# CODING EDUCATION CORNER (2016-01)

## Orthopaedics

**Welcome back to a NEW YEAR of our monthly coding newsletter that is designed** to keep the physicians and/or staff up to date on the ever changing world of coding. While this letter may not cover everything, we will touch on at least one topic each month for coding, denials, and clinic review. **This month we will focus on documentation needed for ICD-10, use for finger modifiers, and clinic review.**

## ***Documentation need for ICD-10***

I'm touching on osteoarthritis and fracture documentation that is needed for proper coding of ICD-10. I know we have reviewed this in the past, but I haven't seen a dramatic improvement. Some cases are going out unspecified OA and we need to avoid this if at all possible.

When coding for ***Osteoarthritis*** we will need the following to be documented within the OP note in order to code and process for billing within a timely manner…

- Nature of Osteoarthritis (**Primary, Secondary, post-traumatic**)
- Laterality (**Left, Right, Bilateral**)
- Anatomical Location (**Hip, Knee, CMC, etc**.)

Using this process will ensure appropriate and specified diagnosis selection.

When coding for ***fractures*** we will need the following to be documented within the OP note in order to code and process for billing within a timely manner…

- Anatomic locations (**Distal, shaft, proximal, Condylar, etc.)**
- Laterality (**Left, Right, Bilateral**)
- Anatomical Location (**Hip, Knee, CMC, etc**.)
- **Displaced, Non-displaced**
- **How many parts**
- **Gustilo** Classification if applicable.

Using this process will ensure appropriate and specified diagnosis selection.

## ***Denials***

There was multiple denials for anatomical modifiers and there usage for the fingers

| **Left Hand:** | **Right Hand:** |
|---|---|
| • Thumb – FA | Thumb – F5 |
| • Index finger – F1 | Index finger – F6 |
| • Middle finger – F2 | Middle finger – F7 |
| • Ring finger – F4 | Ring finger – F8 |
| • Small finger – F5 | Small finger – F9 |

# *Clinical review*

**Chief Complaint: Follow-up:**

The medical record must clearly reflect the chief complaint. Do not use the term "Follow-up or F/U" without expanding upon the reason for the follow-up.

**E/M based on Time:**

An evaluation and management (E/M) service is *only based on time when* counseling and/or coordination of care dominates (more than 50 percent) of the physician/patient and/or family encounter.

***Sample verbiage***:

"Of my 30 minute visit, 20 minutes were spent in discussion of the importance of complying with her diet and exercise regimen."

In review of the above, if the information needed for ICD-10 and proper attestation is not in the OP note, we will place the case on hold for coding and send back to the physician for needed information. Once the needed information has been changed/added to the OP note, we will then proceed with coding and billing of your case. While we realize this will hold up billing of your case, we must have the proper documentation in our OP note in order to be in compliance with our guidelines. Together, I know we all will make this a huge success and easy transition.

**Independent review of imaging:**

If you ordered a diagnostic test and did not bill the professional component independent visualization is a component of Medical Decision Making. When a provider 'independently reviews an image, tracing or specimen,' the documentation must clearly indicate you personally performed the service and your specific findings.

The direct visualization and independent interpretation of an image, tracing, or specimen previously or subsequently interpreted by another physician should be documented. The documentation must clearly reflect the provider 'independently' reviewed the image, tracing, or specimen.

# *Edits*

**Modifier 50:**

When performing a bilateral injection procedure, modifiers RT and LT are not needed. Bill only 20610 with a 50 modifier.

**Modifier 59 with fluro:**

When billing 76000 (fluro), modifier 59 should not be used on this procedures as of 1/2015.

**PA billing for injections:**

When the attending is billing for the visit and the PA is billing for the injections, the documentation should reflect as such. There have been occasions where the documentation read as though the attending is performing both the visit and the injection. Please be mindful to document only the portion of the visit and/or injection that each is performing.

**Compliance modifiers:**

The Compliance modifier needs to reflect the billing provider, not the service provider; e.g., if the PA provides the service or most of it and the attending is billing for the service, mod-WP1 should not be used; it should be FR1

**References:**

AAOS
CPT
ICD-10 coding book

**Shelia K. Harper, CPC**
Medical coding specialist
Orthopaedics
(919) 668-2019

**Melissa Pulliam, CPC**
Medial Coder II
Orthopaedics
(919) 620-4697

**Erika Blackston, MBA**
Revenue Manager
Department of Orthopaedics
(919) 620-3292

**Sheila Kopic, JD, MHA, CPC, CEMC**
Medial Coder II
Edit & Denials
(919) 620-5083