Academy of Professional Coders
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Dear Subscriber,

Medicare has made it clear that HCPCS code **G0289, created in 2003 to allow payment for a knee arthroscopic procedure and a chondroplasty on the same day, same surgical session, has to be performed in a different knee compartment – and the 15-minute time previously mentioned was *not* intended to be a documentation requirement** (*OCPS* 4/03).

In a turnaround, Congress passed a landmark Medicare reform/prescription drug bill Nov. 25 that expands Medicare benefits and puts into place a 1.5% increase for physician pay in 2004, overriding the 4.5% cut originally slated for next year. President Bush has said he will sign it into law.

Overall, the actual CMS payment multiplier (conversion factor or CF) was set to drop from last year's $36.52 to $35.1339. With passage of the Medicare prescription bill, the CF will increase to around $37.37.

"We took some pretty big hits this year," says Robert Haralson, M.D. and member of Chicago-based American Academy of Orthopedic Surgeons' (AAOS) CPT and ICD-9 coding committee. The 1.5% increase should help, boosting what would have been a 5% cut originally slated for orthopedic surgeons.

Code 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) is an add-on code created "to permit appropriate reporting of arthro-

(See Fee schedule, pg. 7)

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Next Issue: Inter-office consults; Bankart code controversy; and more news from the fee sked and Medicare Reform legislation.

HCPCS 2004

Kyphoplasty codes will make reporting easier

Good news – next year, you finally get two new HCPCS codes for kyphoplasty **S2363** (kyphoplasty, first vertebrae) and **S2362** (kyphoplasty, each additional) to code these bone fractures (*OCPS* 11/03). There's never been a HCPCS or a CPT code for these procedures. Up till now, you've had to settle for unlisted code **22899** (unlisted spinal procedure), which is always a hassle since you have to drop the claim to paper.

The new kyphoplasty codes are among the 2004 HCPCS codes that ortho practices will have to use, effective January 1, 2004 (see box for other codes, pg. 4), but payments have yet to be published. "We just got a new spinal surgeon and look forward to using these kyphoplasty

codes," says Wilson Ivey, coding/reimbursement specialist for Alabama Orthopaedic Specialists, Birmingham, Ala. "The 2004 codes will have greater specificity so there will be easier record-keeping," says coder Jann Lienhard in Maple Shade, N.J.

OIG eyes diagnostic services, incident to and CCI modifiers

Diagnostic tests, 'incident to' services, durable medical equipment (DME) and inpatient rehab payments are just some of the areas you should bone up on in your documentation in 2004.

Last month (*OCPS* 11/03), we told you how the Health and Human Services' Office of Inspector General (OIG) will be targeting consults, evaluation and management (E/M) services and use of modifier **-25** and **-59**. This month, we bring you other areas in the OIG's hot list in 2004 that may affect your ortho office (http://oig.hhs.gov/publications/workplan.html):

- **Medical necessity of diagnostic tests:** The IG is looking closely at medical necessity of diagnostic tests, such as nerve conduction studies, performed by physicians. Medicare-allowed amounts for nerve conduction studies increased from $136 million in 2000 to $186 million in 2001 – approximately 37%. The OIG wants to determine the cost of any medically unnecessary and incorrectly paid nerve conduction studies. If you are using handheld devices for these sorts of tests, make sure you are following the rules from the Dec. 31, 2002 *Federal Register* for **G0255**, which states Medicare will not pay for code G0255 because of "insufficient scientific or clinical evidence to consider the use of this device as reasonable and necessary."

- **Incident to:** Take a good look at the way you bill 'incident-to' services and supplies. Let's say a patient comes in for a cast change because he got his cast wet. A cast technician changes it. "Bill it under the physician's number, and the physician must be in the office at the time the service was rendered," says Joan Gilhooly, president, Medical Business Resources, Deer Park, Ill. Also, make sure you are following the rules as stated in *Medicare Carriers Manual,* Section 2050, about following a treatment plan – the physician needs to see the patient and establish a treatment plan. Then, remember, even if there is a treatment plan for cast change and the cast tech is following that plan, the physician must be available in the office.

- **CMNs:** Make sure the certificates of medical necessity (CMN) for DME your physician is ordering are completely filled out and that your documentation supports that the item(s)

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are reasonable and medically necessary as well as. For example, for wheelchairs, you must evaluate the patient before you fill out and sign the CMN form (*OCPS* 10/03). This means you can't sign CMNs without the appropriate documentation in the patient's medical records.

- **National Correct Coding Initiative (CCI) modifiers**: The OIG wants to determine whether claims were paid appropriately when modifiers were used to bypass National Correct Coding Initiative (CCI) edits, which amounted to $565 million in claims in 2002.

Spinal coding: Append modifier -59 as you add levels to 22614

When performing a laminectomy (**22614**) and adding levels, you might want to consider appending the **-59** modifier for each additional level. Why? Chris Galeziewski, a senior coder for Houston-based Kelsey-Seybold says, his office has better success getting these sorts of claims paid right on the first try by adding modifier -59.

"When you are adding to each level, you can use the units box on the CMS form to indicate how many levels you did. But we have found our payers often overlook the units box," he explains. "Then we don't get paid right, have to appeal it and wait and wait for the issue to be cleared up before seeing any of our money."

When he tried applying a –59 for each additional level he found smoother sailing and oftentimes doesn't even have to submit the operative report. And, he adds, payers don't seem to mind: "We have been getting 80% return on contracts (of those contracts the office has, 80% of payers do not feel there are billing problems that need to be addressed). The payers are not questioning how we are billing for these," Galeziewski says.

Another tip for spinal procedural coding comes from consultant Peggy Pugh, Coding Concepts in Steubenville, Ohio. When doing posterior and anterior procedures on the same day, she advises coders to have two separate operative reports: one for posterior and one for anterior spinal.

And, Pugh adds, just follow along with the tools you already have: Crosscheck CPT with your National Correct Coding Initiative (CCI) edits, the *American Academy of Orthopedic Surgeons Global Data Services Book* and the North American Spinal Society's coding manual.

Here are some other tips from Pugh to keep in mind regarding anesthesia during spinal procedures:

- Don't unbundle local anesthesia necessary to perform a spinal puncture (eg, **62311** or **64450**). It's included in the puncture procedure itself, so don't separately code the anesthesia. In addition, it's not appropriate to use nerve block or facet block codes for local anesthesia with diagnostic or therapeutic lumbar punctures "when there is no independent medical necessity of the administration of local anesthetic except for the lumbar puncture," say the CCI guidelines. Also, "…if, in the course of a nerve or other anesthetic block procedure, cerebrospinal fluid is withdrawn, it is inappropriate to bill for a diagnostic lumbar puncture; only the nerve (or other) block should be reported," say the CCI guidelines.
- Make sure you know that codes such as injection codes **62310-62319** are bundled into codes describing more invasive back procedures. That's "because procedures necessary to accomplish a more comprehensive procedure are included in the comprehensive procedure," the CCI guidelines explain. *Editor's Note: For more on spinal coding, see the Reader Q&A on page 8.)*

Added 2004 Ortho HCPCS codes			
J2001	Lidocaine Injection (J2000 has been deleted)	**A6444**	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to 5 inches, per yard
L0112	Cranial cervical orthosis	**A6445**	Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard
L0861	Halo repl liner injection	**A6446**	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard
L1831	Knee orth pos locking joint	**A6447**	Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard
L3031	Foot lamin/prepreg composite	**A6448**	Light compression bandage, elastic, knitted/woven, width less than three inches, per yard
L3917	Prefab metacarpl fx orthosis	**A6449**	Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard
S2113	Athro chondrocyte implant	**A6450**	Light compression bandage, elastic, knitted/woven, width greater than or equal to five inches, per yard
S2135	Neurolysis interspace foot	**A6451**	Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard
S2362	Kyphoplasty, first vertebra	**A6452**	High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches, per yard
S2363	Kyphoplasty, each addl	**A6453**	Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard
A6441	Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard	**A6454**	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard
A6442	Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard	**A6455**	Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard
A6443	Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard	**A6453**	Self-adherent bandage, elastic, non-knitted/non-woven, width less than three inches, per yard
		A6456	Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard

Purchasing Hyalgon or Synvisc from Canada? Buyer Beware!

If your office is like so many others *OCPS* has spoken to, you might be considering purchasing your patients' drugs from Canada since drugs purchased in Canada are often less expensive than their U.S. counterparts.

Even though you may be getting reimbursed for them by private payers – or even Medicare – that doesn't mean it's right. It is illegal per U.S. Food and Drug Administration (FDA) law, not CMS, according to various attorneys *Coder's Pink Sheet* spoke to.

"The FDA has jurisdiction over this issue, not Medicare," says attorney Lester Perling, a partner with Broad and Cassel law firm in Fort Lauderdale, Fla. This is where the confusion lies.

One Michigan reader says her office is getting paid by Medicare for Hyalgon and Synvisc drugs her office buys from Canada (see box below). Medicare doesn't know where the Michigan practice bought the meds, but the FDA is cracking down on such things.

Perling explains: "FDA approvals are manufacturer-specific. If a drug is bought in Canada, then it has not been FDA-approved for use in the U.S. All shipment of drugs will run afoul of the Food and Drug Act. There's also the issue of drug re-importation. For example, the drug is manufactured in the U.S., then sold in Canada, but sold back in the U.S., this could also get you in hot water." CMS officials claim that charging Medicare for a drug bought from Canada could put your office in danger of breaking the False Claims Act.

Caution: If you think that it's okay to purchase drugs from Canada for personal use, be wary. First, if you're purchasing them for a patient, that's not personal use. Second, while the FDA has long tolerated people buying drugs from Canada for personal use, in November the agency persuaded a federal judge to shut down Rx Depot and Rx Canada, which sold Canadian-bought drugs to American visitors to Canada.

Should you get an ABN for Hyalgon and Synvisc injections?

Q: I know of offices who make their patient sign the advance beneficiary notice (ABN) when getting a Hyalgon or Synvisc injection. The ABN states that Medicare may not consider the injections medically necessary. This practice uses the **-GA** modifier and collects the purchase amount of the drug up front from the patient. If, and when, the money from Medicare comes, the patient gets reimbursed. Is this OK?

~A Michigan reader

A: Since Medicare has recognized Hyalgon and Synvisc as covered services in some cases, obtaining an ABN could be appropriate if the physician is unsure if the patient's given medical condition will meet the medical necessity guidelines. Even if a physician knows that a Medicare carrier will deny a claim, Medicare rules still require the physician to submit a claim. These claims should be submitted with the -GA modifier to indicate that an ABN was obtained. Remember that, in general, Medicare carriers cover this type of intra-articular joint injection treatments, but guidelines and documentation vary state by state. Most private insurers pay for it, but sometimes you need pre-authorization. Use code **20610** arthrocentesis and/or injection of a major joint or bursa, plus use modifier **-RT/-LT** to indicate bilateral injections especially if the diagnoses are different (eg, both knees were injected). Use HCPCS code(s) **J7317** (sodium hyaluronate, per 20 to 25 mg dose) for intra-articular injection or **J7320** (Hylan G-F 20, 16 mg) intra-articular injection, whichever is being used. If bilateral injections are given, then you will need to report either the appropriate units or -RT/-LT again depending on carrier.

~ Tina Ommaya, manager of strategic policy services, Covance Health Economics and Outcomes Services of Gaithersburg, Md.

How would you code this tendon sheath procedure?

Test your coding skills with the example below, then check to see if your coding matches up with the codes picked by fellow coder Ruby O'Brochta-Woodward of Twin Cities Orthopedics in Minneapolis.

Preoperative Diagnosis: Left fifth finger flexor tendon rupture with extension contracture.
Postoperative diagnosis: Left fifth finger digitorum pollicis tendon rupture with extension contracture.

Title of Operation:

1. Left fifth finger digitorum superficials and flexor digitorum pollicis tenolysis from the palm through the extent of the fifth digit.
2. Left fifth flexor digitorum pollicis reconstruction.

Description of Operation:

The patient was brought to the OR and placed on the operating table in supine position. General anesthesia was induced without incident. A non-sterile tourniquet was placed over the proximal left upper extremity. The left upper extremity was then prepped and draped in the usual sterile fashion. The left upper extremity was exsanguinated and the tourniquet raised to 250 mmHg. A Brunner's approach to the left fifth digit and palm was made using a #15 blade through the skin. Subcutaneous dissection was carried out using Littler scissors. The flexor apparatus was exposed along the midline. The distal end of the FDP tendon was noted to be retracted proximally to the A2 pulley level with significant scarring to the surrounding tissues. A tenolysis of the FDP tendon was then performed after release of the distal stump from its adhesions. The FDS tendon was also then tenolysed along its length from the distal palm up into the digit. With gentle traction, the excursion of the tendon was restored out of the distal phalanx. The FDP tendon was then threaded through the A2 and A4 pulleys to restore mechanical advantage. The distal tendon stump was secured using a 2-0 Prolene sliding suture. The distal attachment at the site was prepared at the volar base of the distal phalanx using a small curet to create a periosteal window. Two Keith needles were then passed from the periosteal window out through the dorsal nail plate. The tacking tendon ends were then threaded through the Keith needles and advanced through to the dorsal nail plate. The tacking tendon ends were then threaded through the Keith needles and advanced to the dorsal aspect of the digit. The insertion site was reinforced using interrupted 3-0 ethibond sutures. The tourniquet was taken down after 50 minutes. Strict hemostasis was obtained. The wound was irrigated with copius amounts of sterile irrigation. The wound was closed using an interrupted 4-0 nylon simple suture, while maintaining tension at the distal FDP stump. After the volar incision was closed completely, the finger was flexed and the existing 2-0 Prolene sutures tied over a button on the dorsal tip of the digit. The wounds were cleaned and dressed sterilely with a soft compression dressing. The left hand and wrist were placed in a dorsal blocking splint in a flexed position. The patient received a preoperative dose of IV antibiotics. The patient tolerated the procedure well without complications. He was extubated and transferred to recovery in stable condition.

And the answer is …

Brochta-Woodward says the correct codes to use are as follows:
26442 x2 (palm and finger, each tendon) and **26370** (repair or advancement of profundus tendon, with intact superficials tendon; primary, each tendon). While some coders may think of using **26373** (secondary without free graft, each tendon) instead of code 26370, consider that 26373 is for secondary procedures and nowhere in the op note does it say this is a secondary procedure.

Also, this note appears to describe more of a primary repair/advancement procedures with the wording of "with gentle traction." Normally when doing a secondary procedure the surgeon has documented trying to locate the tendon that has recoiled back to its attachment.

Fee schedule . . . cont'd from pg 1

scopic procedures performed in different compartments of the same knee during the same operative session," CMS states in the 2004 Medicare fee schedule, Nov. 7, 2003, *Federal Register*.

"We noted that this code is to be used when a procedure is performed in the lateral, medial, or patellar compartments in addition to the main procedure," CMS adds. Additionally, code G0289 should not be reported if the reason for performing the procedure is due to a problem caused by the arthroscopic procedure itself.

Jump-Start on Ortho Coding & Billing Changes for 2004: Mark your calendar for **Tues., Dec. 9th** for a 90-minute audio seminar, led by ortho-pro Margie Vaught, CPC, ACS-OR, that will bring you up to date on changes from the fee schedule… CPT 2004… CCI edits… OIG's "hit list" for orthos and more. Plus, open Q&A session lets you ask Margie questions on any coding or billing change that's troubling you! See the enclosed flyer for more information or to register, call our conference department toll-free at: 800-260-1545. Or go online to www.decisionhealth.com/conferences/A349/ *(Pre-approved for 1.5 CEUs from AAPC)*

CMS is comparing G0289 to **29874**, **29877** and **29870**, the base procedure for this family of codes. All told, G0289 has been assigned 2.36 relative value units (RVUs) in 2004, which would translate into a payment of $88.21 (Medicare, par, unadjusted for geographic locality) with the 1.5% pay increase. This takes into account that codes 29874 and 29877 would fall under the multiple endoscopy reimbursement, but code G0289 has this already figured in so further reductions should not take place.

CMS also reiterates that the oft-repeated policy that G0289 is reported only when the physician spends and documents, at least 15 minutes in the additional compartment performing the procedure is only a guide – not a requirement.

"This reference to time was intended as a guideline to ensure that this add-on code is used only when the procedure performed is a substantive procedure needed to produce a significant improvement in the patient's condition," CMS explains in the fee schedule. "Documentation supporting this should be reflected in the operative note."

The 15-minute directive surfaced in a CMS program memo A-02-129 related to the outpatient prospective payment system (OPPS) that stated that the code should only be reported if the physician spends 15 minutes in the additional compartment performing the procedure, which many interpreted as a requirement (*OCPS* 4/03). (See the full text of the memo at http://www.cms.hhs.gov/manuals/pm_trans/A02129.pdf)

"A lot of hospitals have contacted physicians and said we are not going to bill for this unless you can give us 15 minutes," explains orthopedic coding consultant Margie S. Vaught,

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CPC, CCS-P, MCS-P, Ellensburg, Wash. "If the operative note did not say it, a lot of hospitals did not bill for that secondary procedure. The *Federal Register* says the 15 minutes should never have been a requirement in documentation."

She urges practices that have received claims denials related to the 15-minute requirement to "go back and re-bill." Vaught says, however, to urge your orthopedic surgeon to be specific in documentation of the secondary procedure to avoid payment hassles. For example, Vaught urges orthopedists to include wording in the documentation for the additional procedure such as "attention is now directed to the lateral compartment, which revealed a Grade X (1-3) chondromalacia. This defect was then debrided, shaved, smooth, etc."

She adds: "(Physicians) need to support the actual work performed and not just say 'chondroplasty performed in lateral compartment'. They need to say what they did, how they did it to support the code."

Reader's Q/A: How to bill for spinal codes

Q: Do you have to bill procedure code **22845** with either code(s) **22548-22558, 22808-22812** as the primary codes, or can you bill it in conjunction with primary codes **63081**, **63075** and **63015**. They were all done at the same surgical setting.

~ A coder from Wichita, Kan.

A: Codes 22845-22848 are instrumentation codes and in the spinal instrumentation guidelines in the CPT manual it states: "Insertion of spinal instrumentation is reported separately and in addition to arthrodesis. Instrumentation procedure codes **22840-22848**, **22851** are reported in addition to the definitive procedure(s), without modifier -51. Do not append modifier '-62' to spinal instrumentation codes 22840-22848 and 22850-22852."

~ Margie Vaught, a consultant in Ellensburg, Wash.

Orthopedic Coder's Pink Sheet Briefs

- Other news from the 2004 Medicare fee schedule expected to affect your orthopedics practice includes an idea being floated by CMS to limit who can perform outpatient therapy services performed 'incident-to' a physician to PTs, OTs, PT assistants, OT assistants. The agency didn't technically propose a rule change; it just solicited comments. The comments rolled in – a wide variety, the agency says – but no decisions have been made yet.
- Good news for your patients regarding therapy caps. **Beginning Jan. 1, 2004 the annual cap for occupational therapy and physical therapy will be set at $1,640** each, a 3.1% increase over the $1,590 cap for the last four months in 2003. (Full text at www.cms.hhs.gov/manuals/pm_trans/R30CP.pdf) The increases in the caps are tied to changes in the Medicare Economic Index (MEI).

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