Baptist Health Medical Group
BAPTIST HEALTH SOUTH FLORIDA

The Physician Edition

BHMG Physician Practice Coding Education Team

March, 2020

ORTHOPEDIC DOCUMENTATION

Orthopedic Coding Questions?
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Orthopedic documentation supports more than just Evaluation and Management (E&M) services, as other opportunities of treatment are performed during a patient's encounter. The goal is to document all pertinent cognitive labor of services provided, by you, the billable healthcare provider! There are several areas within the encounter that requires detailed information to support the provider's cognitive labor.

Documentation for Minor Procedures

Documentation of minor procedures require several elements that support the medical necessity and clinical aspects of the services rendered:

- **Reason for the procedure (to support medical necessity).**
- **Specific anatomical site (i.e. joint, tendon sheath, muscle, etc.)**
- **Technique**
- **Risk and benefits (based on co-morbidities of the patient)**
- **Details of the procedure**
- **Outcome of the procedure**

Documentation Example:

Due to the severity of the pain caused by the patient's osteoarthritis, the decision was made to proceed with bilateral knee joint injections. After alcohol prep on each knee, taking lateral approach, posterior to the patella, a 25-gauge, 3.5-onch needle was advanced into each knee joint. Five mL of 0.25% Marcaine with 20mg of Kenalog was injected into each knee. There were no complications and the patient tolerated the procedure well.

E&M Services with Injection

Over time the effects of an injection often fades and the pain returns, which may require another injection in a series. If the patient returns for another injection as part of a series, standard of care, or treatment plan, do not report a separate evaluation and management (E/M) service. Even if three months pass between the injections, do not report an E/M service if there is no significant patient work-up.

Before you report both an injection and E/M service appended with modifier 25, answer the following questions:

- Is this a new injury/problem?
- Is this an exacerbation of a previous injury/problem?
- Is this an unanticipated change in the condition?
- Is there a change in the treatment plan?

For example, if pain returns but a new work-up to assess the pain is not performed, the E/M service may not be warranted.

Per AAOS, if a patient returns to the office in three months requiring no imaging or additional assessment, the repeat injection does not warrant a separate E/M service. If new imaging studies are

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performed with additional assessment, therefore, a separate E/M service appended with modifier 25 may be warranted.

E&M Visits – Decision for Surgery

The decision for surgery modifier (57) is appended to an E&M visit that is performed **the day of or the day before the surgery.** The CMS definition of a global package is:

The global surgical package, also called global surgery, includes all the necessary services normally furnished by a surgeon before, during, and after a procedure. Medicare payment for a surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty.

Any E&M visit that is performed the day of the surgery, outside of the original decision for surgery visit, **is not billable**. This additional E&M visit is included in the global package.

Modifier 54 and 55- Surgical Care Only and Post-Op Management

Where physicians agree on the transfer of care during the global period, services will be distinguished by the use of the appropriate modifier:

- Surgical care only ***(modifier 54)***
- Post-operative management only ***(modifier 55)***

The physician must use the same CPT code for global surgery services billed with modifiers "-54" or "-55." The same date of service and surgical procedure code should be reported for the surgical care only and post-operative care only.

- Modifier -54 indicates that the surgeon is relinquishing all or part of the post-operative care to a physician
- The physician, other than the surgeon, who furnishes post-operative management services, bills with modifier -55.

Guidelines for Modifier 55- Post-Op Management

- Use modifier "-55" with the CPT procedure code for global periods of 10- or 90-days.
- Report the date of surgery as the date of service and indicate the date that care was relinquished or assumed.
- The receiving physician must provide at least one service before billing for any part of the post-operative care.
- This modifier is not appropriate for assistant-at-surgery services.

CMS Changes to E&M Documentation for CY2021

BIG CHANGES COMING SOON……

CMS is changing the face of E&M documentation in 2021, with a focus on Medical Decision Making and Time being the main factor for coding. The new CMS changes are only affecting the office New and Established patient E&M codes.

These changes include:

- Changes to history and examination documentation/requirements
- the deletion of 99201 E&M code
- changes to RVUs and payments
- code selection based on Medical Decision Making or Time
- Time frame for office E&M codes have changed
- Changes to the Table of Risk
- Accrediting a diagnostic test in your overall decision making versus billing for the performance of a diagnostic test.

The goal is to document a quality note based on the relevant services performed.

Stay tuned for the Coding Education team's upcoming educational opportunities that will focus on these changes that will affect the healthcare industry.