2013 CODING, DOCUMENTATION, AND COMPLIANCE UPDATE
Sports Medicine – Outpatient Facility and Physician

Presented by:
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IMPACT
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Faculty and Planner Disclosure

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Procedural Coding Concepts

- HCPCS Coding Family
- Symbols of CPT
- Bundling Issues:
  - CPT Definitions
  - The Correct Coding Initiative (CCI)
  - Private Software
  - Multiple Procedures
  - Surgical Package Concepts
  - Groupers / APC Packaging
- Payor Coverage Criteria

Case Scenario

A question was posed whether a provider would receive separate payment for a combination of procedures and, if so, whether that payment would be at a reduced amount.

This question is not as "simple" as it originally appeared.
Case Scenario – Issues to Consider

- Some procedure codes are paid separately at full rate.
- Some are subject to the multiple procedure payment reduction.
- Some are ancillary or packaged into other services, either always, or in combination only with specific other codes.
- Some services are clearly not separately reimbursed, based upon the CPT code definitions and/or notes.
- It may vary for open surgery vs. arthroscopic procedures.
- Hospital outpatient rules may differ from ASC.
- It will almost certainly vary by payor type / contract.

Surgical Package Modifiers

<table>
<thead>
<tr>
<th>Included Services</th>
<th>Exceptions</th>
<th>Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidental anesthesia and cognitive services (E/M) in preparation for surgery, within 24 hours in advance</td>
<td>Significant and Separate</td>
<td>-25</td>
</tr>
<tr>
<td></td>
<td>Decision for Surgery</td>
<td>-57</td>
</tr>
<tr>
<td>Typical postoperative follow-up care</td>
<td>Return to O.R. for Related Procedure</td>
<td>-78</td>
</tr>
<tr>
<td></td>
<td>Unrelated E/M</td>
<td>-24</td>
</tr>
<tr>
<td></td>
<td>Unrelated Procedure</td>
<td>-79</td>
</tr>
<tr>
<td></td>
<td>Staged or Related</td>
<td>-58</td>
</tr>
</tbody>
</table>

Some payors have historically varied from these interpretations, but this may be changing.
New Coverage Criteria Trends

• Healthcare payor entities have been adopting increasingly stringent coverage criteria.

• These guidelines may be more conservative than the clinical standards of care developed by specialty medical societies.

• The stricter criteria lead to a need for more specific documentation of patient history and other findings to support medical necessity.
Case Study #1 -- Viscosupplementation

Patient presents with chronic knee pain and reduced mobility due to osteoarthritis. Initial treatments include anti-inflammatory medication(s), home exercises, and physical therapy.

Over time, symptoms have become more severe, and an evaluation of joint function is performed. Following the exam, there is a discussion with the patient regarding options. The decision is made to proceed with injections of ORTHOVISC® High Molecular Weight Hyaluronan, and informed consent obtained.

Each knee is cleansed with alcohol, an injection of lidocaine is administered to numb the knee, followed by injection of hyaluronan into the joint capsule. The patient is instructed on post-procedure care and encouraged to contact the practice if there are any significant side effects. An appointment is scheduled in one week for follow-up and sequential injection.
Case Study #1 -- Viscosupplementation

Week #1 – Initial Treatment

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant and Separate E/M Service with decision for surgery and review of comorbidities</td>
<td>992xx-25</td>
</tr>
<tr>
<td>Major joint injection, bilateral</td>
<td>20610-50</td>
</tr>
<tr>
<td>Hyaluronan or derivative, ORTHOVISC, for intra-articular injection, per dose</td>
<td>J7324 x 2</td>
</tr>
</tbody>
</table>

Week #2 & #3* – Planned injections

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major joint injection, bilateral</td>
<td>20610-50</td>
</tr>
<tr>
<td>Hyaluronan or derivative, ORTHOVISC, for intra-articular injection, per dose</td>
<td>J7324 x 2</td>
</tr>
</tbody>
</table>

CASE NOTES:

- The initial E/M service during which the decision for surgery is made and any comorbid conditions which may affect recovery are assessed may be reported, so long as it represents a “significant and separate” E/M service – modifier -25 will apply. Depending upon circumstances, this may be office visit new patient (9920x), established patient (9921x), or outpatient consultation (9924x), at the level of service appropriate for extent of encounter and documentation.

- Some payors may require a separate diagnosis code for the E/M, or have other limitations on reporting of E/M and minor surgery on the same day.

- Local anesthetic, if used, is included in 20610.
Case Study #1 -- Viscosupplementation

CASE NOTES:

• For subsequent injections, no E/M service is typically reported, as the reason for the encounter is the minor surgery, which was planned prospectively.

• For some payors, no additional surgical modifiers apply to subsequent injections, as code 20610 is assigned a zero-day global period by CMS. However, variations exist between different payors:
  • Plans may attempt to bundle any type of injection into an E/M service the same day
  • Some may consider weekly injections to be overlapping surgical periods, and require use of modifier -58.
  • Payor coverage may require documentation of failed conservative treatment for a specified period of time.

Example – Florida Medicare LCD

Indications for viscosupplementation therapy for the knee when ALL of the following conditions are met:

• The patient is symptomatic.
• Diagnosis is supported by radiologic evidence of osteoarthritis.
• The patient has failed at least three months of conservative therapy, including aspiration and intra-articular corticosteroid injection therapy when inflammation is a component.
• If the first course of treatment produces relief, subsequent courses of treatment if symptoms return, at least six (6) months after the last injection of a previous course of treatment.
• Knee arthroplasty is not being considered as a current treatment option.
• Imaging visualization to provide guidance for needle placement will not be covered.

Excerpted from Local Coverage Determination (LCD) for Viscosupplementation Therapy for Knee (L29307); http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx. Enter "L29307" in Search by Document ID, and effective date of 01/01/2010 on second search screen to access a copy of the complete LCD document.
Case Study #2 – Removal of External Fixation Device

<table>
<thead>
<tr>
<th>PRE-OP DIAGNOSIS:</th>
<th>Left distal radius fracture.</th>
<th>813.42</th>
</tr>
</thead>
<tbody>
<tr>
<td>POST-OP DIAGNOSIS:</td>
<td>Same.</td>
<td></td>
</tr>
<tr>
<td>PROCEDURE PERFORMED:</td>
<td>Removal of external fixator as well as two radial styloid pins, left wrist.</td>
<td>V54.89 V54.12</td>
</tr>
<tr>
<td>SURGEON:</td>
<td>Dr. X</td>
<td></td>
</tr>
<tr>
<td>ASSISTANT:</td>
<td>None.</td>
<td></td>
</tr>
<tr>
<td>ANESTHESIA:</td>
<td>Monitored anesthesia care.</td>
<td></td>
</tr>
<tr>
<td>TOURNIQUET TIME:</td>
<td>No tourniquet.</td>
<td></td>
</tr>
<tr>
<td>COMPLICATIONS:</td>
<td>None.</td>
<td></td>
</tr>
<tr>
<td>DRAINS:</td>
<td>None.</td>
<td></td>
</tr>
</tbody>
</table>

OPERATIVE REPORT: The patient was taken to the operating room and after the induction of adequate IV analgesia, the left upper extremity was prepped with povidone-iodine. The small external fixator frame was removed from the four pins. This was followed by removal of the pins using the small AO external fixator set wrench. This was then followed by removal of the two radial styloid pins. Once this was done, the wounds were irrigated and sterile dressings were applied, the patient tolerated the procedure well and went to the recovery room in stable condition.
Musculoskeletal System
Standard Subheadings Within Each Body Region

- Incision
- Excision
- Introduction or Removal
- Repair, Revision, and/or Reconstruction
- Fracture and Dislocation
- Manipulation
- Arthrodesis
- Amputation
- Other Procedures

Repair, Revision, and/or Reconstruction

- Repair of:
  - Single tendon, multiple tendons, or each tendon
  - Primary vs. secondary
  - May specify through same incision
- Codes may reflect repair, transfer, advancement, lengthening or shortening, or release of a specified muscle, tendon, or ligament
- Some services may be reported separately
- Grafts
- Arthroplasty
Examples:

27650  Repair, primary, open or percutaneous, ruptured Achilles tendon;
27652  with graft (includes obtaining graft)
27654  Repair, secondary, Achilles tendon, with or without graft

27685  Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)
27686  multiple tendons (through same incision) each

(Source: CPT Professional 2012, pg. 134)

Example of Cumulative Descriptors

25000  Incision, extensor tendon sheath, wrist
25001  Incision, flexor tendon sheath, wrist
25020  Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment, without debridement of nonviable muscle and/or nerve
25023  with debridement of nonviable muscle and/or nerve
25024  Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment, without debridement of nonviable muscle and/or nerve
25025  with debridement of nonviable muscle and/or nerve

(Source: CPT Professional 2012, pg. 116)
Example – Variations on a Theme

29290 Correction, hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (eg, Silver type procedure)
28292 Keller, McBride, or Mayo type procedure
28293 resection of joint with implant
28294 with tendon transplants (eg, Joplin type procedure)
28296 with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedure)
28297 Lapidus-type procedure
28298 by phalanx osteotomy
28299 by double osteotomy

(Source: CPT Professional 2012, pp. 138-140)

Case Study #3 – ACL Reconstruction with Tendon Graft

Preoperative Diagnosis: ACL deficient left knee 844.2 / 717.83
Postoperative Diagnosis: Same
Surgeon: Dr. X  Asst: Dr. Y
Procedure: Left ACL reconstruction using patellar tendon graft
Surgery time: Approximately 103 minutes
Anesthesia: Epidural
Operative Report: The patient was taken to the operating room and after the induction of adequate epidural analgesia, the left lower extremity was prepped and draped in the usual sterile fashion. An Esmarch was used to exsanguinate the limb and the tourniquet was inflated to 300 mm. Mercury.
Case Study #3 – ACL Reconstruction with Tendon Graft

At this point in time, a 5-6 cm incision was made over the patellar tendon in the midline, taken down through the skin and subcutaneous tissues until the peritenon was identified. The peritenon was split longitudinally thus exposing the patellar tendon. After this was done, the central third of the patellar tendon along with bone plugs from both the inferior pole of the patella and the proximal tibia were harvested without difficulty. The graft was then placed on another table and prepared for implantation into the knee. Visual inspection of the medial and lateral compartments showed no significant meniscal pathology. There were no chondral lesions wither on the tibia plateau of the femoral condyles, however, there was evidence of a disruption of the ACL. The PCL looked intact and normal in configuration.

Case Study #3 – ACL Reconstruction with Tendon Graft

At this point in time, a shave was introduced into the joint. The remnants of the ACL as well as part of the fat pat were debrided. This was then followed by a notchplasty that was done using a combination of a burr and the (Brand) wand. Once adequate notchplasty was performed, the (Brand) tibial guide was placed into the joint and a tibial tunnel was drilled in the appropriate fashion. This was then followed by placement of the over the top (Brand) tibial guide followed by drilling of a femoral tunnel. Both tunnels were deemed to be in adequate position arthroscopically. Once this was done, the graft was then drawn from the tibial tunnel into the femoral tunnel under direct guidance and secured in the femoral tunnel with a 7 x 25 interference screw as well as 7 x 20 screw in the tibial tunnel.
The knee was put through a range of motion. There is no evidence of the graft impinging in flexion or extension, the wound was thoroughly irrigated and then the patellar tendon was closed in layers initially with the tendon and peritenon followed by suture of the subcutaneous tissues. This was followed by instillation of local anesthetic into the joint as well as placement of a drain. The initial arthroscopic portals were closed as well and went to the Recovery Room in a stable condition.

**Notes:** Code 20924 is defined as “tendon graft, from a distance”; the tendon graft is not documented as obtained through a separate incision, so it is not separately reported.

Operative report does not specify new vs. old injury. However, as current surgical repair, the acute injury code 844.2 may be reported even if initial injury was some time earlier.

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**Case Study #3 – Lateral Epicondylitis**

**PREOPERATIVE DIAGNOSIS:** Lateral epicondylitis.  
**POSTOPERATIVE DIAGNOSIS:** Lateral epicondylitis.  

**OPERATIONS PERFORMED:** Lateral release with shortening of the ECRB tendon.

**DESCRIPTION OF PROCEDURE:** With the patient under adequate anesthesia, the upper extremity was prepped and draped in a sterile manner. The arm was exsanguinated and the tourniquet elevated to 290 mm/Hg. An incision was made over the lateral aspect of the right elbow anterior to lateral epicondyle and centered on the lateral epicondyle. Blunt dissection exposed the antebrachial fascia. The interval between the extensor carpi radialis longus and anterior edge of the extensor aponeurosis was identified.
Case Study #3 – Lateral Epicondylitis

The antebrachial fascia was then incised and further blunt dissection developed the interval between ECRL and extensor aponeurosis from the lateral epicondyle distal to the joint line. The ECRL was then released by sharp dissection and retracted anterior to expose the origin of the extensor carpi radialis brevis. Medial dissection further delineated the origin of the ECRB. The origin of the ECRB was then further inspected and gross pathological changes of grayish tissue were identified and this friable tissue was then excised. The joint capsule was then incised. The radial capitellar joint was inspected and found to be without pathological changes.

24358

The wound was then copiously irrigated. The joint capsule was closed with interrupted 3-0 sutures. The ECRB was then lengthened and then sutured to the undersurface of the ECRL using 3-0 sutures. The antebrachial fascia was closed with a running 3-0 suture with a Krackow technique. The wound was then infiltrated with 10 cc of .025% bupivicaine HCl.

The skin was closed in a layered fashion. Sterile dressings were applied. The tourniquet was deflated. The patient was awakened from anesthesia and returned to the recovery room in satisfactory procedure having tolerated the procedure well.

24305
Case Study #4: Open Plantar Fasciotomy

PREOPERATIVE DIAGNOSIS: Chronic plantar fasciitis, right foot.
POSTOPERATIVE DIAGNOSIS: Chronic plantar fasciitis, right foot.
PROCEDURE: Open plantar fasciotomy, right foot.
ANESTHESIA: Local infiltrate with IV sedation.
INDICATIONS FOR SURGERY: The patient has had a longstanding history of foot problems. The foot problem has been progressive in nature and has not been responsive to conservative care despite multiple attempts at conservative care. [Informed Consent Discussion]. The patient requested for surgical repair since the problem has reached a point to interfere with normal daily activities. The purpose of the surgery is to alleviate the pain and discomfort.

DETAILS OF THE PROCEDURE: The patient was given (drug) for antibiotic prophylaxis 30 minutes prior to the procedure. The patient was brought to the operating room and placed in the supine position. Following a light IV sedation, a posterior tibial nerve block and local infiltrate of the operative site was performed with (medications). The lower extremity was prepped and draped in the usual sterile manner. Balance anesthesia was obtained.

PROCEDURE: Plantar fasciotomy, right foot. The plantar medial tubercle of the calcaneus was palpated and a vertical oblique incision, 2 cm in length with the distal aspect overlying the calcaneal tubercle was affected. Blunt dissection was carried out to expose the deep fascia overlying the abductor hallucis muscle belly and the medial plantar fascial band.
Case Study #4: Open Plantar Fasciotomy

A periosteal elevator did advance laterally across the inferior aspect of the medial and central plantar fascial bands, creating a small and narrow soft tissue tunnel. Utilizing a Metzenbaum scissor, transection of the medial two-third of the plantar fascia band began at the junction of the deep fascia of the abductor hallucis muscle belly and medial plantar fascial band, extending to the lateral two-thirds of the band. The lateral plantar fascial band was left intact. Visualization and finger probe confirmed adequate transection. The surgical site was flushed with normal saline irrigation.

Case Study #4: Open Plantar Fasciotomy

The deep layer was closed with 3-0 suture and the skin edges coapted with combination of 1 horizontal mattress and simples. Non-adhering wound dressing, 4x4, and an elastic wrap to provide mild compression were applied. The patient tolerated the procedure and anesthesia well, and left the operating room to recovery room in good postoperative condition with vital signs stable and arterial perfusion intact. A walker boot was dispensed and applied. The patient will be allowed to be full weightbearing to tolerance, in the boot to encourage physiological lengthening of the release of plantar fascial band. After a short recuperative period, the patient was discharged home with vital signs stable and in no acute distress.
Case Study #5 – Multiple Digit Capsular Release, Hand

PREOPERATIVE DIAGNOSIS: Contractures right hand including MP and IP joints.

POSTOPERATIVE DIAGNOSIS: Contractures right hand including MP and IP joints.

INDICATIONS FOR PROCEDURE: The patient is a pleasant 41-year-old female with a severe crush injury to the right hand. She now has extension contractures of the MP and IP joints of the right hand as well as retained hardware in the small finger. She has had a recent rotational osteotomy of the small finger.

The patient is taken to the OR today for dorsal capsular release of the MP and PIP joints as well as extensor tenolysis and removal of hardware of the small finger.

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room, placed supine upon the operating table, after an adequate general anesthesia, her right upper extremity was prepped and draped in the standard surgical fashion. I exsanguinated the arm with ___ dressing, inflated the tourniquet to 250 mm Hg.

I began with the small finger. I made a longitudinal incision over the dorsum of the small finger. I used the previous longitudinal incision that was used for the osteotomy. I incised sharply through the skin and dermis and identified the extensor mechanism. The extensor mechanism was split longitudinally down the middle, identified the MP joint and made a transverse incision over the MP joint capsule.
Case Study #5 –
Multiple Digit Capsular Release, Hand

I identified the buried K-wires and these were both removed without difficulty. These were buried into the proximal phalanx. I then had to flex the MP joint, I was able to flex it to 100 degrees. An extensor split was continued to the proximal interphalangeal joint, and the level of the proximal interphalangeal joint I performed a dorsal capsulotomy. I left the central slip intact on the dorsum of the middle phalanx. I released the collateral ligament. I recessed the collateral ligament on both sides of the proximal interphalangeal joint and once this was accomplished I was able to flex the PIP joint to about 95 degrees. I copiously irrigated the incision, closed the extensor split with a running 4-0 suture, closed the small finger incision with a running nylon suture.

Case Study #5 –
Multiple Digit Capsular Release, Hand

I then turned my attention to the ring finger, where I made a longitudinal incision over the ring finger, incising sharply through skin and dermis, identified the extensor mechanism, split the extensor mechanism longitudinally. Over the MP joint I made a transverse incision through the capsule. I then manipulated the MP joint. I was able to obtain 100 degrees of flexion. I then identified the proximal interphalangeal joint, made a transverse capsulotomy over the PIP joint. I left the central slip intact. I recessed the collateral ligaments and then I was able to flex the PIP joint to approximately 95 degrees. I then copiously irrigated the incision. The extensor tendon was repaired with a running suture and the skin was repaired with interrupted nylon.
Case Study #5 –
Multiple Digit Capsular Release, Hand

The same procedure was repeated on the long finger and the index finger in the same fashion and again
long finger MP joint flexion was to 100, PIP joint was to 95, index finger MP joint to 100, PIP joint was approximately to 95 and again simultaneous full flexion was not obtained. However, no intrinsic tightness was identified in any of the digits. They all had signs of extrinsic tightness.

When we were finished, a sterile dressing was applied followed by a dorsal splint to keep the wrist in the most extension it could be, which was approximately 10 degrees and to keep the fingers flexed. The patient tolerated the procedure well. There were no complications.

Case Study #5 –
Multiple Digit Capsular Release, Hand

PROCEDURES PERFORMED:

1. Capsulotomy, index finger, MP joint. 26520-F6
2. Capsulotomy, index finger, PIP joint. 26525-F6
3. Extensor tenolysis index finger. 26445-F6
4. Capsulotomy, long finger, MP joint. 26520-F7
5. Capsulotomy, long finger, PIP joint. 26525-F7
6. Extensor tenolysis long finger. 26445-F7
7. Capsulotomy, ring finger, MP joint. 26520-F8
8. Capsulotomy, ring finger, PIP joint. 26525-F8
9. Extensor tenolysis ring finger. 26445-F8
10. Capsulotomy, small finger, MP joint. 26520-F9
11. Capsulotomy, small finger, PIP joint. 26525-F9
12. Extensor tenolysis small finger. 26445-F9
13. Removal of hardware, small finger. Bundled
Case Study #5 –
Multiple Digit Capsular Release, Hand

CASE NOTES:

• Level II modifiers clarify coding for digits on hands and feet -- reduces likelihood of denials for “duplicate” procedures. Alternative option is number of units.

• 2013 CCI states, “If a superficial or deep implant (e.g., buried wire, pin, rod) requires surgical removal (CPT codes 20670 and 20680), it is not separately reportable if it is performed as an integral part of another procedure.

• Operative note stated “recent” rotational osteotomy -- if within 90 days of either this osteotomy or initial treatment, modifiers -58, -78, and/or -79 may apply.

Fracture Care

• Closed treatment: { 1) without manipulation 2) with manipulation 3) with or without traction

• Open treatment

• Percutaneous skeletal fixation

• Manipulation

TRACTION DEVICES

• Skeletal traction

• Skin traction

• External fixation

(Source: CPT Professional 2012, pg. 88)
Case Study #6 –
Open Reduction and Internal Fixation

DIAGNOSIS:  Left distal radius fracture  813.42

TITLE OF OPERATION:  Left distal radius open reduction and internal fixation and application of external fixator.

PROCEDURE IN DETAIL:  After the patient was identified and after adequate anesthesia, he was positioned supine on the operating table. The left arm was placed on the arm table. It was prepped and draped in a sterile fashion. The arm was exsanguinated with an Esmarch bandage and then tourniquet was inflated to 250 mmHg. A volar approach was done, distal modified Henry approach. Care was taken to protect the superficial radial nerve and also the radial artery and its venae comitantes. The pronator quadratus was incised longitudinally and elevated off the bone. The fracture was identified, reduced, and the joint was also visualized.

Once the fracture had been reduced, it was plated with a (brand) plate. Using AO technique, the plate was applied. The fracture was controlled in both AP and lateral planes using image intensifier. It was found to be well reduced, and the screws and the tips of the screws were not impinging any vital structures and were extra-articular.

After that was done, the wound was irrigated copiously with antibiotic normal saline solution. It was closed in layers using 2-0 absorbable and 3-0 nylon sutures. Next, an external fixator was placed dorsolaterally in order to provide additional stability. Dressings were applied without difficulty again using standard AO technique. The incision was closed with 3-0 nylon after it had been irrigated copiously. A dressing was applied and the patient was aroused from anesthesia without any complications.
Endoscopy / Arthroscopy

- Diagnostic arthroscopy is included in surgical arthroscopy.
- Some surgical arthroscopies are also bundled.
- G-code for knee arthroscopy:
  G0289  Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty) at the time of other surgical knee arthroscopy in a different compartment of the same knee
- Diagnostic arthroscopy followed by open treatment, report arthroscopy with modifier 51.
- If no arthroscopy code exists, do not report as open surgery -- use unlisted arthroscopy.

Case Study #7 – Knee Arthroscopy with Meniscectomy

OPERATIVE REPORT

Preoperative diagnosis: Medial compartment arthritis with torn medial meniscus.  715.36
Postoperative diagnosis: Same with torn lateral meniscus and synovitis.  836.1

Operation(s): Arthroscopy, partial medial meniscectomy, partial lateral meniscectomy, abrasion arthroplasty and synovectomy.  727.00

Description of procedure: After the administration of general anesthesia the patient’s knee was examined. There was a large effusion and a mild varus deformity, crepitus upon range of motion.
Case Study #7 – Knee Arthroscopy with Meniscectomy

The knee was then prepped and draped in the normal fashion and secured to a leg holding device. Through a superior and medial stick an inflow cannula was inserted and 25 ccs of joint fluid were returned via the inflow cannula.

The arthroscope was introduced in the inferolateral portal and the arthroscopy was begun. The suprapatellar pouch area showed a lot of synovial hypertrophy. The undersurface of the patella showed mostly grade II changes of chondromalacia. The medial joint space was entered and one could immediately see there was a large degenerative tear of the medial meniscus and an area of bare bone 1.5cm in diameter on the tibia, and matching area of the medial femoral condyle.

Small medial arthroscopy incision was made and a meniscal probe was introduced. The tear of the meniscus was then delineated. Then with a series of instruments, including a meniscus scissors, grasping forceps, biopsy forceps and motorized meniscal cutter, the entire torn portion of the meniscus was removed, leaving a well-balanced and stable rim.

Attention was then directed to the intercondylar notch area, where a lot of synovial hypertrophy was debrided with the motorized synovectomy tool. The lateral joint space was entered and the lateral meniscus was well visualized. There was a tear at the posterior horn region, which was quite soft, and this was removed with the motorized meniscus cutter.

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Case Study #7 – Knee Arthroscopy with Menisectomy

The lateral joint space looked much better, the medial joint space with only a small area of grade I chondromalacia. Areas of synovitis were then debrided in the medial and lateral compartments and the undersurface of the patella was smoothed off. Following this with a small abrader, the area of the bare bone in the medial joint compartment was burred. The abrasion extended intracortically to a depth of about 1 mm until there was bare bleeding bone.

Following this the knee was irrigated and suctioned off. Sterile dressing was applied and the procedure was terminated. Patient tolerated the procedure well and was taken to the recovery room in good condition.

Case Study #8 – Arthroscopic Rotator Cuff Repair

OPERATIVE REPORT

Preoperative diagnosis: Right rotator cuff tear. Right subacromial impingement. 727.61
Postoperative diagnosis: Right rotator cuff tear. Right subacromial impingement. Acromioclavicular joint arthritis. 726.10 715.31


Indications: This patient has persistent pain within his right shoulder. It has been ongoing. He has failed conservative regimen and is in need of the above procedure.
Case Study #8 – Arthroscopic Rotator Cuff Repair

OPERATIVE PROCEDURE: Following preoperative informed consent the patient was brought to the operating room. He underwent general anesthesia and interscalene block. The right shoulder was prepped and draped in sterile manner. We first did a manipulation under anesthesia and indeed he did have some adhesions present going into external rotation as well as with internal rotation.

We then went into the shoulder and did a diagnostic arthroscopy. You could see some bleeding where we had lysed adhesions. We cleaned those up gently via an anterior portal. We then looked up and there was a small, almost full thickness tear of the supraspinatus behind the biceps tendon. We debrided this area out and then completed the tear via the bursal side.

We marked the area of significant partial tear and then went into the subacromial space. We then debrided out the bursa and you could see the almost full thickness tear. We completed it at that point, removing the marking stitch. There was a small tear present. We then debrided the subacromial bursa and went up and noticed the fairly significant subacromial spur and we debrided this back to stable rim using an oval burr.

We then went over the AC joint and I took off the undersurface of the AC joint and it was really, really arthritic. It hung down over onto the rotator cuff musculature. I debrided the undersurface of that and then went ahead via the anterior portal and debrided out the entire distal clavicle. We removed about the distal 8 mm of the clavicle.
Case Study #8 –
Arthroscopic Rotator Cuff Repair

There was good free motion at that point after that. We then went back to the tear and freshened the greater tuberosity up and then placed a [brand] anchor there. We placed the anchor off the articular surface.

We then brought the two suture ends up through a small tear. I didn't think it needed a double row repair. We went ahead at that point and placed two sutures without difficulty. We then tied simple sutures and this gave a good solid repair there.

We then thoroughly irrigated the wound and removed the arthroscope. Sterile dressing was applied. The patient was taken to the recovery room in stable condition.

2013 CCI Notes

• NEW FOR 2013: CMS considers the shoulder joint to be a single anatomic structure. An NCCI procedure to procedure edit code pair consisting of two codes describing two shoulder joint procedures should never be bypassed with an NCCI-associated modifier when performed on the ipsilateral shoulder joint. This type of edit may be bypassed only if the two procedures are performed on contralateral joints.

• When it is necessary to perform skeletal/joint manipulation under anesthesia to assess range of motion, reduce a fracture or for any other purpose during another procedure in an anatomically related area, the corresponding manipulation is not separately reportable.
Case Study #8 – Arthroscopic Rotator Cuff Repair

<table>
<thead>
<tr>
<th>PROCEDURES</th>
<th>2012 PROCEDURE CODES</th>
<th>2013 PROCEDURE CODES</th>
<th>DIAGNOSIS CODES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthroscopy, shoulder; with rotator cuff repair</td>
<td>29827</td>
<td>29827</td>
<td>727.61</td>
</tr>
<tr>
<td>Arthroscopy, shoulder; distal claviclectomy</td>
<td>29824</td>
<td>29824</td>
<td>726.10</td>
</tr>
<tr>
<td>Arthroscopy, shoulder; debridement. limited (29822) vs. extensive (29823)</td>
<td>29822/29823</td>
<td>29822/29823</td>
<td>715.31 726.13</td>
</tr>
<tr>
<td>Diagnostic arthroscopy of shoulder (Bundled)</td>
<td>29805</td>
<td>29805</td>
<td></td>
</tr>
<tr>
<td>Manipulation of shoulder under anesthesia (Bundled)</td>
<td>23700</td>
<td>23700</td>
<td></td>
</tr>
</tbody>
</table>

**CASE NOTES:** 29827 is the primary procedure. Neither 29824 nor 29823 is bundled into 29827; however, 29823 is bundled into 29824 per CCI — and therefore must be dropped with this new instruction. Previously, it might have been reported separately with modifier -59 when performed in distinct part of shoulder.

Case Study #9 – Arthroscopic Debridement & Labral Repair

**PREOPERATIVE DIAGNOSIS:** Femoroacetabular impingement.  
**POSTOPERATIVE DIAGNOSIS:** Femoroacetabular impingement.  719.85

**OPERATIONS PERFORMED**
1. Left hip arthroscopic debridement.
2. Left hip arthroscopic femoral neck osteoplasty.
3. Left hip arthroscopic labral repair.

**ANESTHESIA:** General.

**OPERATION IN DETAIL:** The patient was taken to the operating room, where he underwent general anesthetic. His bilateral lower extremities were placed under traction on the Hana table. His right leg was placed first. The traction post was left line, and the left leg was placed in traction. Sterile skin cleansing and alcohol prep and drape were then undertaken.
Case Study #9 – Arthroscopic Debridement & Labral Repair

A fluoroscopic localization was undertaken. Gentle traction was applied. Narrow arthrographic effect was obtained. Following this, the portal was made under the fluoro visualization, and then, a direct anterolateral portal made and a femoral neck portal made under direct visualization. The diagnostic arthroscopy showed the articular surface to be intact with a moderate anterior lip articular cartilage delamination injury that propagated into the acetabulum.

For this reason, the acetabular articular cartilage was taken down and stabilized. This necessitated takedown of the anterior lip of the acetabulum and subsequent acetabular osteoplasty debridement with associated labral repair. The labrum was repaired using absorbable [brand] anchors with a sliding SMC knot. After stabilization of the labrum and the acetabulum, the ligamentum teres was assessed and noted to be stable.

The remnant articular surface of the femoral head and acetabulum was stable. The posterior leg was stable. The traction was left half off, and the anterolateral aspect of the head and neck junction was identified. A stable femoral neck decompression was accomplished starting laterally and proceeding anteriorly. This terminated with the hip coming out of traction and indeterminable flexion. A combination of burrs and shavers was utilized to perform a stable femoral neck osteoplasty decompression. The decompression was completed with thorough irrigation of the hip.

The cannula was removed, and the portals were closed using interrupted nylon. The patient was placed into a sterile bandage and anesthetized intraarticularly with 10 mL of [medication] and subcutaneously with 20 mL of [medication] and at this point was taken to the recovery room. He tolerated the procedure very well with no signs of complications.
Nervous System

- The group of nervous system codes most applicable to general orthopaedic surgery are the neuroplasty procedures, which describe decompression.
- Specific codes (63000s) exist for decompression of spinal nerves.
- Additional code groups which may be utilized include:
  - Excision of neuromas or neurofibromas -- codes 64774 - 64792.
  - Neurorrhaphy, suturing of a nerve -- codes 64831 – 64876.

Case Study #10 – Tenosynovectomy & Corticosteroid Injections

PREOPERATIVE DIAGNOSES
1. EMG-proven left carpal tunnel syndrome.
2. Tenosynovitis of the left third and fourth fingers at the A1 and A2 pulley level.

POSTOPERATIVE DIAGNOSES
1. EMG-proven left carpal tunnel syndrome.
2. Tenosynovitis of the left third and fourth fingers at the A1 and A2 pulley level.

PROCEDURE: Left carpal tunnel release with flexor tenosynovectomy; steroid injections of trigger fingers, left third and fourth fingers.

ANESTHESIA: Local plus IV sedation (MAC).
ESTIMATED BLOOD LOSS: Zero.
SPECIMENS: None.
DRAINS: None.
Case Study #10 – Tenosynovectomy & Corticosteroid Injections

PROCEDURE DETAIL: Patient brought to the operating room. After induction of IV sedation the left hand was anesthetized suitable for carpal tunnel release; 10 cc of (anesthetic) was injected in the distal forearm and proximal palm suitable for carpal tunnel surgery. Routine prep and drape was employed. Arm was exsanguinated by means of elevation of Esmarch elastic tourniquet and tourniquet inflated to 250 mmHg pressure. Hand was positioned palm up in the lead hand-holder.

A short curvilinear incision about the base of the thenar eminence was made. Skin was sharply incised. Sharp dissection was carried down to the transverse carpal ligament and this was carefully incised longitudinally along its ulnar margin. Care was taken to divide the entire length of the transverse retinaculum including its distal insertion into deep palmar fascia in the midpalm.

Proximally the antebrachial fascia was released for a distance of 2-3 cm proximal to the wrist crease to insure complete decompression of the median nerve. Retinacular flap was retracted radially to expose the contents of the carpal canal. Median nerve was identified, seen to be locally compressed with moderate erythema and mild narrowing. Locally adherent tenosynovium was present and this was carefully dissected free. Additional tenosynovium was dissected from the flexor tendons, individually stripping and peeling each tendon in sequential order so as to debulk the contents of the carpal canal. Epineurotomy and partial epineurectomy were carried out on the nerve in the area of mild constriction to relieve local external scarring of the epineurium. When this was complete retinacular flap was laid loosely in place over the contents of the carpal canal and skin only was closed with interrupted 5-0 nylon horizontal mattress sutures.
Case Study #10 – Tenosynovectomy & Corticosteroid Injections

A syringe with 2 cc of (corticosteroid) and 2 cc of 1% (anesthetic) using a 25 gauge short needle was then selected; 1 cc of this mixture was injected into the third finger A1 and A2 pulley tendon sheaths using standard trigger finger injection technique; 1 cc was injected into the fourth finger A1 and A2 pulley tendon sheaths using standard tendon sheath injection.

Routine postoperative hand dressing with well-padded, well-molded volar plaster splint and lightly compressive Ace wrap was applied. Tourniquet was deflated. Good vascular color and capillary refill were seen to return to the tips of all digits. Patient discharged to the ambulatory recovery area and from there discharged home.

Radiology

- Professional and technical components
- Component coding
- Code order in Diagnostic Radiology
- Specialized subcategories of X-ray
- Documenting radiology services
- ASC Packaging / Rates
Diagnostic Coding Issues

- Annual code changes are effective Oct. 1st.
- ICD-9-CM is published as a three-volume set
  - Volume 1 -- Tabular List of Diseases
  - Volume 2 -- Alphabetic Index
  - Volume 3 -- Procedures
- There are sixteen basic guidelines for physicians and outpatient services.
- ICD-9-CM Changes for FY 2013 -- **NONE**
ICD-10-CM

On January 16, 2009, the Department of Health and Human Services (HHS) published a Final Rule for the adoption of ICD-10-CM and ICD-10-PCS, with a compliance date of **October 1, 2013 (now 2014)**.

Under the electronic health transaction standards final rule, also issued on January 16, 2009, covered entities must comply with Version 5010 (for some health care transactions) and Version D.0 (pharmacy transactions) on **January 1, 2012 (extended to July 1)**.


However, the codes in ICD-10 are not currently valid for any purpose or use in the United States.

ICD-10-CM

- ICD-10 is the international standard to report and monitor diseases and mortality, with U.S. implementation scheduled for October 2013.
- ICD-10-CM reflects advances in medicine and medical terminology.
- ICD-10-CM provides codes to allow comparison of mortality and morbidity data.
- ICD-10 provides better data for:
  - Measuring care furnished to patients;
  - Designing payment systems;
  - Processing claims;
  - Making clinical decisions;
  - Tracking public health;
  - Identifying fraud and abuse; and
  - Conducting research.
ICD-9-CM vs. ICD-10-CM

• Some codes do have direct translations from ICD-9-CM to ICD-10-CM.
• Some ICD-10 diagnosis codes combine multiple presentations or facets of a condition into a single code – such as incorporating underlying cause, concurrent condition, or complication as a subclassification – which in ICD-9-CM requires 2 or more codes.
• For some categories, terms may be defined in different ways, or whole chapters are organized along a different axis of classification, such that the mapping is only only a series of approximations or possible compromises.
• There are cases where ICD-9 contains more detail than ICD-10, where a clinical concept or axis of classification is no longer deemed essential information.
• ICD-9 may also contain more detail than ICD-10 when ICD-9-CM captured information on issues relating to procedures, which ICD-10 does not consider an appropriate element of the diagnosis code.

Sample Code Comparisons

And many of the ICD-10 categories offer a much greater degree of specificity / granularity than is possible with ICD-9, such as more precise anatomic site, laterality, and/or episode of care.

<table>
<thead>
<tr>
<th>ICD-9-CM</th>
<th>ICD-10-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>727.xx Other disorders of</td>
<td>ICD-10 has <strong>565 codes</strong> for disorders of synovium, tendons, and bursa which includes:</td>
</tr>
<tr>
<td>synovium, tendon &amp; bursa</td>
<td>• Synovium and tendons are a separate code range from bursa</td>
</tr>
<tr>
<td>ICD-9-CM 4th digit choices:</td>
<td>• Specific anatomic sites, including laterality</td>
</tr>
<tr>
<td>.0 synovitis and tenosynovitis</td>
<td>• Abscess vs. other infective</td>
</tr>
<tr>
<td>[8]</td>
<td>• Type of tendon affected (flexor, extensor, other)</td>
</tr>
<tr>
<td>.1 bunion</td>
<td>• Transient vs. chronic</td>
</tr>
<tr>
<td>.2 specific bursitides,</td>
<td>• Greatly expanded</td>
</tr>
<tr>
<td>occupational</td>
<td>• For example, there are 16 distinct codes just for trigger finger – which is a single code (727.03) in ICD-9.</td>
</tr>
<tr>
<td>.3 other bursitis</td>
<td></td>
</tr>
<tr>
<td>.4 ganglion and cyst [5]</td>
<td></td>
</tr>
<tr>
<td>.5 rupture of synovium [3]</td>
<td></td>
</tr>
<tr>
<td>.6 nontraumatic rupture of</td>
<td></td>
</tr>
<tr>
<td>tendon [10]</td>
<td></td>
</tr>
<tr>
<td>.8 other [4]</td>
<td></td>
</tr>
<tr>
<td>.9 unspecified</td>
<td></td>
</tr>
<tr>
<td>For a total of <strong>34 codes</strong>.</td>
<td></td>
</tr>
</tbody>
</table>
Coding and Documentation Improvement

• With complete information in the record, coders can effectively analyze, code, and report necessary information for claims and for quality measures
  • Physician review / sign all facility documentation
  • Make sure key elements are captured – query when needed
  • Specificity of diagnosis documentation, including documentation for POA indicators

• Without such documentation, the application of all coding guidelines is a difficult, if not impossible, task – and accuracy of reimbursement is affected

Coding and Documentation Improvement

• Health care is increasingly data driven
• Cross functional skill sets support evolving activities
• Enhanced roles of HIM and Coding Department staff in quality of information
• Education and open communication are key
• Work Smart
Questions?

THANK YOU ALL FOR PARTICIPATING!

Presented by: Sheila Sylvan
Hosted by: DePuy Synthes

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