CODING EDUCATION CORNER (2016-04)

Orthopaedics

Welcome 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 coding for Haglund's deformity.**

Haglund's Deformity

Haglund's deformity is defined as retrocalcaneus bursitis concurrent to Achilles tendonitis with a bony growth at the back of the heel.

28120

- Partial excision bone; talus or calcaneus
- In 28120 the periosteum is reflected and the infected portion of bone is removed and irrigated. 28120 is for infected bone.

28118

- Ostectomy, calcaneus
- In 28118 the bursa and tendons are dissected to the insertion point of the Achilles tendon. The periosteum of the calcaneus is incised and resected.

CPT Assistant Guidance

- According to the May 2011CPT assistant Volume 21 Issue 5, states *If a Haglund's deformity of the heel and retrocalcaneal bursa were removed, then code 28118, Ostectomy, calcaneus, should be reported.*

Edits

- ***Linkage of DX***
  - Anatomic DX needs to be linked to anatomical procedure
    - i.e. Knee DX needs to be linked to Knee procedures
    - Hip DX needs to be linked to Hip procedure, etc.
- ***Casting codes need laterality modifiers***
  - Casting requires RT, LT, or 50 modifier
- ***Modifiers needed for the following injection codes***
  - 20550
  - 20610
  - 20611
  - 64483

- 64493
  - All need to be specific if RT, LT or 50
  - If separate structures are being injected & multiple injection codes we need to be specific on the 2nd injection by using modifier XS for separate structure or XU for overlapping
    - **REMINDER**: We cannot bill 2 injections to the same structure
      - Shoulder i.e. anterior and posterior
      - Knee
      - Hip, etc

Clinical review

Prolonged Service-Outpatient Visits

Doctor/APP

-CPT 99354 / 99355 -Prolonged time, outpatient, requires (face-to-face) contact-Doctor/APP.

- **Prolonged Time** is 30 or more minutes beyond the typical time that is associated with the E/M visit of medical necessary services.
  - Medicare does not allow resident's time to be used for prolonged time.
  - Time spent performing separately billable services may not be included in the total time for prolonged services.

Clinical Staff

CPT 99415 / 99416 -Prolonged time, outpatient, requires (face-to-face) contact-Clinical Staff with direct supervision by Doctor/APP.

- **Prolonged Time** is 45 or more minutes beyond the typical time that is associated with the E/M visit of medical necessary services.
  - -Medicare does not allow resident's time to be used for prolonged time.
  - -Time spent performing separately billable services may not be included in the total time for prolonged services.

Prolonged time codes are add-on codes. They are billed in addition to the E/M code.

Documentation requirements to bill Prolonged Time

Document ***Start and Stop*** time (outpatient)
Document in enough detail to justify the duration and medical necessity of the prolonged time

Prolonged time can be due to many reasons, when it is due to **counseling**
"I spent > 50% of the total time counseling the patient. Start time-Stop Time, ____total time spent (minutes),summary of prolonged time"

Charge capture

Provider will select both the E/M (LOS) and prolonged time code (The LOS field shows the typical time for the E/M)

References:

CPT Assistant, May 2011
AAOS News Now

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