Coding For Orthopaedic Trauma;
“Receiving Correct Reimbursement for Complex Cases”
Coders Challenge

- Presenting the claims for “appropriate” payment
- Unless the documentation is clear
  - Coders cannot properly code
  - No basis of appeal without addendum
  - Lost revenue
- Operational Flow of Information
- Volume – Over Worked – Expectations
- Communication (The lack of)

Obstacles

- Coding is more complex
- Multiple anatomical sites
- Multiple provides
- Different specialists
- Each case is unique
- Adjudicators are not as knowledgeable
- Edits work against you
  - Part A stays
  - Consolidated Billing
  - Hospice Care
Lost Revenue
Evaluation & Management

- E&M should always accompany trauma surgery.
  - CMS will not pay Consults
  - Private Payer ... Many Continue to pay!
  - RVUs for other E&M codes adjusted
  - AI Modifier for Admitting Physician
  - All report hospital service codes and outpatient E&M
- Admission
- Observation
- ER Services
- Critical Care
- Prolonged Care Services
- Modifier 57 (decision for surgery)

Wound Debridements

- 2011 Debridement Codes
  - “each additional”
- Unassociated to fractures
  - 11042–11047 Debridement
  - 12001–13153 Repairs
  - 15002–15005 Grafts site prep
  - 16000–16030 Burns abrasions
Open Fracture Debridement

- The depth of excisional debridement
  - Curette bone ends etc.
  - Devitalized portions of muscle and tendons
- This is not a “wash out”
- Using these codes with closed fractures?
- CPT Assistance Reference

Lacerations

- Poor documentation
- Repair of traumatic wounds
- Unassociated with fractures
  - Length – depth – Type of closure location (complexity of debridement)
Complex Closure

- Undermining
- Creation of flaps
- Retention sutures
- Bolsters
  Plastics Repair – DOCUMENTATION

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Traumatic Wounds

- Unassociated to fractures
- Muscle – Ligament
  - repair / reconstructions
- Vascular repair
- Explore penetrating wound

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Medicare Physician Fee Schedule Data Base. (Fee for Service)

Defines and standardizes payments based in components of each procedure.

Practice Exp + Work Exp + MP Exp

Pre – Intra– Post Facility / Non facility

Comprehensive and Component Coding Combinations

Component edits relate to procedures that are

- Included as part of a more extensive procedure
- Specified as “separate procedures” by CPT
- Defined in CPT guidelines as component

Mutually Exclusive Coding Combinations

Represent services/procedures that based on CPT definition or standard medical practice would not or could not reasonably be performed at same session by same provider on same patient

Providers cannot submit mutually exclusive codes together
Multiple Operative Sessions

- Surgical Package
- Modifiers to pull out of edits
- Repeat procedures
- Same MD – Different MD same group
- Different MD same group different specialty

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Orthopaedic Emergencies

1. Open Fracture
2. Dislocated Joint
3. Septic Joint
4. Compartment Syndrome
5. Neurovascular injury
6. Gangrene

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Orthopaedic Emergencies

› HMO POS Medicaid

› CMS 1500 forms “Emergency”

› Conditions supports payment regardless of site of service requirements by payers
Injuries

- Wounds
- Lacerations
- Exploration penetrating wounds
- Traumatic amputations
- Dislocations
- Repairs –Primary repairs.

***** MODIFIERS ****
Risk vs. Reimbursement
Lost Revenue
High Risk with Inappropriate Use
Modifiers Impact on Payment

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E & M

- 24—Unrelated E/M Service by the Same Physician in a Postoperative Period
- 25—Significant, Separately Identifiable E/M Same Physician on the Same Day of the Procedure
- 57—Decision for Surgery
Surgical Modifiers

58 Staged or More Complicated Procedure
59 Distinct Procedure ***
78 Return to OR (Complications)
79 Unrelated procedure
50 Bilateral
51 Multiple Procedure ***
54 Surgical Care (Intra operative only) 69%
55 Post op care 21%
56 Pre-operative Care only 10%
Pre op Clearance by another Physician is payable V72.8X surgery diagnosis 2nd

HCPCS Modifiers

Use of these modifiers may
- Prevent claim denials as duplicate claim or component code/bundled procedure
- Identifies procedures separately performed on different anatomical sites, digits, different sides of body
Examples: LT (left side)
E1 (upper left, eyelid)
F4 (left hand, fifth digit)

(Know your locals)
Modifier 51 Exempt

- Does not have to be performed with another service
- Codes can stand alone without the modifier
- Can be part of a major service
- 100% Reimbursement
- Appeals Denials... WATCH EOB’s

i.e. 22840–22848
Appendix E in CPT professional “E for EXEMPT”

ADD-on Codes

- Appendix D
- Watch Payment
- Careful with negotiations
- Do not append modifier 51
Single Provider

- Multiple procedure concept will apply
  - Unless add-on or exempt
- Identify highest valued procedure
- Sequence by RVU OR negotiated allowed amount
- Modifier 51 = not required
- Anatomical Modifiers! RT–LT TA–9, FA–9
- Modifier 59 (NCCI edits)

Single Provider

- Global Established w/ Initial Trauma

  Multiple Sessions in the OR
  - Related to the original PROCEDURE? 69%
  - Anticipated return? 100%
  - More difficult? 100%
  - Not related? 100%
Single Provider

- Same for third and fourth returns
- Procedure related to patients condition?
- Procedure related to original procedure?
- Diagnosis coding is critical

Multiple Providers

- Identify (Specialty and / or group)
- Different Specialist
- Separate anatomical site.
Multiple Providers

**Same Surgical Wound**
- Type & number of specialists
- Coding depends on work performed by each provider
- Who starts the case
- Two surgeons vs. Team Surgery
- Codes support TEAM Surgery?
- What codes Support Co-Surgery?

**Different Surgical Wounds**
- Same group
- Different groups
- Sup specialty i.e. hands
  (payer defined!)
Complex Cases
Complex Claims

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Not all Things Are Equal

› Guidelines not Laws
› Exceptions are made
› Payers see the complexity
› Medical Necessity

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Coding Outside the Box

“DOCUMENTATION”

- Clean claim (know the locals)
- Letter describing the complexity
- Justification for what is billed
- Send hard copy

Basic Procedures

- Incision “otomy”
- Excision “ectomy”
- Introduction (i.e. centesis)
- Repair / Revision / Reconstruction (i.e. “oplasty” “opexy” “orrhaphy”)
- Fracture Repair “ORIF” “Manipulation” “Percutaneous”
- Dislocation “Reduction”
- Arthrodesis “Fusion”
- Amputation
- (CPT organization of the musculoskeletal section)
The Operative Report

- Pre Dx
- Post Dx
- Indications
- Co-Morbidities!
- MD
- Assistant
- Body

Key Terms

- Position
- Approach – Open, Endoscopic
  Laparoscopic, Arthroscopic
- Incision site
- Excision / repair / removal / replace
- Biopsy
- Number of incisions
Within CPT

- Separate procedure
- Unlisted procedure
- Multiple Procedure

Each surgical section has specific nuances
- Read CPT instructions
- Green
- Images at the start of each chapter
- Icons on bottom of pages
- Pay close attention to (S) / and / each
- Use your index!
- If you do not understand language in the example look up in ICD-9

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Category II and III

- Category I 5 digit numeric
- Performance “F”
- Technology “T”
- HCPCS Codes Medicare
  - Healthcare Common Procedure Coding System
  - HCPCS Level I CPT = Category I, II, III
  - HCPCS Level II Medicare / BCBS G = S codes Alpha numeric

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ICD–9–CM
Critical !!

Trauma Injury Codes
Late effect Codes
Aftercare codes for healing T–fractures
Complication codes
Infection –post operative
Infection – Traumatic wound
E codes
Co–Morbidities
Scenario / Discussion

71 Yr. female presents to ER
Fell from bed. Assisted living center
Open fracture right mid-shaft tibia
Fracture right proximal femoral neck
6CM laceration on the right forearm
Post status Total hip replacement left side
Weight 280 lbs height 5’2”
Diabetic neuropathy and vascular insufficiency

1) ER- Repair right forearm laceration  layered closure
1) Admission to hospital
1) Urgent to OR for open fracture debridement
3) OR for fracture hip (Percutaneous screw fixation femoral neck
3) Repeat irrigation and debridement open tibial shaft fracture as planned following the initial debridement
3) ORIF tibia l shaft with plates and screws
4) Return to OR after week 10 screws migrated, unrelenting pain. Remove screws and performs a total hip replacement
5) Follow-up in office post THA for x-rays

CPT   ICD-9-CM   Modifiers foe all 5 episodes of care

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Review

› Daily Operational procedures
› Communications (Hospital staff) (Other involved providers)
› Documentation
› Coding from habit (No! No! No!)
› Slow Down
› Dissect the note
› Clean Claim (Patient Data) (Operational)
› Know your modifiers and reimbursement
› If you can’t justify in an appeal, Do not bill for it.
› Check the EOB’s
› Identify each injury large or small
Review

- EACH injury
- Each incision
- EACH anatomical site
- EACH provider
- EACH specialty
- EACH episode of care

Confused???
Resources

- **CPT® professional edition (Instructions)**
- **ICD-9-CM**
- **HCPCS Level II**
  - Electronic Resources
  - Encoders – Free Data Base – CMS
  - Newsletters – "Orthopaedic Coding Alert"
  - Specialty Society Websites
  - AAPC forum
  - The best resource you have is YOUR MD

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AAMA, CPT 2011
AMA “CPT Changes 2011 an Insiders View”
CMS National Correct Coding Manual
AHA Coding Clinic
ICD-9-CM for Physicians 2011 Volume 1 and 2
HCPCS Level II 2011
American Association of Orthopaedic Surgeons [www.aaos.com](http://www.aaos.com)
Orthopaedic Trauma Association [www.ota.org](http://www.ota.org)
[https://www.cms.gov/NationalCorrectCodInitEd/01_overview.asp](https://www.cms.gov/NationalCorrectCodInitEd/01_overview.asp)
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