presents...

Orthopedic Coding in ASCs

90-minute audio conference

June 11, 2008

2:00 p.m.–3:30 p.m. (Eastern)
1:00 p.m.–2:30 p.m. (Central)
12:00 p.m.–1:30 p.m. (Mountain)
11:00 a.m.–12:30 p.m. (Pacific)

SLIDE PREVIEW
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V-Codes

1. Use V-Codes for encounters for reasons other than injury or illness (i.e., patient history, family history, diagnostic tests, attention to devices, some symptoms, etc.).
2. Use for planned care or treatment of a patient with a condition that is resolving.
3. Use for the following situations:
   - Aftercare
   - Attention to
   - Admission/encounter for
   - Administration (prophylactic)
   - Contraception
   - Sterilization
   - Evaluation
   - Examination
   - Follow-up
   - Supervision

   • V45.4 for Arthrodesis Status
   • V58.61 for Long-Term use of Anti-Coagulants
   • V58.69 for Long-Term use of Other Medications
   • V54.01 for Encounter for Removal of Internal Fixation Device
   • V54.09 for Other Aftercare Involving Internal Fixation Device
   • V54.89 for Other Orthopedic Aftercare
   • V54.9 for Unspecified Orthopedic Aftercare
   • V64.43 for Arthroscopic Surgical Procedure Converted to an Open Procedure

E-Codes

1. Used to classify external causes, such as:
   • Environmental events
   • How an accident happened
2. Used on Workers’ Comp. claims
3. Do NOT use E-codes on Medicare claims
4. Do not use an E-code as a primary or the only diagnosis
5. Use E-codes in addition to codes identifying the trauma or condition
6. E-Codes may be located in the Alphabetic Index under the following terms:
   • Admission for
   • Complications of
   • Disease/disorder/condition
   • Observation
   • Status-Post
7. E-Codes beginning in the E929 section can be used for Late Effects of accidental injury, causing conditions which persist for a year or more after the original injury.

CPT codes are copyrighted by the AMA

Coding Neoplasms

1. Codes for Neoplasms are located in the Neoplasm Table in Volume I and are located according to site or anatomic location.
2. Begin location of a neoplasm code by looking up the name/diagnosis first in the Alphabetic Index.
3. If the diagnosis does not indicate whether the tumor is primary or secondary, code it as primary.
4. Unless the coding book indicates otherwise, assume the following are usually secondary (metastatic) sites: Bone, brain, meninges, peritoneum, pleura, spinal cord, and retroperitoneum.
5. Unless you know where the secondary sites are to which the Cancer has traveled, you cannot specifically code them. You can use the Neoplasm for the Primary Site as your first code and the 199.0 code (for Metastasis to Multiple Sites NEC) to cover all of the Secondary Sites.
6. **Wait until the path report comes back prior to coding the claim** for those surgery situations that look like a malignant process might be involved (i.e., a Breast tumor, patients with previous cancer who have a new growth, etc.), as the exact diagnosis is needed for correct coding of a neoplasm condition.
7. Terms for Neoplasms:
   - **Malignant** – Cells which spread/multiply with an invasive nature to other parts of the body
   - **Primary Site** – The area of the body or organ that was the original site of the neoplasm
   - **Secondary Site** – The area of the body or organ to which the tumor has metastasized or spread and implanted or grown. This can include local spread or direct extension and distant spread (metastasis)
   - **Ca. In Situ** – A pre-malignant condition where a tumor is undergoing malignant changes, but is still localized at the point of origin
   - **Benign** – Cells that grow, but are non-invasive in nature and do not spread to distant sites
   - **Uncertain Behavior** – Neoplasms which are changing in nature, and which is neither malignant nor benign at the time of diagnosis. It may undergo malignant changes/behaviors at a future time
   - **Unspecified Nature** – The diagnosis statement does not specify the behavior of the neoplasm as malignant or benign.
Diagnosis Coding for Foot Procedures

**Tenosynovitis**
Tenosynovitis is an inflammation of a tendon and its synovial sheath. These codes fall into the 727.0X section of the diagnosis coding book. It is also referred to as Tendosynovitis, Tenontothecitis, Tenontolemmitis, and Tendinous Synovitis.

**Bunions**
Bunions are coded as 727.1. This condition is a localized enlargement at the first metatarsal head caused by either malposition of the metatarsal or by overgrowth of the metatarsal. Bunions occurring on the medial aspect are associated with Hallux Valgus (where the Great Toe turns towards the Second Toe).

**Bursitis**
Bursitis is coded as 727.3, which is an inflammation of the fluid-filled sac which cushions bony prominences.

**Ganglions**
Ganglions and cysts of the synovium, tendon, and bursa are coded from the 727.4X section. These are thin-walled cystic lesions containing thick, clear, mucinous fluid. They usually occur on the hands and feet.

**Paget’s Disease**
Paget’s Disease (also called osteitis deformans) is coded as 731.0, which involves the slow and progressive enlargement/deformity of multiple bones and resorption of bone, which eventually become thick and dense.

**Osteochondropathies**
These disorders are coded from the 732.X category, and this condition primarily affects children from 3 to 10 years of age. The etiology of this disease is unknown.

**Flat Foot**
Flat Foot is coded 734 and is a condition where one or more of the arches of the foot have flattened. Acquired Pes Planus and Talipes Planus are included in this category. There are several kinds of flat foot, including congenital, rigid, and spastic flat foot. Congenital Flat Foot is coded 754.61.

**Other Foot Diagnoses**
- Hallux Valgus (Acquired) – code 735.0
- Hallux Varus (Acquired) – code 735.1
- Hallux Rigidus/Hallux Limitus – code 735.2
- Hallux Malleus – code 735.3
- Hammertoes (Acquired) – code 735.4
- Claw Toe (Acquired) – code 735.5
Implants/Devices

While not all Implants will be covered by Medicare, some Implants will be separately reimbursed when billed as a separate line item with a CPT or HCPCS code. However, for a few procedures, the related Implants will be reimbursed as part of the surgical CPT code itself. How this will work for some procedures is that Medicare will take into account the average/standard cost of an implant and build that cost into what they reimburse for the CPT code for the procedure. The Implants billed on those procedures should not be broken out for billing separately. This will primarily affect the specialty of Orthopedics and increases reimbursement in 2008 for many procedures from what they paid under the Medicare Grouper system in 2007.

Medicare coverage will vary from state to state, as CMS allows individual Medicare Carriers to use “carrier discretion” in coverage of implants.

Those procedures with high device costs where the cost of the device is equal to or exceeds 50% of the medical cost of the APC amount should be separately reimbursed under the new 2008 payment system. This is described in CMS’s Tables 63, 64 and 65. Some of these procedures include Spinal Cord Neurostimulator devices.

Unfortunately, some Implantable devices, such as stents and mesh, which were not covered under the previous Medicare Grouper system, are still not covered under Medicare’s new 2008 payment system.

Bill implants to payors other than Medicare unless your facility’s contract with the payor specifically prohibits it.

Commonly used codes for Orthopedic Implants include:

C1713 – Anchor/Screw
L8630 – Metacarpophalangeal Joint Implant
L8631 – Metacarpophalangeal Joint Replacement Implant
L8641 – Metatarsal Joint Implant
L8642 – Hallux Implant
L8699 or 99070 – Misc. Implants

Overnight Stays/23-hour Stays

Medicare considers 12 Midnight to be the defining measure of an overnight stay under the new payment system. This has still not been clarified by Medicare, and the ASC Assoc. continues to fight this issue vigorously. To be on the safe side, if it is KNOWN on the front-end that a Medicare patient will require an overnight stay, the case should be diverted to the hospital at the time of scheduling.
## FEE EXAMPLES FOR COMMON PROCEDURES

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>APC No.</th>
<th>Hospital APC Rate 2008</th>
<th>Proposed CY 2008 fully implemented payment</th>
<th>Proposed CY 2008 first transition year payment</th>
<th>Grouper Number</th>
<th>2007 Grouper Fee</th>
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<td>$510.00</td>
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<td>$630.00</td>
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</tbody>
</table>

### Procedure for Sequencing CPT Codes for surgical procedure(s) performed in Freestanding ASC Facilities on Medicare Claim Forms:

1. Review the OP Report(s) for the surgical case.
2. Code out the CPT procedure code(s) for all surgical procedures performed.
3. Look up each pertinent CPT procedure code(s) with all of the other pertinent CPT procedure code(s) in the CCI material to determine Unbundling for the case.
4. Determine if those procedures designated as “Separate Procedures” in the CPT book and those CPT codes which are Unbundled in the CCI material are billable using the -59 Modifier or they should not be billed. Arrive at the final CPT procedure code(s) that can be billed for the surgery(s) performed.
5. Look up each CPT code to be billed on the Medicare ASC List for the associated fee.
6. Sequence the CPT codes for billing from Highest to Lowest fee listed on the Medicare ASC List.
7. Remember, the –SG Modifier is not used on CPT codes billed on Medicare claims for dates of service in 2008.
8. Observe Medicare’s revised requirements for 2008 for the billing of Bilateral Procedures (i.e., don’t use the -50 Modifier). Details are discussed on p. 21-22.
9. Those CPT codes to be billed which are NOT listed on the Medicare ASC List are not covered by the Medicare program and should be billed using the –GY Not Covered Modifier.
CPT CODING of ORTHOPEDIC PROCEDURES

Coding Tips:

- CPT codes for procedures and surgeries need to be listed on the claim form in order of descending relative value (from highest to lowest Medicare reimbursement, Payment Groupings for other payors, or RVUs, depending on the facility’s contract with the payor). This helps the payors identify the primary procedure and prevents them from placing the procedures in a different order, which could result in lower reimbursement.

- In the CPT book, certain words and descriptions will make a substantial difference in reimbursement and your audit liability. The selection of the appropriate code for the situation is, of course, dependent on the medical record documentation supporting the higher paying code chosen.

  Similar words and phrases that can alter your reimbursement are as follows:

  - Closed vs. Open
  - Simple vs. Complicated
  - Benign vs. Malignant
  - Unilateral vs. Bilateral
  - Deep vs. Superficial
  - Excision vs. Destruction

  Each (for example, each digit)
  One or More Sessions
  Separate Procedure
  List/Charge in Addition To
  Charge or List Separately

Unlisted Procedure Codes

Sometimes, you have no alternative but to use an Unlisted procedure code, when an exact code cannot be found. When an Unlisted procedure code is used, the service or procedure should be described. In the CPT book, identifying words for these codes are “Unlisted” service or code and “Special Report”. Drop the claim to paper and submit the claim with medical record documentation (the OP Note) to justify the procedure performed and explain what was done. You might want to contact the Medicare Carrier or BC/BS to ask if they can recommend a code. Remember that for 2008, Medicare does not accept Unlisted Procedure Codes – if it is known on the front-end that the main procedure or only procedure to be performed involves the use of an Unlisted Procedure Code, it is best to divert it at the time of scheduling to another place of service.

Bilateral Procedures

If a surgical procedure is by (CPT) definition unilateral, and is performed bilaterally, the ASC should report the CPT code on the claim form in a bilateral manner. The policies each payor has for the use of modifiers for reporting bilateral procedures can vary widely, so the ASC facility should check with each payor to which they submit claims for their preferred method of billing Bilateral procedures. Modifier –50 identifies a procedure performed identically on the opposite side of the body (mirror image). Some payors prefer the use of the –RT Anatomic Modifier on one code and the –LT Modifier on the other. Don’t mix the use of –50 and –RT or –LT Modifiers on the same code. Be consistent in the method used for claims going to a particular payor. If the surgical code is by definition bilateral, the CPT procedure code is reported once (with no modifier),
even if the procedure is performed on both sides. If the procedure is often performed bilaterally, but is performed only unilaterally for a surgery, the usual fashion is to bill using an –RT or –LT Modifier on the CPT code.

The five usual methods for the billing of Bilateral procedures include:
1. Bill the same code as two line items, using the –RT Modifier on one code and the –LT Modifier on the other (same) code.
2. Bill the bilateral procedures as two line items with no Modifier on the 1st code and a –50 Modifier on the 2nd line item (same code).
3. Bill the procedure as a single line item on the claim form with a –50 Modifier on the procedure code. Be sure if you use this method to double the facility fee.
4. Bill the same code as two line items with no Modifiers. (**Medicare)
5. Bill the code as one line item with a “2” in the Units field of the claim and double the fee. (**Medicare)

***With the changes in the Medicare program for ASC billing for 2008, these last two methods (#4 and #5) are how Medicare is directing Bilateral procedures should be billed. If you experience denials for Bilateral procedures filing to Medicare with these methods, use method #1.

Multiple Procedures
Modifier –51, which designates multiple procedures, (other than Evaluation and Management services), is used for procedures which are rendered on the same date of service, at the same operative session, and commonly at the same surgical site by the same provider. When a procedure is performed with another appropriate or separately-identifiable procedure, the highest valued code is listed as the primary procedure and additional procedures are appended with the modifier –51. This modifier is for use on physician claims only. ASC’s should not use this modifier on their claims, unless the payor specifically requires its use.

Add-on Codes
For some multiple procedures, “Add-on” codes should be used, when required. “Add-on” codes are identified with a “+” notation. These can be seen in Pain Management claims for Injections done at subsequent levels. Do not list an Add-on code first on the claim form. List the code for the main procedure/first level procedure first, followed by the subsequent level Add-on codes.

Separate Procedures
Those procedures designated as “Separate Procedures” in the CPT book must be treated differently from other procedures. If these procedures are not coded and billed correctly, the facility can experience a denial from the payor similar to a CCI Unbundling denial – even if the codes are not Unbundled in the CCI Unbundling material. A “Separate Procedure”, by definition, is a component of a more complex service and is usually not identified separately. These services are typically an integral component of a more extensive service. When these services are performed alone, or not as part of a larger or more inclusive procedure, then the “separate procedure” should be reported. When the
“separate procedure” is carried out independently or distinctly from other procedures, it may be reported by itself or with the -59 modifier, in some instances (i.e., separate site or by a separate incision). The separate procedure designation indicates that a certain procedure or service may be:
- Performed independently;
- Unrelated or distinct from other procedure(s)/service(s) provided at that time; or
- Considered an integral component of another procedure/service.

Codes designated as Separate Procedures may be billable with the use of the –59 modifier, to indicate that the procedure is not considered a component of another procedure, but a distinct, independent procedure, such as a:
- Separate Compartment/Area;
- Different site or organ system;
- Separate incision/excision;
- Separate lesion; or
- Treatment of a separate injury (or area of injury in extensive injuries).

**Unbundling**

To define, Unbundling is the practice of breaking out each individual part of a procedure and billing for it separately. This is most frequently done with surgical procedures. **It is an unethical practice.** Unbundling is to be avoided, as it can flag an audit from a payor. The individual components, or incidental services of a surgical package, should not be coded when the primary procedure code includes these components. This is referred to as **Unbundling**.

To avoid Unbundling, check each procedure code to be billed with every other procedure code to be billed in the current CCI Unbundling material to see if any of them are components of another code. Pay close attention to code selection by coding with the most accurate and complete code available for use, using CPT guidelines. If there is a doubt, check with the physician as to what the main procedure is and what might be included.

In some (very few) cases, even though one code is Unbundled from another listed procedure, it can be billed anyway using a –59 Modifier (such as a 29877 Chondroplasty done in a separate compartment from an Arthroscopic Knee Meniscectomy procedure, as long as the OP Note is very specific about the description of the procedure occurring in a separate area/compartment). If the procedure was done in a separate area, by a separate incision, etc., it might be billable. Check the OP Note and the procedure book descriptions carefully, assess correct modifier usage, and contact the Medical Review or Coding department at the payor for guidance. This situation would not occur very often. Usually, if it is Unbundled, it is not billable.
Synovectomy vs. Debridement Procedures

Sometimes, it can be difficult to distinguish whether a Synovectomy or Debridement was performed (based on the documentation).

The AAOS directs that Debridement codes are billed when articular cartilage is debrided and Chondroplasty procedures are performed.

Synovectomy codes should be used when only soft tissue is removed, synovium is excised, or plica is excised.

The AAOS further clarifies that if Loose or Foreign Bodies are removed from the same compartment/area where a synovectomy or debridement is performed, the Loose or Foreign Body removal would not be separately billable. If the loose or foreign body removed is very large (over 5 mm.), and/or it is removed through a separate incision, it can be billed with the -59 Modifier, if it is Unbundled in the CCI material.

Orthopedic Procedures Added to Medicare ASC List
In 2008 Advantageous to Perform/Add

<table>
<thead>
<tr>
<th>CPT</th>
<th>MC Reimb.</th>
<th>Procedure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>20150</td>
<td>$1,779.62</td>
<td>Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision</td>
</tr>
<tr>
<td>20552</td>
<td>$22.14</td>
<td>Trigger Point Injection of 1-2 Muscles – Low reimbursement – we recommend performing as an Add-on Procedure only and not as the only procedure</td>
</tr>
<tr>
<td>20553</td>
<td>$24.87</td>
<td>Trigger Point Injection of 3 or more Muscles – Low reimbursement – we recommend performing as an Add-on Procedure only and not as the only procedure</td>
</tr>
<tr>
<td>20555</td>
<td>$1,208.50</td>
<td>Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure) – this is a new CPT code for 2008</td>
</tr>
<tr>
<td>20610</td>
<td>$34.41</td>
<td>Joint Injection of Shoulder, Hip, or Knee – Low reimbursement – we recommend performing as an Add-on Procedure only and not as the only procedure</td>
</tr>
<tr>
<td>24149</td>
<td>$1,208.50</td>
<td>Radical resection of capsule, soft tissue, and heterotopic bone, elbow, with contracture release (separate procedure)</td>
</tr>
<tr>
<td>CPT Code</td>
<td>Description</td>
<td>Price</td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>24152</td>
<td>Radical resection for tumor, radial head or neck</td>
<td>$1,179.62</td>
</tr>
<tr>
<td>24153</td>
<td>Radical resection for tumor, radial head or neck; with autograft (includes obtaining graft)</td>
<td>$3,288.25</td>
</tr>
<tr>
<td>24300</td>
<td>Manipulation, elbow, under anesthesia</td>
<td>$611.32</td>
</tr>
<tr>
<td>24343</td>
<td>Repair lateral collateral ligament, elbow, with local tissue</td>
<td>$1,208.50</td>
</tr>
<tr>
<td>24344</td>
<td>Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)</td>
<td>$3,288.25</td>
</tr>
<tr>
<td>24346</td>
<td>Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)</td>
<td>$1,779.62</td>
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<tr>
<td>24357</td>
<td>Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneous</td>
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<tr>
<td>24358</td>
<td>Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open</td>
<td>$1,208.50</td>
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<tr>
<td>24359</td>
<td>Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment</td>
<td>$1,208.50</td>
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<tr>
<td>25109</td>
<td>Excision of tendon, forearm and/or wrist, flexor or extensor, each</td>
<td>$880.55</td>
</tr>
<tr>
<td>25431</td>
<td>Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone</td>
<td>$1,089.28</td>
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<td>25651</td>
<td>Percutaneous skeletal fixation of ulnar styloid fracture</td>
<td>$1,083.02</td>
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<tr>
<td>25652</td>
<td>Open treatment of ulnar styloid fracture</td>
<td>$1,701.96</td>
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<tr>
<td>27416</td>
<td>Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])</td>
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<td>27440</td>
<td>Arthroplasty, knee, tibial plateau</td>
<td>$1,486.46</td>
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<td>27446</td>
<td>Partial Knee Replacement/Arthroplasty of the condyle and plateau; medial OR lateral compartment</td>
<td>$11,371.67</td>
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<td>27769</td>
<td>Open treatment of posterior malleolus fracture, includes internal fixation, when performed</td>
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<td>CPT Code</td>
<td>Price</td>
<td>Description</td>
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<td>29828</td>
<td>$1,892.32</td>
<td>Arthroscopic shoulder biceps tenodesis</td>
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<td>29866</td>
<td>$1,892.32</td>
<td>Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])</td>
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<td>$1,191.53</td>
<td>Ankle Arthroscopy, subtalar joint, with removal of loose body or foreign body</td>
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<td>$1,191.53</td>
<td>Ankle Arthroscopy, subtalar joint, with synovectomy</td>
</tr>
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<td>29906</td>
<td>$1,191.53</td>
<td>Ankle Arthroscopy, subtalar joint, with debridement</td>
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<tr>
<td>29907</td>
<td>$1,892.32</td>
<td>Ankle Arthroscopy, subtalar joint, with subtalar arthrodesis</td>
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RESOURCES

Ingenix’s 2008 ICD-9-CM for Hospitals, Vols. 1, 2, & 3 Coding Expert
Ingenix’s Coding Illustrated - Spine and Hip and Knee
Ingenix’s Coding and Payment Guide for Podiatry Services, 7th edition
Ingenix’s CPT Coder’s Desk Reference
Ingenix’s Medical Documentation
AMA CPT Assistant Newsletters
AMA’s CPT Companion
Southern Medical Association’s Coding-Beyond the Basics: Orthopaedics material by SMA Practice Management-div. of SMA Services, Inc., speaker Margi Clark, RRA, CCS, CPC, CCS-P
Conomikes MEDICARE Hotline
UCG Physician Practice Coder
UCG Coding Answer Book
UCG Part B News
CPT codes and AMA CPT Professional Edition are copyrighted by AMA
Healthcare Consultants of America Physician’s Fee & Coding Guide
UCG’s Part B Answer Book
UCG’s Pain Management Coding & Billing Answer Book
The American Society of Interventional Pain Physicians’ First Regional Interventional Pain Symposium Seminar Material
Healthcare Consultants of America, Inc.’s Part B Billing Guide
Ingenix’s Coding Companion for Orthopedics
Ingenix’s Coding & Reimbursement for Orthopedics Newsletter
Ingenix’s Complete Guide to Part B Billing and Compliance
PMIC’s Medicare Compliance Manual
The Medical Management Institute’s Medicare Rules & Regulations
The Medical Management Institute’s Coding and Medicare for Orthopedics
Healthcare Consultants of America, Inc.’s Health Care Fraud and Abuse
Global Success Corp., The Coding Institute’s Orthopedic Coding Alert Newsletters
Dorland’s Medical Dictionary
Orthopedic Coding Workshop material, sponsored by THIMA, Karen Scott Seminars
Coding & Reimbursement Update for Orthopaedic Surgery material, sponsored by The American Academy of Orthopaedic Surgeons, Karen Zupko & Assoc., Inc.
HMI’s CPT Coding Seminar Material
FASA published seminar material (specifically-referenced) and coding guidance
CIGNA Medicare Bulletins and LCDs
Lessons on Coding for ASCs FASA CPT Coding Seminar
AMA’s CPT 2008 Professional Edition
AAOS Bulletin Article “Accurately Code Shoulder Procedures” by Robert Haralson, III, MD, MBA, Richard Friedman, MD, & Margie Vaught, CPC, CCS-P, ASC-OR, MSC-P
AAOS Global Service Data for Orthopaedic Surgery, Volumes 1 & 2

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