CODING EDUCATION CORNER (2016-02)

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 documentation needed for ICD-10 and the use of modifier 22 and the requirements.**

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. I know this is a repeat from last month, but we are starting to receive denials for the use of a more specific diagnosis code.

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

Use of modifier 22 and the requirements

Modifier 22 is defined as

- Increased Procedural Services
- Work required to perform a service is substantially greater than what is usually required
- Documentation must support the substantial additional work and the reason for the additional work

Documentation requirements

- **Description** of the extenuating circumstances encountered during the procedure that required additional work beyond the usual procedure
- **Increased Intensity** - Extent of work performed. Additional not-separately reportable services that are required to treat patient. Multiple attempts or multiple approaches.
- **Technical Difficulty** - Details of the nature of patient's condition. Identified complications or unexpected findings that made procedure complex. Necessary equipment used to provide service.
- **Severity** - Need for procedure. Pre-existing conditions and additional diagnosis identified during procedure. Management of co-morbid conditions
- **Time** - Amount of time beyond what is normally expected for the procedure performed. Can be documented as a percentage or as actual work time. Refers to intra-operative time spent addressing extenuating circumstances
- **Physical and Mental Effort Required** - Specific skills needed to achieve desired results or complete procedure. Extra work due to morbid obesity or other unusual anatomic anomalies

Documentation requirements when using 22 for BMI

- AHA Coding Clinic, Q2, 2010 further supports this, which confirms that the BMI may be recorded by non-physician clinicians, like nurses or dieticians; but it cannot be reported unless also documented by the physician and associated with a related condition, such as overweight or obesity. Therefore, unless the physician makes a comment on the significance of the BMI, it cannot be coded. Work required to perform a service is substantially greater than what is usually required
- Stating a BMI of 50 as the reason for a 22 modifier is not supporting documentation. There is no other explanation within the body of the op note to substantiate the increased work the physician had to do, there is not increased "time" to perform the procedure due to BMI of 50; no reason in the body of the note to explain why this shoulder was so much more difficult, no scar tissue, no excess muscle that had to be opened - something else has to be documented.

Denials

Coding for Flat Foot

When coding Dx-M21.4- for Flat Foot (Pes Planus) **MOST** payers do not cover this condition *especially Medicare*. Either do not code this as a primary Dx code or either have the Patient sign a waiver for non covered service for OV.

Clinical review

Injection visits

If an office visit leads to the decision to do an injection, an office visit is billed with the injection administration and the appropriate drug. 25 modifier is added to the office visit.

Example

99213 – 25
20610 – RT/LT
Med (Synvisc, Kenalog, etc)

For injection only appointments and series of injections, an office visit should not be billed.

Example

20610 – RT/LT
Med (Synvisc, Kenalog, etc)

If an injection only visit(s), becomes more detailed and circumstances warrant a full exam and all components of a traditional office visit(s) happened, then an office visit can be billed. Thoroughly document the details of the visit.

Office visits and the use of the 25 modifier has continued to be an area of focus for the OIG.

References:

22 Modifier presentation given by QA group
ICD-10 coding book
Guidance for Use of Modifier 22, Increased Procedural Services. URMC Compliance Office

Shelia K. Harper, CPC Medical coding specialist
Melissa Pulliam, CPC Medial Coder II
Erika Blackstone, MBA Revenue Manager

Orthopaedics
(919) 668-2019

Orthopaedics
(919) 620-4697

Department of Orthopaedics
(919) 620-3292

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