REVIEWED

	Points
Review &/or order of clinical lab tests	1
Review &/or order in the radiology section of CPT	1
Review &/or order of tests in the medicine section of CPT	1
Discussion of test results with performing physician	1
Review and summarization of old records &/or obtaining history from someone other than patient &/or discussion of case with another health care provider	2
Independent visualization of image, tracing or specimen itself (not simply review of report)	2
Total	

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Medical Decision Making

- Risk of Complication and/or Morbidity/Mortality
  - **Four Levels**
    - Minimal
    - Low
    - Moderate
    - High

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Table of Risk			
Level of Risk	**Presenting Problem(s)**	**Diagnostic Procedure(s) Ordered**	**Management Option Selected**
Minimal	* One self-limited or minor problem, e.g. cold, insect bite	* Lab tests requiring venipuncture * CXRs * ECG/EEG, U/A, echo	* Rest * Gargles * Elastic bandages * Superficial dressings
Low	* 2 or more self-limited or minor problems * 1 stable chronic illness • * Acute uncomplicated illness or injury, e.g. cystitis, sprain	* Physiologic tests not under stress, e.g. PFTs * Non–CV imaging with contrast, e.g. barium enema * Superficial needle biopsy * Clinical lab test requiring arterial puncture * Skin biopsies	* OTC drugs * Minor surgery w/ no identified risk factors * PT, OT • IV fluids w/out additives
Moderate	* 1 or more chronic illnesses with mild exacerbation, progression, or side effects of treatment * 2 or more stable chronic illnesses * Undiagnosed new problem with uncertain prognosis, e.g., lump in breast * Acute illness with systemic symptoms, e.g. pyelonephritis, pneumonia, colitis * Acute complicated injury, e.g. head injury with brief LOC	* Physiologic test under stress, e.g. cardiac stress test, fetal contraction stress test * Diagnostic endoscopies with no identified risk factors * Deep needle or incisional biopsy * CV imaging studies with contrast and no identified risk factors, e.g. arteriogram and cardiac cath * Obtain fluid from body cavity	* Minor surgery with identified risk factors * Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors * Prescription drugs * Therapeutic nuclear medicine * IV fluids w/ additives * Closed tx of fracture or dislocation without manipulation
High	* 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment * Acute or chronic illnesses or injuries that may pose a threat to life or bodily functions, e.g. peritonitis, acute failure, multiple injuries, acute MI * An abrupt change in neurological status, e.g. seizure	* CV imaging studies with contrast with identified risk factors * Cardiac EP test * Diagnostic endoscopies with identified risk factors * Discography	* Elective major surgery w/ identified risk factors * Emergency major surgery * Parenteral controlled substances * Drug therapy requiring intensive monitoring for toxicity * Decision not to resuscitate or to de–escalate care because of poor prognosis

Final Medical Decision-Making Level

- 2 of the 3 Elements must be met or exceeded
  - **Number of Diagnosis or Treatment Options**
  - **Amount and/or Complexity of Data Reviewed**
  - **Risk of Complication and/or Morbidity/Mortality**

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Final Result for Medical Decision Making (must meet or exceed two out of three elements)				
Number diagnoses/treatment options	<1 Minimal	2 Limited	3 Multiple	>=4 Extensive
Amount & complexity of data	<=1 Minimal	2 Limited	3 Multiple	>=4 Extensive
Highest risk	Minimal	Low	Moderate	High
Type of decision making	Straight forward	Low Complex	Moderate Complex	High Complex

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Who can document what for E/M?

(as of TODAY – things could be changing!)

- Ancillary staff
  - Chief Complaint (if it is listed as separate item)
  - ROS and PFSH
  - Vital signs as part of physical exam
- Physician or QHP
  - HPI, including chief complaint if part of HPI
  - Physical examination (excluding vital signs if done)
  - All elements of Medical Decision Making
  - All procedures

Using Medical Scribes

- Definition
  - Joint Commission defines a medical scribe as an unlicensed individual hired to enter information into the electronic health record (EHR) or chart at the direction of a physician or licensed independent practitioner.
- Common Documentation Duties for Medical Scribes
  - History of present illness
  - ROS and Physical examination
  - Vital signs and lab values
  - Results of imaging studies
  - Progress notes
  - Continued care plan and medication lists

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Scribe's Note Should Include

- Name of the provider providing the service
- Date and time the service was provided
- Name of the patient for whom the service was provided
- Authentication, including date and time

- Since provider is ultimately responsible for the contents of the documentation, the provider's note should indicate:
  - Affirmation of the provider's presence during the time the encounter was recorded
  - Verification that the provider reviewed the information
  - Verification of the accuracy of the information
  - Any additional information needed
  - Authentication, including date and time

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DIRECT
INCIDENT-TO
SPIT/SHARED

Physician Assistant/ APP Billing in Orthopaedics

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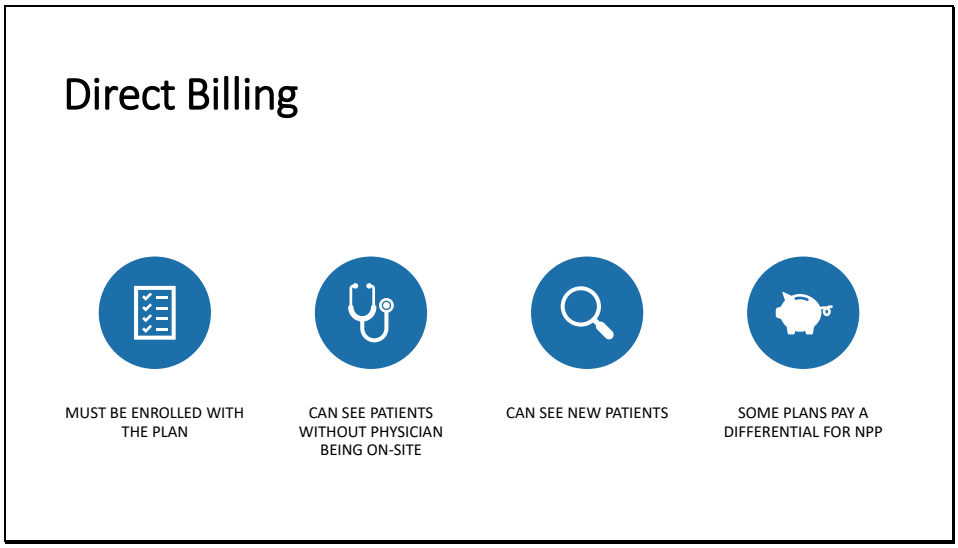
Direct Billing
MUST BE ENROLLED WITH THE PLAN
CAN SEE PATIENTS WITHOUT PHYSICIAN BEING ON-SITE
CAN SEE NEW PATIENTS
SOME PLANS PAY A DIFFERENTIAL FOR NPP

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"Incident to"

- A Medicare concept – not all health plans recognize
- For E/M services only
  - Must be in physician office or patient home
- Cannot see new patients or established patients with a new condition/illness/injury – physician must see first for there to be a service that is "incident to" a physician service
- Physician must always be "on-site"(in the suite) when NPP seeing patients
- Bill the supervising physician as the "rendering/performing" provider
- Payment at 100% physician fee schedule

Split / Shared Visit

- A Medicare concept
- Similarities with “incident to”, but there are differences
- Commercial payers – check with the payers to see of they recognize the concept – specifically those carriers who credential NPPs.
- E/M visits that are “shared” or “split” between a physician and a NPP where each performs a substantive portion of an E/M visits face-to-face with the patient on the same date of service
  - A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M
- If documentation meets the requirements, can be billed under the physician’s NPI
  - If documentation does not meet guidelines, service needs to be billed under NPP’s NPI

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Split / Shared Visit

- Can be done in:
  - Hospital inpatient or outpatient
  - Emergency department
  - Hospital observation
  - Hospital discharge
  - Office or clinic (when “incident-to” requirements are met)
- Can NOT be done in:
  - Skilled nursing facility or nursing facility
  - Consultation services
  - Critical Care services
  - For procedures
  - In patient’s home or domiciliary site

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Key Documentation Requirements

1. A shared/split visit can only be utilized if the NPP and physician are from the same group practice, including the same specialty

2. The NPP and physician must both perform and document their face-to-face encounter with the patient
    1. The physician must personally document his/her involvement in the patient's care and cannot leave his/her documentation of the visit to the NPP

3. The portion of the E/M service performed and documented by ***both*** the NPP and physician must be substantive, which includes part or all of the history, exam or medical decision making

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Remember – with all these services

- NPP must be licensed in the state where the service is performed
- There must always be a supervising or collaborating physician on file
  - And available for consultation if needed
- Practices should have a written delegation of services agreement on file (required by many health plans and most IPAs)
- Practice should monitor productivity of these professionals, just as they do with other providers

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DOCUMENTATION
DIAGNOSIS
YOUR QUESTIONS
Payor Policies & Denials
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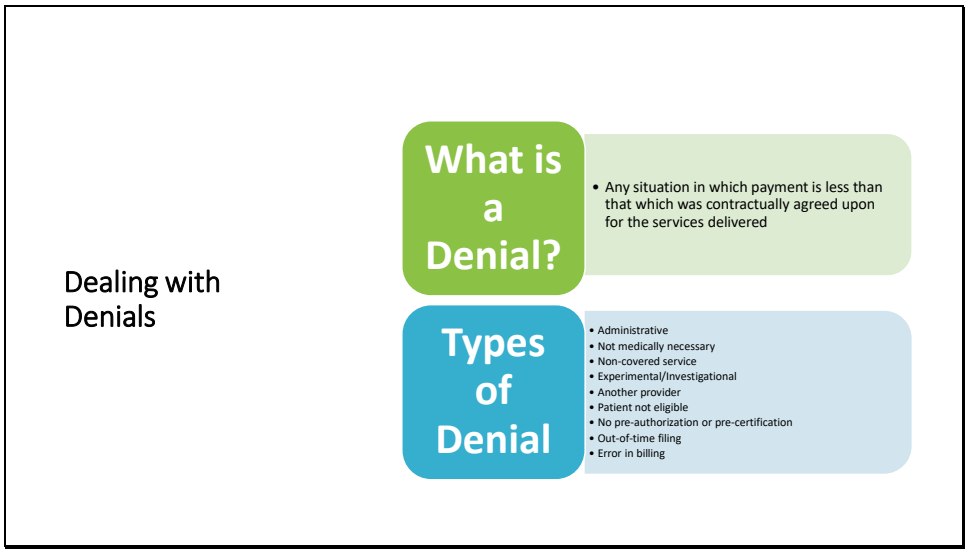
Dealing with Denials
What is a Denial?
• Any situation in which payment is less than that which was contractually agreed upon for the services delivered
Types of Denial
• Administrative
• Not medically necessary
• Non-covered service
• Experimental/Investigational
• Another provider
• Patient not eligible
• No pre-authorization or pre-certification
• Out-of-time filing
• Error in billing

Everyone Plays a Part

- **Patient access staff and schedulers:** These employees are the first to make contact with patients. They verify and validate health care coverage and demographic information and obtain referrals and prior authorizations. Fundamentally they are the individuals who can thwart denials medical necessity problems before they occur.

- **Coders:** These professionals translate clinical documentation into coded data that insurers subsequently use to determine whether services are medically necessary and payable. Thus, coders must understand the payers implications of the codes they assign. Ideally, they would have access to all local coverage determinations (LCDs), national coverage determinations (NCDs), and payer policies, plus be provided sufficient time to research medically necessity-related and other questions.

Everyone Plays a Part

- **Physicians:** Physician documentation is a the core of compliance. Thus, physicians must understand medical necessity and other implications of their documentation, which requires ongoing education. Medical necessity and other denials are often associated with poor documentation and a lack of specificity at the front end.

- **Chief Medical Officers:** Successful denial mitigation requires executive buy-in. In particular, CMOs must reach out to all physicians. Focusing on clinical documentation to drive patient care yields better results than focusing specifically on a particular LCE, NCD, or medical necessity requirement.

Everyone Plays a Part

- **Patient advocates:** In an era of patient engagement, patients are increasingly responsible for their physical – as well a fiscal – health care. In some cases, patients actually are among an organization's best tools to mitigate denials (medical necessity included). Patient empowerment, however, does require education

Some organizations have been inspired to hire patient advocates.

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Your Challenges & Questions

1.

2.

3.

4.

5.

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WHAT'S INCLUDED?
What can you bill separately?
Global Surgical Package
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Surgical "Package"

- The majority of surgical codes are "package" services – they include the actual surgical procedures, local infiltration, metacarpal and digital block or topical anesthesia (when used) and an allowance for normal postoperative care.
- It is imperative that one know the surgical package make-up for each payer with whom your office contracts. This may vary from payer to payer, and many payers have adopted Medicare's global service guidelines.
- CPT definition of services included in the global package differs a little from Medicare's definition

CPT Surgical Package

- Pre-Op
  - Local Infiltration
  - Digital Block
  - Topical anesthesia
- Intra-Op
  - Operation per-se
- Post-Op
  - Normal uncomplicated follow up care

Medicare Surgical Package

- Pre-Op
  - All visits 24 hours before surgery
- Intra-Op
  - Operation per se
- Post-Op
  - All follow-up care, including complications that do not require a return to the operating room

Global Periods

- For each CPT® code, there is a corresponding global period. These global periods indicate the number of postoperative days of care that are included in the payment for a procedure or surgery.

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Global Periods

- 000 Postoperative care is not included in the payment, but any related evaluation and management work is included if done on the same day
- 010 10 days of postoperative care are included in the payment
- 090 90 days of postoperative care are included in the payment
- XXX Global concept does not apply and any evaluation and management and other services performed may be reported separately on the same day
- YYY Global period is to be set by the carrier (e.g., unlisted surgery codes)
- ZZZ The code is part of another service and falls within the global period for the other service

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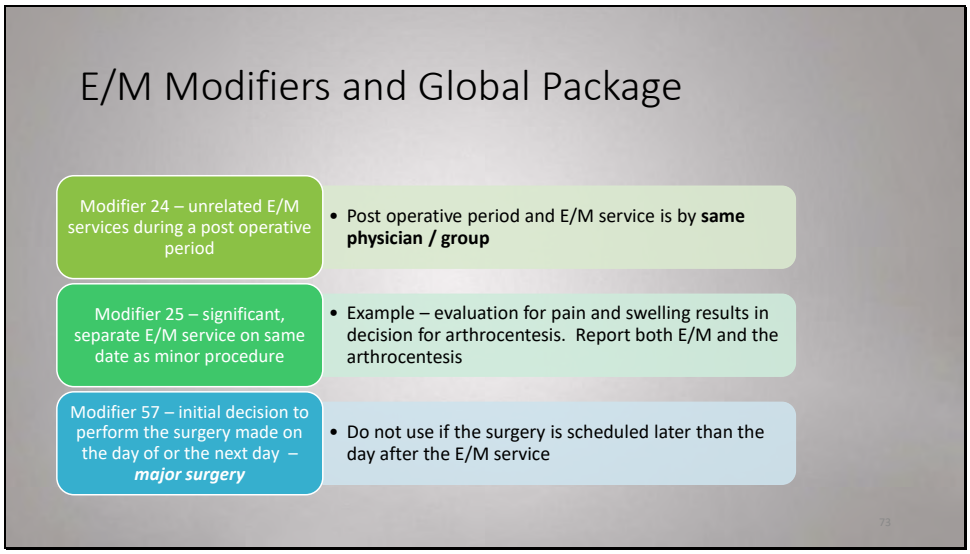
E/M Modifiers and Global Package
Modifier 24 – unrelated E/M services during a post operative period
• Post operative period and E/M service is by **same physician / group**
Modifier 25 – significant, separate E/M service on same date as minor procedure
• Example – evaluation for pain and swelling results in decision for arthrocentesis. Report both E/M and the arthrocentesis
Modifier 57 – initial decision to perform the surgery made on the day of or the next day – ***major surgery***
• Do not use if the surgery is scheduled later than the day after the E/M service
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The Preoperative H&P – how do you bill it (or do you)?

- From CPT

  "if the decision for surgery occurs the day of or before the major procedure and includes the preoperative evaluation and management (e/M) services, then this visit is separately reportable. Modifier -57, Decision for Surgery, is appended to the E/M code to indicate this is the decision-making service, not the history and physical (H&P), and this service occurs in the interval between the decision-making visit and the day of surgery, regardless of when the visit occurs (1 day, 3 days o 2 weeks) the visit is not separately billable as it is included in the surgical package. Example: the surgeon sees the patient on March 1 and makes a decision for surgery. Surgery is scheduled for April 1. The patient returns to the office on March 27 for the H&P, consent signing, and to ask and clarify additional questions. The visit on Mach 27 is not billable, as it is the preoperative H&P visit and is included in the surgical package."

  Source: AMA CPT Assistant, May 2008/Volume 19, Issue 5, pp.9,11

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Another Case; Another Visit

- In some cases a patient may be a candidate for a surgical procedure, but has a number of medical issues (such as cardiac disease and diabetes) that require a medical evaluation to determine if he/she is healthy enough for surgery. After the patient has had a "medical clearance", he/she returns to you to review the medical doctor's evaluation and you at that point decide to proceed with surgery. This visit can be billed as an E/M visit as the decision for surgery is just now being made.

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WHAT'S INCLUDED?

What's separately reportable

WHAT HAPPENS AFTER THE PATIENT WAS SEEN IN THE ER?

FRACTURE CARE

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What's Include?

1. Treatment of fracture
2. The first cast or splint application
3. 90 days of normal, uncomplicated, follow up care

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Procedures/Items Not Included

- X-rays
- All casting supplies (including those used with the first cast application)
- Any replacement cast application
- The evaluation and management of any additional problems or injuries
- The treatment of complications

Closed Treatment of Fractures

- Global: the physician reports the services by using the 90-day global fracture treatment code, with or without an evaluation and management (E/M) service that resulted in the decision for closed treatment and/or was related to a separate injury or separate diagnosis
- Itemized: The physician reports each service independently using E/M codes and cast/splint codes, but does not enter into a 90-day global period.

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Per AAOS

- "Restorative treatment" and follow-up care

Two keys to understanding the appropriate coding for closed treatment of fractures is to:

1. First, determine whether the physician provides "restorative treatment" of the fracture
2. Second, determine whether the same physician will be providing all the follow-up care within the 90-day global period.

Restorative treatment is more than simply realigning the limb and applying a splint or cast; it entails a closed reduction by the application of manually applied forces. This closed reduction must achieve satisfactory alignment of the fracture or dislocation – i.e., closed reduction must be acceptable for healing and restoration of limb function

If the physician is providing restorative care of the fracture (eg, closed treatment with manipulation) and all follow-up management, the physician should report the service with the global fracture care code. If the physician is providing restorative care, but not providing the follow-up care, the physician should report the encounter using the appropriate fracture treatment code and add modifier -54 (intraservice only)

Source : AAOSnow/2017/May

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Fracture Care – The ER Physician and the Orthopedist

Per CMS

- "Global fracture care" includes treating the fracture and providing any necessary follow-up care ("performing and accepting the are of restorative and follow up treatment of the fracture until healed"0.
- In order to submit a claim for fracture care, the treatment must meet the definition of "restorative" care and must involve more than merely splinting the fracture after straightening the limb
- Physicians that treat a fracture **and** provide a "significant" portion of the global fracture care" may submit the appropriate CPT code for treating the fracture and be reimbursed for the global surgery package of care

ER and Orthopedics

- Emergency Department (ED) physicians (and NPP authorized to provide emergency room services) that treat the fracture (as described in the second bullet previously noted) but **do not** provide follow –up care may submit a claim for the fracture treatment code with CPT modifier 54 (surgical care only).

- A non-ED physician, such as an orthopedic surgeon, who provides casting, follow-up evaluations(s) and management of the fracture until healed, may submit a claim for the fracture treatment code with CPT modifier 55 (follow-up care only).

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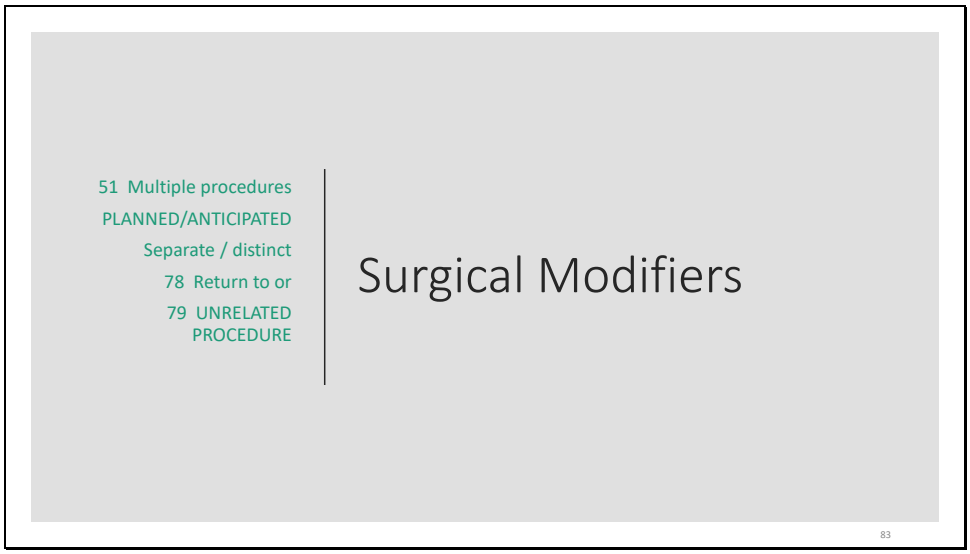
51 Multiple procedures
PLANNED/ANTICIPATED
Separate / distinct
78 Return to or
79 UNRELATED
PROCEDURE
Surgical Modifiers
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Modifier 51

- Describes Multiple Procedures done at same session/day
- Second procedure performed on the same day, not bundled into the first procedure
  - Will by ranked by payers based on the allowed amount, not necessarily the billed amount
  - Should you use it – yes or no – most payors don't require it
  - Reimbursement reduced for multiple procedures done

Modifier 59

- Describes Distinct Procedural Service
  - Modifier of “last resort” that unbundles the second procedure
  - Use on a second procedure, which is a component code of the first to indicate the second procedure was a separate service
  - The second procedure was at a different session, on a different site/lesion, separate incision/excision
  - May also be used when the service is performed twice in one day, such as two excisions described by the exact same CPT code; some payers refer modifier 76 instead
  - Medicare developed, but not all carriers implemented HCPCS modifiers to further define the situations in which modifier 59 is used.

HCPCS Modifier 59 subsets

- XE = separate encounter, a service that is distinct because it occurred during a separate encounter
- XP = Separate practitioner, a service that is distinct because it was performed by a different practitioner
- XS = Separate structure, a service that is distinct because it was performed on a separate organ/structure
- XU = unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service

Reporting Multiple Procedures

- Physician Responsibility
  1. List all codes for the procedures performed
  2. Note whether the procedures performed were done via the same compartment, incision, site, organ system, lesion, injury, session and by the same surgeon. If all are the same, note "same." If any of the above were different, not "different"

Reporting Multiple Procedures

- Coder Responsibility
  1. Check the RVU for each procedure, and note them next to the code. The code with the highest RV is the primary procedure. The others are secondary procedures. Note the primary procedure.
  2. Check the CCI edits. If the secondary procedures are component codes of the primary procedures, the procedure was the same (as indicated above), bill only the primary procedure. Use the current version of the NCCI edits.
  3. If the secondary procedures are not component codes of the primary procedure, and the procedure was the same (as defined above), bill the primary procedure with no modifier, and the secondary procedures with -51 modifier. This indicates that multiple procedures were performed that fall into the category of "same" as indicated above.
  4. If the secondary procedures are component codes of the primary procedure, but the procedure meets the different criteria above (different session, compartment, lesion, injury, etc.) bill the primary procedure with no modifier and bill the secondary procedures with a -59 modifier

Modifier 58

- Used to describe Staged or Related procedure or Service by the Same Physician During Post-operative Period
  - Planned or anticipated (staged)
  - More extensive than the original procedure
  - For therapy following a surgical procedure
- Keys
  - During the post op period
  - May be used in any location
  - Should result in full payment
  - Resets the global period, unless second procedure has fewer global days
  - Same physician (or same specialty physician in the same group) performs a second procedure in the global period

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Modifier 78

- Unplanned return to the operating room by the same physician or other QHP following the initial procedure for a related procedure during the postoperative period (eg, complications)
  - Service performed by the same surgeon (or same specialty surgeon in the same group); this includes call coverage relationships
  - Second procedure is not a planned procedure
  - Second procedure is related to the first procedure and most commonly is a complication (although that work isn't used by CPT or CMS)
  - Second procedure must be performed in an approved operative suite (operating room, ambulatory surgical center, cath lab, angiography suite or endoscopy suite).
  - If the patient needs to return to the operating room on the same calendar day due to bleeding, obstruction or other complications, use modifier 59
  - Does not restart the global period

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Modifier 79

- Describes unrelated procedure or service by same physician or QHP during the postoperative period
  - Same surgeon or surgeon of same specialty, same group performs a second unrelated procedure during the global procedure
  - Service may be performed in any place of service
  - Although there should be a different diagnosis, they may on occasion have the same diagnosis. ICD has increased specificity for laterality, which will decrease confusion about a second procedure
  - Payment should be at 100% and this procedure has its own global period

Assistant at Surgery Modifiers

- 80 – Assistant Surgeon – add to all services where assistance provided
- 81 – Minimum Assistant Surgeon – minimum surgical assistant services are identified (usually second assist)
- 82 – Assistant Surgeon (when qualified resident surgeon not available) – the unavailability of a qualified resident surgeon is a prerequisite for use of this modifier
- AS – used to indicate the assistant at surgery was a non-physician practitioner

Assistant at Surgery Indicators (Medicare)

- 0 = payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity
- 1 = Statutory payment restriction for assistants t surgery applies to this procedure. Assistant at surgery may not be paid
- 2 = Payment restriction for assistants at surgery does not apply to tis procedure. Assistant at surgery may be paid.
- 9 = Concept does not apply

Assistant at Surgery Documentation

- The primary surgeon should document the necessity for the assistant
- The assistant does not need to document a note
- If in a teaching hospital and no qualified resident is available, the surgeon should indicate that in operative note

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WHAT DO YOU BILL

Office Injections

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What to Bill; What to Bill

1. The procedure
    1. Therapeutic – carpal tunnel
    2. Enzyme (Dupuytren's)
    3. Single tendon sheath or ligament or origin/insertion
    4. Trigger points – by # muscles
    5. Arthrocentesis, aspiration and/or injection
        1. With or without ultrasound guidance (and permanent recording & reporting)
        2. Small, intermediate, major joint/bursa
2. The medication
    1. Xylocaine considered local anesthesia and often not reimbursed

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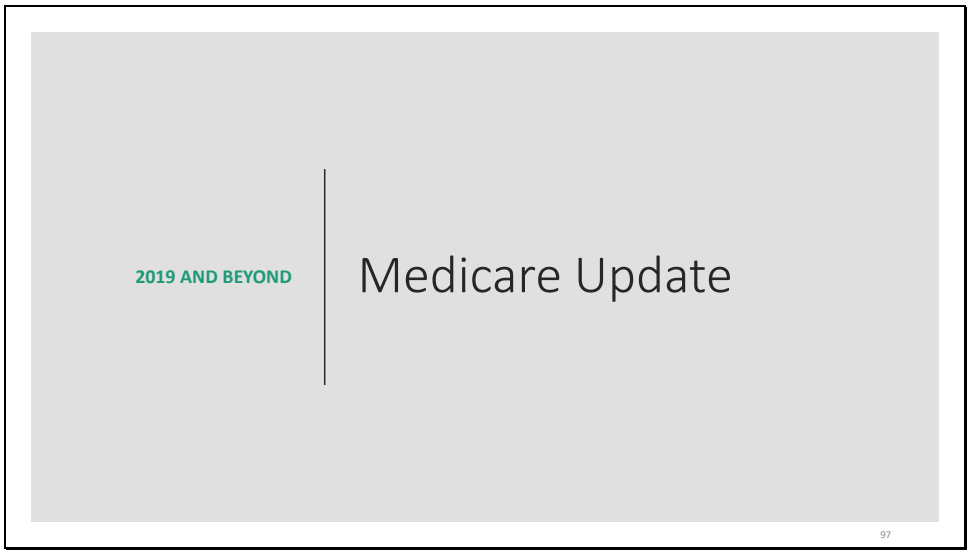

New Codes for Structural Allografts CPT Update

- New add-on codes 20932, 20933, 20934 were established to describe structural allograft procedures. There was no previous code for this work
- These services are performed in conjunction wit the primary procedure such as radical resection of the bone tumor
- An instructional parenthetical note is provided for separate reporting of the joint prosthesis. Any soft tissue coverage such as a rotation flap would also be coded separately

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MCR Conversion Factor

- 2018 = $35.99
- 2019 = $36.04
  - +0.25% update mandated by statute
  - -0.15% relative value unit (RVU) budget neutrality adjustment
- As always – some services/procedures “revalued”

Patients over Paperwork

- Office/Outpatient Visits – 2019
  - Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit
  - For established patient's history and exam, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evident that the practitioner reviewed the previous information and updated it as needed.
  - For new and established patients, chief complaint and history, the practitioners need not re-enter in the medical record information that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.

Policies for E/M Office/Outpatient Visits - 2021

- Single rates for levels 2-4 for established and new patients, maintaining the payment rates for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients
- Add-on codes for level 2-4 visits that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care
- A new “extended visits” add-on code for level 2-4 visits to account for the additional resources required when practitioner need to spend additional time with patients
- For level 2-5 visits, choice to document using the current framework, MDM or time
  - When time is used to document, practitioner will document the medical necessity of the visit, and that the billing provider personally spent the required amount of time face-to-face with the beneficiary (use CPT typical times)

Outpatient Therapy

- Medicare will no longer require the G-codes and modifiers for outpatient therapy services furnished on or after January 1, 2019
- Therapy Services furnished by Therapy Assistants (2020)
  - Bipartisan budget Act of 2018 requires payment for services furnished in whole or in part by a therapy assistant at 85% of the applicable Part B payment amount for the service, effective 1/1/2022
  - The law requires CMS to establish a new modifier by 1/1/2019
    - One modifier for therapy services furnished in whole or in part by a physical therapy assistant
    - Second modifier for therapy services furnished in whole or in part by an occupational therapy assistant
  - Modifiers will be required on Outpatient Physical and Occupational Therapy claims as of 1/1/2020

Part B Drugs

New Payment Policy for First quarter of Sales for New Part B Drugs

- Average Sales Price (ASP) not yet available for new Part B drugs
- Currently, new drugs are paid at Wholesale Acquisition Cost (WAC) plus 6%
- As of January 1, 2019, new drugs will be paid at WAC plus 3%
- Lower cost sharing for Medicare beneficiaries

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Thanks for Your Attention!

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