Coding, Documentation, and Compliance Update for Outpatient Orthopaedic Surgery

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Serve as outside faculty for educational programs funded by DePuy Mitek, DePuy Orthopaedics, and DePuy Spine.

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PHYSICIAN AND OUTPATIENT FACILITY PROCEDURAL CODING (CPT-4) ISSUES
Procedural Coding Concepts

- HCPCS Coding Family
- Symbols of CPT
- CPT Surgical Package
- Bundling Issues:
  - CPT Definitions
  - The Correct Coding Initiative (CCI)
  - Private Software
  - Multiple Procedures
  - Surgical Package Concepts
  - Groupers / APC Packaging

Case Scenario

A question was posed whether an outpatient hospital or ASC would receive separate payment for a combination of procedures and, if so, whether that payment would be at a reduced amount.

This question is not as "simple" as it originally appeared.
Case Scenario – Issues to Consider

- Some procedure codes are paid separately at full rate.
- Some are subject to the multiple procedure payment reduction.
- Some are ancillary or packaged into other services, either always, or in combination only with specific other codes.
- Some services are clearly not separately reimbursed, based upon the CPT code definitions and/or notes.
- It may vary for open surgery vs. arthroscopic procedures.
- Hospital outpatient rules may differ from ASC.
- It will almost certainly vary by payor type / contract (as already discussed).

Integumentary System

- Fracture Debridement
- Wound Repair
  1. Severity of wound / complexity of repair:
     - Simple Repair
     - Intermediate Repair
     - Complex Repair
  2. Anatomic site of wound
  3. Size of wound
- Implants
2011 CPT Orthopaedic Updates

- Spinal allografts – revised to include morphogenetic bone protein
- Spinal fusion – new all-inclusive codes for anterior cervical arthrodesis
- Language revisions:
  - I&D of soft tissue abscess
  - Application of halo
  - Vertebral fractures
  - Pelvis and hip bone excisions
- Arthroscopy
- Category III codes


CPT Musculoskeletal System -- General

- Wound Exploration
- Injections
  - Tendon sheath or origin/insertion (each)
  - Trigger point(s) - # muscles
  - Arthrocentesis - size of joint
- Application of Fixation Systems
- Grafts or Implants
- Other Procedures
Case Study #1 – Removal of External Fixation Device

PRE-OP DIAGNOSIS: Left distal radius fracture.  
POST-OP DIAGNOSIS: Same.  
PROCEDURE PERFORMED: Removal of external fixator as well as two radial styloid pins, left wrist.  
SURGEON: Dr. X  
ASSISTANT: None.  
ANESTHESIA: Monitored anesthesia care.  
TOURNIQUET TIME: No tourniquet.  
COMPLICATIONS: None.  
DRAINS: None.

OPERATIVE REPORT: The patient was taken to the operating room and after the induction of adequate IV analgesia, the left upper extremity was prepped with Betadine. The small external fixator frame was removed from the four pins. This was followed by removal of the pins using the small AO external fixator set wrench. This was then followed by removal of the two radial styloid pins.

Once this was done, the wounds were irrigated and sterile dressings were applied, the patient tolerated the procedure well and went to the recovery room in stable condition.
Musculoskeletal System
Standard Subheadings Within Each Body Region

- Incision
- Excision
- Introduction or Removal
- Repair, Revision, and/or Reconstruction
- Fracture and Dislocation
- Manipulation
- Arthrodesis
- Amputation
- Other Procedures

Repair, Revision, and/or Reconstruction

- Repair of:
  - Single tendon, multiple tendons, or each tendon
  - Primary vs. secondary
  - May specify through same incision
- Codes may reflect repair, transfer, advancement, lengthening or shortening, or release of a specified muscle, tendon, or ligament
- Some services may be reported separately
- Grafts
- Arthroplasty
Examples:

27650  Repair, primary, open or percutaneous, ruptured Achilles tendon;
27652  with graft (includes obtaining graft)
27654  Repair, secondary, Achilles tendon, with or without graft

27685  Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)
27686  multiple tendons (through same incision) each

(Source: CPT Professional 2011, pg. 134)

Example of Cumulative Descriptors

25000  Incision, extensor tendon sheath, wrist
25001  Incision, flexor tendon sheath, wrist
25020  Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment, without debridement of nonviable muscle and/or nerve
25023  with debridement of nonviable muscle and/or nerve
25024  Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment, without debridement of nonviable muscle and/or nerve
25025  with debridement of nonviable muscle and/or nerve

(Source: CPT Professional 2011, pg. 116)
Example -- Variations on a Theme

29290 Correction, hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (eg, Silver type procedure)
28292 Keller, McBride, or Mayo type procedure
28293 resection of joint with implant
28294 with tendon transplants (eg, Joplin type procedure)
28296 with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedure)
28297 Lapidus-type procedure
28298 by phalanx osteotomy
28299 by double osteotomy

(Source: CPT Professional 2011, pp. 139-141)

Case Study #2 – ACL Reconstruction with Tendon Graft

Preoperative Diagnosis: ACL deficient left knee 844.2 / 717.83
Postoperative Diagnosis: Same
Surgeon: Dr. X Asst: Dr. Y
Procedure: Left ACL reconstruction using patellar tendon graft
Surgery time: Approximately 103 minutes
Anesthesia: Epidural

Operative Report: The patient was taken to the operating room and after the induction of adequate epidural analgesia, the left lower extremity was prepped and draped in the usual sterile fashion. An Esmarch was used to exsanguinate the limb and the tourniquet was inflated to 300 mm. Mercury.
Case Study #2 –
ACL Reconstruction with Tendon Graft

At this point in time, a 5-6 cm incision was made over the patellar tendon in the midline, taken down through the skin and subcutaneous tissues until the peritenon was identified. The peritenon was split longitudinally thus exposing the patellar tendon. After this was done, the central third of the patellar tendon along with bone plugs from both the inferior pole of the patella and the proximal tibia were harvested without difficulty. The graft was then placed on another table and prepared for implantation into the knee. Visual inspection of the medial and lateral compartments showed no significant meniscal pathology. There were no chondral lesions wither on the tibia plateau of the femoral condyles, however, there was evidence of a disruption of the ACL. The PCL looked intact and normal in configuration.

Case Study #2 –
ACL Reconstruction with Tendon Graft

At this point in time, a shave was introduced into the joint. The remnants of the ACL as well as part of the fat pat were debrided. This was then followed by a notchplasty that was done using a combination of a burr and the (Brand) wand. Once adequate notchplasty was performed, the (Brand) tibial guide was placed into the joint and a tibial tunnel was drilled in the appropriate fashion. This was then followed by placement of the over the top (Brand) tibial guide followed by drilling of a femoral tunnel. Both tunnels were deemed to be in adequate position arthroscopically. Once this was done, the graft was then drawn from the tibial tunnel into the femoral tunnel under direct guidance and secured in the femoral tunnel with a 7 x 25 interference screw as well as 7 x 20 screw in the tibial tunnel.
**Case Study #2 –
ACL Reconstruction with Tendon Graft**

The knee was put through a range of motion. There is no evidence of the graft impinging in flexion or extension, the wound was thoroughly irrigated and then the patellar tendon was closed in layers initially with the tendon and peritenon followed by Vicryl on the subcutaneous tissues. This was followed by instillation of Plain Marcaine into the joint as well as placement of a Hemovac drain. The initial arthroscopic portals were closed as well and went to the Recovery Room in a stable condition.

**Notes:** Code 20924 is defined as “tendon graft, from a distance”; the tendon graft is not documented as obtained through a separate incision, so it is not separately reported.

Operative report does not specify new vs. old injury. However, as current surgical repair, the acute injury code 844.2 may be reported even if initial injury was some time earlier.

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**Case Study #3 –
Multiple Digit Capsular Release, Hand**

**PREOPERATIVE DIAGNOSIS:** Contractures right hand including MP and IP joints.

**POSTOPERATIVE DIAGNOSIS:** Contractures right hand including MP and IP joints. 727.81

**INDICATIONS FOR PROCEDURE:** The patient is a pleasant 41-year-old female with a severe crush injury to the right hand. She now has extension contractures of the MP and IP joints of the right hand as well as retained hardware in the small finger. She has had a recent rotational osteotomy of the small finger.

The patient is taken to the OR today for dorsal capsular release of the MP and PIP joints as well as extensor tenolysis and removal of hardware of the small finger.
Case Study #3 –
Multiple Digit Capsular Release, Hand

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room, placed supine upon the operating table, after an adequate general anesthesia, her right upper extremity was prepped and draped in the standard surgical fashion. I exsanguinated the arm with (brand) dressing, inflated the tourniquet to 250 mm Hg.

I began with the small finger. I made a longitudinal incision over the dorsum of the small finger. I used the previous longitudinal incision that was used for the osteotomy. I incised sharply through the skin and dermis and identified the extensor mechanism. The extensor mechanism was split longitudinally down the middle, identified the MP joint and made a transverse incision over the MP joint capsule.

I identified the buried K-wires and these were both removed without difficulty. These were buried into the proximal phalanx. I then had to flex the MP joint, I was able to flex it to 100 degrees. An extensor split was continued to the proximal interphalangeal joint, and the level of the proximal interphalangeal joint I performed a dorsal capsulotomy. I left the central slip intact on the dorsum of the middle phalanx. I released the collateral ligament. I recessed the collateral ligament on both sides of the proximal interphalangeal joint and once this was accomplished I was able to flex the PIP joint to about 95 degrees. I copiously irrigated the incision, closed the extensor split with a running 4-0 suture, closed the small finger incision with a running nylon suture.
Case Study #3 –
Multiple Digit Capsular Release, Hand

I then turned my attention to the ring finger, where I made a longitudinal incision over the ring finger, incising sharply through skin and dermis, identified the extensor mechanism, split the extensor mechanism longitudinally. Over the MP joint I made a transverse incision through the capsule. I then manipulated the MP joint. I was able to obtain 100 degrees of flexion. I then identified the proximal interphalangeal joint, made a transverse capsulotomy over the PIP joint. I left the central slip intact. I recessed the collateral ligaments and then I was able to flex the PIP joint to approximately 95 degrees. I then copiously irrigated the incision. The extensor tendon was repaired with a running suture and the skin was repaired with interrupted nylon.

Case Study #3 –
Multiple Digit Capsular Release, Hand

The same procedure was repeated on the long finger and the index finger in the same fashion and again long finger MP joint flexion was to 100, PIP joint was to 95, index finger MP joint to 100, PIP joint was approximately to 95 and again simultaneous full flexion was not obtained. However, no intrinsic tightness was identified in any of the digits. They all had signs of extrinsic tightness.

When we were finished, a sterile dressing was applied followed by a dorsal splint to keep the wrist in the most extension it could be, which was approximately 10 degrees and to keep the fingers flexed. The patient tolerated the procedure well. There were no complications.
Case Study #3 –
Multiple Digit Capsular Release, Hand

PROCEDURES PERFORMED:

1. Capsulotomy, index finger, MP joint. 26520-F6
2. Capsulotomy, index finger, PIP joint. 26525-F6
3. Extensor tenolysis index finger. 26445-F6
4. Capsulotomy, long finger, MP joint. 26520-F7
5. Capsulotomy, long finger, PIP joint. 26525-F7
6. Extensor tenolysis long finger. 26445-F7
7. Capsulotomy, ring finger, MP joint. 26520-F8
8. Capsulotomy, ring finger, PIP joint. 26525-F8
9. Extensor tenolysis ring finger. 26445-F8
10. Capsulotomy, small finger, MP joint. 26520-F9
11. Capsulotomy, small finger, PIP joint. 26525-F9
12. Extensor tenolysis small finger. 26445-F9
13. Removal of hardware, small finger. 20680-F9 x2

A NOTE ON MODIFIERS:

• Level II modifiers clarify coding for digits on hands and feet -- reduces likelihood of denials for “duplicate” procedures. Alternative option is number of units.

• Operative note stated “recent” rotational osteotomy -- if within 90 days of either this osteotomy or initial treatment, modifiers -58, -78, and/or -79 may apply.
Fracture Care

- Closed treatment:
  1) without manipulation
  2) with manipulation
  3) with or without traction

- Open treatment

- Percutaneous skeletal fixation

- Manipulation

TRACTION DEVICES

- Skeletal traction
- Skin traction
- External fixation

(Source: CPT Professional 2011, pg. 88)

Case Study #4 – Open Reduction and Internal Fixation

DIAGNOSIS: Left distal radius fracture 813.42

TITLE OF OPERATION: Left distal radius open reduction and internal fixation and application of external fixator.

PROCEDURE IN DETAIL: After the patient was identified and after adequate anesthesia, he was positioned supine on the operating table. The left arm was placed on the arm table. It was prepped and draped in a sterile fashion. The arm was exsanguinated with an Esmarch bandage and then tourniquet was inflated to 250 mmHg. A volar approach was done, distal modified Henry approach. Care was taken to protect the superficial radial nerve and also the radial artery and its venae comitantes. The pronator quadratus was incised longitudinally and elevated off the bone. The fracture was identified, reduced, and the joint was also visualized.
Case Study #4 – Open Reduction and Internal Fixation

Once the fracture had been reduced, it was plated with a (brand) plate. Using AO technique, the plate was applied. The fracture was controlled in both AP and lateral planes using image intensifier. It was found to be well reduced, and the screws and the tips of the screws were not impinging any vital structures and were extra-articular.

After that was done, the wound was irrigated copiously with antibiotic normal saline solution. It was closed in layers using 2-0 Vicryl and 3-0 nylon. Next, an external fixator was placed dorsolaterally in order to provide additional stability. Dressings were applied without difficulty again using standard AO technique. The incision was closed with 3-0 nylon after it had been irrigated copiously. A dressing was applied and the patient was aroused from anesthesia without any complications.

Endoscopy / Arthroscopy

• Diagnostic arthroscopy is included in surgical arthroscopy.
• Some surgical arthroscopies are also bundled.
• G-code for knee arthroscopy:
  
  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

• Diagnostic arthroscopy followed by open treatment, report arthroscopy with modifier 51.
• If no arthroscopy code exists, do not report as open surgery -- use unlisted arthroscopy.
Case Study #5 –
Knee Arthroscopy with Meniscectomy

OPERATIVE REPORT

Preoperative diagnosis: Medial compartment arthritis with torn medial meniscus. 

Postoperative diagnosis: Same with torn lateral meniscus and synovitis.

Operation(s): Arthroscopy, partial medial meniscectomy, partial lateral meniscectomy, abrasion arthroplasty and synovectomy.

Description of procedure: After the administration of general anesthesia the patient’s knee was examined. There was a large effusion and a mild varus deformity, crepitus upon range of motion.

The knee was then prepped and draped in the normal fashion and secured to a leg holding device. Through a superior and medial stick an inflow cannula was inserted and 25 ccs of joint fluid were returned via the inflow cannula.

The arthroscope was introduced in the inferolateral portal and the arthroscopy was begun. The suprapatellar pouch area showed a lot of synovial hypertrophy. The undersurface of the patella showed mostly grade II changes of chondromalacia. The medial joint space was entered and one could immediately see there was a large degenerative tear of the medial meniscus and an area of bare bone 1.5cm in diameter on the tibia, and matching area of the medial femoral condyle.
Case Study #5 – Knee Arthroscopy with Meniscectomy

Small medial arthrotomy incision was made and a meniscal probe was introduced. The tear of the meniscus was then delineated. Then with a series of instruments, including a meniscus scissors, grasping forceps, biopsy forceps and motorized meniscal cutter, the entire torn portion of the meniscus was removed, leaving a well-balanced and stable rim.

Attention was then directed to the intercondylar notch area, where a lot of synovial hypertrophy was debrided with the motorized synovectomy tool. The lateral joint space was entered and the lateral meniscus was well visualized. There was a tear at the posterior horn region, which was quite soft, and this was removed with the motorized meniscus cutter.

The lateral joint space looked much better, the medial joint space with only a small area of grade I chondromalacia. Areas of synovitis were then debrided in the medial and lateral compartments and the undersurface of the patella was smoothed off. Following this with a small abrader, the area of the bare bone in the medial joint compartment was burred. The abrasion extended intracortically to a depth of about 1 mm until there was bare bleeding bone.

Following this the knee was irrigated and suctioned off. Sterile dressing was applied and the procedure was terminated. Patient tolerated the procedure well and was taken to the recovery room in good condition.
**Spinal Procedures**

- Arthrodesis – 22xxx
- Spinal Instrumentation – 2284x
- Decompression – 63xxx
  - Approach
  - Spinal Region
  - Number of Levels
- Spinal Injection Procedures
  - Type of injection
  - Location
  - Catheter placement
  - Fluoroscopic guidance

**Radiology**

- Professional and technical components
- Component coding
- Code order in Diagnostic Radiology
- Specialized subcategories of X-ray
- Documenting radiology services
- ASC Packaging / Rates
Diagnostic Coding Update

- Annual code changes are effective Oct. 1st.
- ICD-9-CM is published as a three-volume set
  - Volume 1 -- Tabular List of Diseases
  - Volume 2 -- Alphabetic Index
  - Volume 3 -- Procedures
- There are sixteen basic guidelines for physicians and outpatient services.
ICD-10-CM

On January 16, 2009, the Department of Health and Human Services (HHS) published a Final Rule for the adoption of ICD-10-CM and ICD-10-PCS, with a compliance date of October 1, 2013.

Under the electronic health transaction standards final rule, also issued on January 16, 2009, covered entities must comply with Version 5010 (for some health care transactions) and Version D.0 (pharmacy transactions) on January 1, 2012.


However, the codes in ICD-10 are not currently valid for any purpose or use in the United States.

Clinical Documentation

• The importance of consistent, complete, accurate, and timely documentation in the medical record cannot be overemphasized.

• With complete information in the record, coders can effectively analyze, code, and report necessary information for claims and for quality measures.

• Without such documentation, the application of all coding guidelines is a difficult, if not impossible, task – and accuracy of reimbursement is affected.
Questions

Q: We had an orthopedic tell us anytime he made an incision that it was a open reduction with internal fixation. Can you elaborate on the difference between open reduction internal fixation and closed reduction internal fixation?

A: Open reduction is used when the fractured bone is either: (1) surgically opened (exposed to the external environment) and the fracture (bone ends) visualized and internal fixation may be used; or (2) the fractured bone is opened remote from the fracture site in order to insert an intramedullary nail across the fracture site.

Percutaneous fixation describes fracture treatment which is neither open nor closed. In this procedure, the fracture fragments are not directly visualized, but fixation (eg, screws, pins) is placed across the fracture site, usually under imaging guidance.

So, either percutaneous fixation or open with internal fixation may involve some (perhaps small) incision and placement of device. A good example of percutaneous fixation is at the joint, and the femoral head or neck is a common site; a small incision may be made, but minimal to no bone exposure is performed, and pins/screws are placed across the condyle and into the femoral head. Diagrams displaying percutaneous fixation and open with internal fixation treatments of the femoral neck are found on page 128 in the 2011 CPT® Professional Edition.
Questions

Q: For CPT codes for facet injections, codes were changed to include fluoroscopy and limited levels reimbursed. CMS also cut the reimbursement for 2nd & 3rd levels which payers are then cutting again as a 50% and 25% multiple code reduction. Those codes would never be performed and reported on line one and have already been reduced. How can I prevent the multi code reduction from being taken?

A: Additional multiple procedure reductions are not appropriate for these services, as they are designated “add-on” codes per CPT (+ symbol), where reduction is already built in. Unfortunately, there is no modifier or other mechanism to easily identify this on a claim, and it may have to be addressed in appeal and/or communication with the Medical Director. This is a contractual issue with those payors, regarding how they address add-on codes. Review the plan’s policy manual, and your participation agreement, for language regarding add-on codes.

Questions

Q: I have a question re: the number of levels billed for facets and medial branch blocks. I’ve read conflicting information and the coders are looking at it differently than one of the PM&R physicians. A lot of the questions stem from the MDs documentation,

A: Facet joint injections are reported as single, second, and third or more (which is all the rest, not per each) for either cervical/thoracic or lumbosacral. These are unilateral by definition, so modifier -50 would apply for left and right at the same vertebral level,

For medial nerve branch blocks, the guidelines would be the same – medial branch nerves are small nerves which feed out from the facet joints; each facet joint is connected to two medial nerves. The facet injection codes (64490-64495) are defined as injections at the joint “or nerves innervating that joint” – so, conservatively, a medial branch block injection would be another name for the same procedure. It does appear to be related to the way each level is described in documentation, as these nerves are between the vertebral levels.
Questions

Q: 29879 abrasion chondroplasty you stated is bundled in same compartment. Did you mean 29877 or G0269?

A: Both codes were listed, as Medicare identifies G0269 for use in a different compartment; whereas some commercial plans do not cover G0269, but use 29877 (possibly requiring modifier -59) for chondroplasty is a separate compartment. In the case study, both codes are “crossed out”, indicating that they would not be reported separately in this instance, being in the same compartment as a more extensive procedure (meniscectomy).

Questions

Q: When performing 64483 can you also bill for 96372 and use modifier 59?

A: Yes, an intramuscular injection of other therapeutic substance may be reported additionally, so long as it is indeed distinct (eg, not local anesthetic at the site of the epidural). Individual payor bundling guidelines may be more strict, and sometimes will not accept modifier -59 to override an edit; however, these should be appealed as inappropriate when it is a distinct and separate procedure.
Questions

Q: When our Ortho physician does a surgery procedure, he uses the C-arm to run Fluoroscopy to obtain an accurate picture. He will dictate that in the operative report. Can we report and charge out the 76000 if it does not conflict with the surgical procedure?

A: Unless there is an identified bundling issue, imaging guidance could be separately reportable. Depending upon the specific images, a more specific radiology code may apply – either a “guidance for” code, or a specific image if the C-arm is used to obtain a single film rather than continuous imaging throughout the procedure. As with any x-ray, an interpretation report must be documented to support the procedure.

Questions

Q: In a repair of a shoulder that started arthroscopically then converted to a mini-open repair of the rotator cuff, can both open & arthroscopic CPT codes be reported together?

A: If the initial procedure began the surgical repair, and then converted to open, then only report the open surgery. If the initial arthroscopy was diagnostic only (possibly identifying that the repair could not reasonably be complete arthroscopically), then both may be reported, with modifier -51 and/or -59 on the diagnostic arthroscopy.
Thank You All for Participating!

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