CODING AND BILLING

The history and language

THE AMERICAN ORTHOPAEDIC ASSOCIATION®

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Fellowship Education Coalition

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Part of the Fellowship Education Transition to Practice Lecture Series, this white paper accompanies the “Coding and Billing” module, an educational resource to help fellowship directors answer their fellows’ crucial questions about coding and billing. The Lecture Series is a production of the American Orthopaedic Association in collaboration with the Fellowship Education Coalition comprised of the following orthopaedic specialty societies: AOA/CORD, AAHKS, AANA, AAOS, ABOS, ACGME, AOFAS, AOSSM, ASES, NASS, OTA and POSNA. Visit aoassn.org or one of the subspecialty society websites to access the Lecture Series. Updated April 2020.

Background

The language of coding

CPT (Current Procedural Terminology) was first developed and published by the AMA in 1966.
It was meant to standardize physician services and had no initial connection to reimbursement. In 1983, Centers for Medicare & Medicaid Services (CMS) mandated the use of CPT for billing.

A five-digit system was adopted:

- 10000 – 19999 Anesthesia
- 20000 – 69999 Surgery
- 70000 – 79999 Radiology
- 80000 – 89999 Pathology
- 90000 – 99999 Medicine
- 99201 – 99499 Evaluation/Management

Coding in the Office: Evaluation and Management (E/M)

How to maximize the value of your work in the office.

Visit Type

New: New patients have not been seen by the treating orthopaedist or another orthopaedist (or non-physician provider, NPP) in the same practice within the past 3 years. The 3-year rule for new patients does not apply to consultations.

Consultation: For a visi\t to be considered a consultation, there must be documentation of a request from another physician to either recommend care for a specific problem or determine whether transfer of care will be accepted for the patient's entire care or for the care of a specific problem. At a minimum, the orthopaedist must include a statement in the documentation such as "I was asked to see this patient in consultation by Dr. X for an opinion regarding problem Y."

Under special circumstances, an orthopaedist in a practice may consult an associate within the same practice. For example, a joint surgeon treating a patient for hip pain may request a consultation with a spine colleague to obtain an opinion on whether spinal arthritis may be the primary cause of the hip pain. In contrast, if a hand specialist refers a patient to a joint specialist to treat a degenerative hip, a transfer of care occurs. Similarly, a referral by a physician's assistant or an "office-only" orthopaedist to another orthopaedist for additional treatment would not qualify as a consultation. As of 2010, consultation codes are no longer accepted by Medicare, but are still accepted by private insurers.

Established: Established patients have been seen by the treating orthopaedist or another orthopaedist (or NPP) in the same practice within the last 3 years.

The level of service for each visit ranges from level 1 to 5, with corresponding CPT codes from 99201 – 99205 for new patients and 99211 – 99215 for established patients.

New Patient Visits

There are three key components to every patient evaluation:

- History
- Physical Exam
- Medical Decision-Making (MDM)

A new patient visit is reimbursed based on the lowest level documented among all three of these key components. The goal for all new patient visits should be to document and bill as at least a **level 3** visit.

History

The history component consists of:

- Chief complaint (CC)
- History of present illness (HPI)
- Review of systems (ROS)
- Past, family, and social history (PFSH) sections.

The goal for every patient should be to obtain a **level 4** history.

The HPI requires 4 bullets among the following:

- location
- severity
- timing
- duration
- context
- modifying factors
- associated conditions

A simple example with 4 bullets is as follows: “The patient reports right knee pain [location] for 2 months [duration]. The pain is intermittent [timing] and worsens with activity [modifying factors].”

Adequate documentation of ROS and PFSH can be aided by the use of patient intake forms. The information on the intake form must be reviewed with the patient and documented as such, noting pertinent positives. The intake form must be signed and dated by the treating physician and scanned into the medical record.

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

Sample patient history intake form

Physical Exam

The physical exam is often the rate-limiting component for determining level or service in the current system. A **level 3** exam requires 12 bullets, as detailed on the bullet counter below. This should be the minimum standard exam utilized for new patient visits. If you plan to bill a new patient visit at **level 4**, you must examine four body areas and document 30 bullet points in the physical exam component.

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

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			

Medical decision-making (MDM)

The medical decision-making component (MDM) has three parts: data, diagnosis, and risk. It is a measure of the complexity of the case and the recorded evaluation. For a given level of service, the medical record must quality in 2 of the 3 areas of MDM as detailed in the chart below, with 2 points qualifying as **level 3**, and 3 points qualifying as a **level 4**.

For a new patient, ordering and interpreting imaging (3 points), diagnosing a new problem (3), and/or pursuing any number of management plans including prescription for medication, CT/MRI order, injection, or discussion of surgery (3 points for any one) would qualify as level 4 for the MDM component.

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***

Time

In some cases, time may be a factor in determining the level of service. Although time is not one of the three key components in selecting a level of service, time can become the determinant for CPT code selection when the visit consists predominantly of counseling or coordination of care. This method of billing must be documented as detailed below.

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

Established Visits

An established patient visit is reimbursed based on the lower of the top 2 key components. Generally, these will include the history and MDM sections, passing on the physical exam. A level 4 history for an established patient requires the CC, HPI with 4 bullets, ROS with at least 2 systems, and at least 1 element from Past, Family, and/or Social History. The MDM criteria is identical for new and established patients.

The goal for established patients should be to document and bill as a **level 4** visit whenever appropriate. The MDM section can help guide the level of service and working backwards from here is helpful. For example, if an injection is given, CT or MRI ordered, or surgery discussed, the history and MDM should be documented accordingly, and the visit billed as an established **level 4** visit.

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

Global Period

The global period is a defined period of time following a surgical procedure. For major surgery, the global period is 90 days. The payment for the index surgical procedure covers all additional costs of management during this period, regardless of the number or length of visits. The E/M code 99024 should be used for post-operative visits in this period.

Modifiers

Modifiers are 2-digit codes that can be appended to evaluation and management (E/M) services to indicate the physician has provided a service that is variant to the normal definition or surgical package.

Common modifiers in orthopaedics include the following:

- -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
    - When E/M visit results in the decision to proceed with surgery, and surgery is scheduled for the same day or the next calendar day

Telemedicine

Telemedicine is a rapidly evolving area of evaluation and management. Telemedicine carries the advantages of:

- Decreasing patient travel and increasing access to care, particularly in rural and underserved areas
- Increasing access for emergency consultations in areas where specialists may not be available
- Potentially decreasing cost to the system overall

CMS maintains a list of services that are normally furnished in-person that may be furnished via telemedicine. This list is available here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes . These services are described by CPT codes and paid under the Physician Fee Schedule.

Take Home Points

- Document all three key components (History, Physical Exam, and MDM), and choose a level of service that is appropriate for new patients (generally level 3, or 99203) and established patients (level 3 or 4, 99213 or 99214)
- Develop patient intake forms to assist in documenting the history component
- Make sure to include at least 2 of 3 elements in MDM (Data, Diagnosis, Plan/Risk)
- Understand the decision-making elements that increase the level of service. For established patients, if you prescribe medication, perform an injection, order advanced imaging, or discuss surgery, ensure that the note is documented appropriately to bill for a level 4 established visit (99214). Remember that only 2 of 3 key components must meet the level of service criteria for established patients
- Always bill accurately and judiciously. Overbilling with an unusual number of level 4 or 5 new patient visits will come under scrutiny

Future Directions

Significant changes to the E/M billing requirements have been adopted by Medicare and are set to go into effect **in 2021**. These changes include the following:

- The history and physical exam will no longer be factors in determining level of service.
- The level of service (CPT code) will now be determined *solely based on Medical Decision-Making (MDM) or Time*.
- MDM calculation will be similar to, but not identical to, 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.

In general, these new guidelines will be beneficial in orthopaedic surgery. The determination of level of service will shift primarily to Medical Decision-Making, where orthopaedic surgeons spend the majority of their time. For a new patient with a complicated problem, where extensive effort is spent in developing and discussing the diagnostic and therapeutic plan, the onerous burden of documenting a 30-bullet physical exam will no longer be necessary to justify a level 4 visit.

Coding for Surgery

How to bill for surgical cases accurately and effectively while staying out of trouble

Surgical coding is generally more straightforward than coding for evaluation and management, as each procedure is associated with a distinct CPT code. The CPT code(s) billed should reflect the procedure(s) performed as documented in the operative report. When multiple procedures are performed, the procedure associated with the highest work units (RVUs) should be listed first. Secondary procedures may be eligible for a modifier.

The most commonly used modifier in surgical coding is the modifier -59, which indicates a distinct procedural service. This is used to identify procedures that are not normally reported together but are appropriate under the circumstances. For example, an arthroscopic rotator cuff repair may be listed along with arthroscopic biceps tenodesis performed at the same patient, with a -59 modifier applied to the latter procedure.

Bundling packages define which CPT codes can be reimbursed either separately or in combination. Be cautious of bundling packages when billing for multiple CPT codes.

The best resources to assist in accurate coding are listed in the Additional Resources section below. These include the AAOS Musculoskeletal Coding Guide and web-based Code-X. The Code-X allows you to easily search for CPT codes, compare codes and check for bundling conflicts, and reduce errors that would lead to denied claims.

Additional Educational Resources

- AAOS Coding Resources

  https://aaos.org/education/about-aaos-products/coding-resources/

- AAOS Orthopaedic Code-X

  https://aaos.org/education/about-aaos-products/codex/

- AAOS Musculoskeletal Coding Guide 2020

  https://www5.aaos.org/store/product/?productId=17050727&_ga=2.209074962.1010128051.1585089347-607220517.1575954066

- Karen Zupko Coding Workshops

  https://www.karenzupko.com/orthopaedics/

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Fellowship Education Coalition

The American Orthopaedic Association engages the orthopaedic community to develop leaders, strategies and resources to guide the future of musculoskeletal care. The Fellowship Education Coalition brings together the orthopaedic community to identify, curate or develop educational tools and resources to better prepare graduating fellows for practice. The Coalition is comprised of the the following orthopaedic specialty societies: AOA/CORD, AAHKS, AANA, AAOS, ABOS, ACGME, AOFAS, AOSSM, ASES, NASS, OTA and POSNA.