



**Coding and Reimbursement Panel Discussion:  
Common E/M Coding Mistakes in Orthopaedics  
PAOS 2024**



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**Disclosures – Angie Van Utrecht, MHA**

- Financial compensation for Vodcasts with Veradigm Health



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**Most Common Coding Errors - Topics**

- Inaccurate Use Of Modifiers
- Appropriate Use of Unspecified ICD 10
- Lack of Documentation
- Coding for Multiple Procedures
- Lack of Understanding of Coding Guidelines



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### Inaccurate Use of Modifiers

- **Modifier 24**
  - Unrelated E/M Service by the Same Physician/Other Qualified Health Care Professional During a Postoperative Period
    - Diagnosis has to be distinctive if on the same appendage
- **Modifier 25**
  - Significant, Separately Identifiable E/M Service by the Same Qualified Health Care Professional on the Same Day of the Procedure or Other Service
    - E/M visit and patient given an injection that was not planned
- **Modifier 50**
  - Bilateral procedures
    - X-rays and injections are most common



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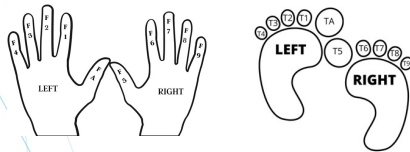
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### Inaccurate Use of Modifiers

- **Modifier 59**
  - Separate and distinct procedure – example two separate injections on in elbow one in knee
- **Laterality modifiers**
  - RT, LT, F9(Fingers), T9(Toes)



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### Appropriate Use of Unspecified ICD 10 Codes

- Unspecified ICD Codes - Indicate condition(s) unknown at the time of treatment
- If a definitive diagnosis has not been established by end of the visit – report ICD 10 codes for either signs or symptoms or both instead of a definitive diagnosis
- When enough clinical information isn't known or available about a health condition to assign a specific code, it is acceptable to report the appropriate unspecified code
- Documentation has to be solid if using an unspecified code
  - Payers will request medical records more so than not when using an unspecified code



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### Lack of Documentation

- Not documenting the drug/dosage amount
- Laterality not documented
- DME – missing proof of delivery and/or orders
- Consent for treatment/discussion regarding risks and benefits
  - Injections/procedures in office
- Payors now requesting medical records when using the modifier 25
  - Important to clearly document that this is a different diagnosis than previously seen for on the same body part



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### Coding for Multiple Procedures

- **Modifier 50**
  - Indicates a bilateral procedure: used frequently in xray and injections
- **Modifier 59**
  - Separate and distinct procedures
    - Knee injection with a shoulder injection
    - Office visit for fracture and casting done (modifier added to case codes)



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### Lack of Understanding of Coding Guidelines

- **LCD/NCD guidelines: Determine what diagnosis codes meet medical necessity for procedures**
  - **Local Coverage Determinations (LCD):** decisions that are applicable only within the issuing Medicare Administrative Contractors (MAC) jurisdiction
  - **National Coverage Determinations (NCD):** Binding on all MAC's

<https://www.cms.gov/medicare-coverage-database/downloads/downloads.aspx>
- **Global days for procedures**
  - **0-day post-operative period:** Extremely minor procedures i.e., ones that have no pre-op period and are not generally billable as a separate service.
  - **10-day postoperative period:** Similar to 0-day periods in those procedures that have this classification have no pre-op period and that the visit on the day of the procedure is not billable as a separate service.
  - **90-day postoperative period:** Classification for major Orthopedic surgery procedures that include pre-operative periods



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