Coding Basics and Guidelines for Musculoskeletal Office Evaluation and Management

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Abstract

» In documenting a patient encounter, the orthopaedic evaluation consists of 3 key components: "History," "Physical Examination," and "Medical Decision-Making."

» The level of service coded must be supported by the complexity of the problem, the care provided, and the documentation of the encounter.

» Determining whether the patient is new or established is the first step in the evaluation and management (E/M) process and relies on same-practice/same-specialty rules.

» Careful attention must be paid to documentation and coding to allow for appropriate care of the patient and efficient use of the orthopaedist's time. The available step-by-step guidelines include all necessary criteria to accomplish this.

» Continue to monitor for the U.S. Centers for Medicare & Medicaid Services (CMS) changes to stay up-to-date on changes in the guidelines.

In order to reduce the administrative burden of coding guidelines, the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Board and the U.S. Centers for Medicare & Medicaid Services (CMS) have proposed simplifications of the office evaluation and management (E/M) coding system to begin January 2021[1].

These changes will provide a welcomed respite for practicing orthopaedic surgeons in the U.S., but as with past proposals for programs such as the International Classification of Diseases, Tenth Revision (ICD-10) and their meaningful use, delays might occur.

This article addresses coding rules at the time of article submission and applicable up until the new guidelines come into effect. Future publications will focus on the 2021 changes and updated CPT and CMS coding guidelines.

Since the CMS Musculoskeletal Single Specialty Evaluation guidelines were published in 1997[2], clarifications, interpretations, and recommendations have evolved for coding guidance. CMS and CPT rules on coding often differ and are

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complex and subject to interpretation. The following guidelines and the included tables were previously summarized in an American Academy of Orthopaedic Surgeons *AAOS Now* article in 2007, and revised in 2010[3,4]. In the current article, we have expanded on that information to provide a review of current coding basics for any musculoskeletal care provider according to CPT rules. The goals are to assist with correct documentation and coding and minimize claim denials, delays, and potentially costly errors.

These guidelines and tables summarize and organize information from the 1997 CMS Musculoskeletal Single Specialty Evaluation, the AMA, and the AAOS[2,5,6]. Providers are encouraged to use the included tables for reference when documenting and coding. This is not an exhaustive reference on the broad and nuanced topic of E/M coding; instead, it provides a simple and reproducible system for correct coding and documentation for physicians and nonphysician providers (NPPs), such as physician assistants and nurse practitioners, who are the billing provider of record. What we describe for physicians as the billing provider can be applied to other NPPs as well.

We have referred to sources that were up-to-date at the time of submission. Guidelines for coding are evolving, and as new rules and interpretations expand our understanding, changes in documentation will be required. This information is for reference use only.

Medical Necessity and Its Routine Documentation

The patient encounter consists of the orthopaedic evaluation, documentation, and coding. The physician gathers subjective and objective data relevant to the patient's condition, formulates a plan, and then documents all key concepts. The level of service reported must be supported by the complexity of the problem, the care provided, and the documentation of the encounter.

With the conversion to electronic health records (EHRs) has come an increase in the prevalence of cloned notes and auto-populated examination records, and the concept of medical necessity has been a greater focus of auditors and payers. In general, a more complex physical examination with documentation of more "bullets" will contribute to a higher code. However, the orthopaedist cannot bill a Level-4 or 5 visit for a simple strain or contusion regardless of their documentation[7,8]. Similarly, the inclusion of a complete review of systems and review of family and social history is not typically medically necessary in an encounter with an established patient, unless that encounter includes a decision for surgery and is relevant to the presenting problem. Dot phrases or defaults generated by the EHR should be avoided. If the provider has a good reason for examining other body parts (other than comparisons of left and right extremities), the medical necessity will need to be explained in the "History" or "Medical Decision-Making" sections of the note[7].

The use of templates and carrying forward from past notes may simplify documentation of the orthopaedic evaluation. To avoid cloned notes, the physician should customize the template for each patient on the basis of the patient's current or interval history. Take care to avoid carrying forward non-pertinent information from past to current notes. Most payers will not accept documentation that appears to be carried over from prior visits or another patient's notes. Being a coding outlier puts you and your group at risk for an audit. It is uncommon for orthopaedists to have a New 99204 or an Established 99215 level of service. Interestingly, landing on the bell curve does not necessarily mean that visits are coded properly[9]. For further information on audits, CMS.gov has a tabulated recording of audits by sponsor, overall audit scores, and calculations as well as the number of audits by year. Readers are encouraged to familiarize themselves with the 2020 Audit Process Overview and proceedings of frequent sponsors[10,11].

Guidelines for E/M Coding

Orthopaedic Evaluation

As summarized previously[4] and updated here, the orthopaedic evaluation consists of 3 key components: "History," "Physical Examination," and "Medical Decision-Making (MDM)." Additional components that may contribute to the level of service are counseling/coordination of care, the nature of the presenting problem, and time[4,8].

History Component

The History component includes the chief complaint (CC); history of present illness (HPI); review of systems (ROS); and past, family, and social history (PFSH) sections.

A CC must be documented for every visit, and it is typically stated in the patient's own words. The HPI uses descriptive elements to document the current problem(s). For non-Medicare patients, the CC and HPI must be obtained and documented by the physician who is the billing provider. For Medicare patients, as of 2019, physicians need to document that they have reviewed the information and verified whether it was obtained by assisting staff or via a patient portal[12].

Information pertaining to the ROS and PFSH sections may be recorded in the EHR by assisting staff or by the patient via a patient portal. The physician must attest to reviewing this information and comment on pertinent positive and negative responses. During follow-up visits, any changes, or lack thereof, should be documented with a date reference (if not automated by the EHR). The physician should review and agree with the data before then signing off electronically after each encounter.

The ROS involves an inventory of 14 body systems, focusing on descriptive symptoms (e.g., chest pain or shortness of breath) rather than diseases (e.g., heart attack or COPD [chronic obstructive pulmonary disease]). To receive credit from a payer for each body system, there must be an individual entry of a positive or negative response documented within the record. Note that this is an area of

risk in an encounter with an established patient; you may not get credit from a payer for carrying forward ROS elements that are not pertinent to the presenting problem.

The PFSH involves a review of 3 areas: past, family, and social history. Pertinent positive or negative responses may be documented. Statements such as "noncontributory" without further description are not acceptable.

For new and established patients, a statement may be placed above your signature such as: "I, XXXX, MD, have personally obtained the history, reviewed the PFSH and ROS as noted, and performed the physical examination today. The patient and I discussed the assessment and options and developed the plan." This concise statement adequately declares that the billing provider has properly assessed all necessary components for complete documentation of the encounter. It also verifies that the physician acknowledges their role in reviewing this information for billing purposes. For established patients, the EHR will typically allow reference to the date of the prior PFSH and ROS. For example, "PFSH and ROS from 6/1/2019 reviewed today as noted; no changes required." This statement verifies that the physician has independently reviewed the patient's most recent medical information, again as is required for billing purposes.

Physical Examination Component

The second key component is the Physical Examination component. The 1997 Musculoskeletal Single Specialty Evaluation includes both general examination elements and 6 musculoskeletal areas (neck, back, right and left upper extremities, and right and left lower extremities)[2]. Each area that is examined should be described in the report. There are 5 specific examination components for each of the 6 musculoskeletal areas: (1) inspection/palpation (note malalignment, asymmetry, crepitation, osseous deformity, defects, tenderness, or masses or effusions), (2) range of motion (note pain, e.g., with straight leg-raising, crepitation or contracture, and active and passive limits), (3) stability (note laxity, subluxation/dislocation), (4) muscle strength and tone (documented on a scale from 0 of 5 [complete atony] to 5 of 5 [full strength]; note atrophy, abnormal movements, flaccid, cogwheel, spastic, etc.), and (5) skin (note scars, lacerations, ecchymosis, rashes, lesions, cafe-au-lait spots, ulcers, etc.)[2]. An examination of gait and station are also components of the musculoskeletal system assessment.

For a comprehensive examination, the following other systems must be assessed if medically necessary: constitutional (at least 3 of 7 vital signs and general appearance), cardiovascular (peripheral vascular examination, swelling varicosities, pulses, edema, etc.), lymphatic (nodes), and neurological/psychological (coordination, reflexes, sensation, orientation, and mood and affect)[2].

Medical Decision-Making Component

The MDM component consists of 3 parts: Data, Diagnosis, and Risk[2]. These indirectly measure the complexity of the patient encounter[5,7]. This component is considered more complex for patients undergoing multiple tests, with multiple diagnoses, and with multiple risk factors. The risk of treatment options as they pertain to the individual patient should be included here. In general, MDM is a metric of the work-up performed by the physician to develop a medical diagnosis, while medical necessity should then validate the complexity of the MDM[7,8]. This means that a healthy patient with a complex orthopaedic problem, such as a fracture/dislocation, may still be considered lower complexity for the MDM than a patient with a chronic disease, such as emphysema or diabetes mellitus, who only requires straightforward orthopaedic intervention.

Time

Occasionally, time may be a factor in determining the level of service. This may influence CPT code selection if the visit predominantly consists of counseling and/or care coordination. In this instance, greater than half (50%) of the time spent face-to-face between the physician and the patient (not including non-providers) in an outpatient setting must consist of counseling and/or care coordination. The content of those activities must then be summarized in documentation. Time spent reviewing records while the provider is not with the patient does not qualify. In addition, face-to-face time should be "rounded down" in the documentation. The provider must include the following in their note: total face-to-face time, that >50% of the face-to-face time was spent counseling and/or coordinating care, and a summary of the discussion[5,6].

New and Established Patients

Determining whether the patient is new or established is the first step in the E/M coding process and relies on same-practice/same-specialty rules[5].

What is *same practice*? Any 2 physicians within a group are in the same practice, regardless of the location where the physicians practice.

What is *same specialty*? In the instance of multispecialty groups, CMS has established specific specialty codes (see Appendix 1) to define areas of specialization for health-care providers: orthopaedics, hand, family practice, sports medicine, and podiatry are all distinct specialties, just as internal medicine, pediatrics, general surgery, etc., are distinct specialties[13]. Orthopaedic surgery, adult reconstructive surgery, trauma, spine, and pediatric orthopaedics, however, all fall within the orthopaedics specialty, as determined by specialty codes. A physician's specialty is usually set during initial Medicare credentialing.

For physicians in a multispecialty practice (for example, orthopaedic surgery, hand, family practice, internal medicine), a patient who has not been seen by a physician in the same specialty for 3 years is a new patient. A patient who has been seen by a physician (or

NPP) in the same specialty, in the same group practice, within 3 years is considered an established patient.

For example, a patient who is seen by an orthopaedist (specialty code 20) who has not seen another orthopaedist (specialty code 20) within the same group during the last 3 years may be considered a new patient. Even if that patient saw a hand surgeon (specialty code 40), podiatrist (specialty code 48), or family practice sports medicine (specialty code 23) provider in the same group during the past 3 years, the patient is a new patient to the orthopaedist. We understand that some payers may choose not to recognize specialty code designations for the purpose of "new patient" definitions.

If a patient sees a surgeon while carrying 1 insurance plan for a CC, and subsequently returns for a different or follow-up CC under a different insurance plan (within 3 years), the visit is considered to be that of an established patient. The 3-year rule for same specialty/same practice applies even if the patient changes insurance plans.

Consultations

CMS carriers, Part C Medicare plans, Medicaid, and some private payers do not accept consultation codes. While some private insurance carriers still allow consultation codes with specific requirements, some physicians have discontinued the use of consultations to simplify documentation and billing practice. As of October 2019, Cigna had become the most recent payer to deny all claims billed with CPT consultation codes, in favor of those billed as new or established patient codes[14]. For a visit to be considered a consultation, 3 criteria must be met: the requesting physician must be seeking the advice from the consulting physician and not transferring care, there must be documentation of a request from another provider in the patient's record either by the requesting or consulting physician, and the patient's record must document that the consulting physician communicated the findings to the requesting physician via a separate report[5,6].

The process whereby a physician who is providing management of some, or all, of a patient's problems then relinquishes this responsibility to another physician without requesting an opinion is not considered a consultation. The physician transferring care is then no longer providing care for these problems, although he or she may continue providing care for other conditions when appropriate. If there is no request for consultation, then the visit is billed as a new or established patient visit, as appropriate.

The request for consultation may be a verbal or written request from another provider and must be documented in the patient's record. At a minimum, the orthopaedist must include a statement such as "I was asked to see this patient in consultation by Dr. X, for an opinion regarding problem Y" in documenting the CC, as this is the reason for the encounter. As part of a consultation service, the orthopaedist may order tests and/or institute treatment at the time of the consultation.

The patient's record must reflect communication of the orthopaedist's findings in writing via a written report to the requesting provider. This is usually in the form of a letter summarizing the orthopaedist's opinion that may accompany the standard office note and include summaries, findings, and recommendations on that consultation. Do not send a formulated letter that says, "see attached office note." For consultations, as with all categories of E/M, the documentation criteria for the level of service reported must be met[4].

The 3-year rule for new or established patients does not apply to consultations. As previously described[4], a primary care physician may ask the orthopaedist for a consultation on a patient's foot problem, then a year later, ask for a second consultation on the same patient's shoulder. Both visits may be reported as consultations, presuming all requirements for a consultation are met. Follow-up visits with the orthopaedist for these problems are established visits.

Five Steps for Use of Summary Tables

The original tables from CMS use the terms "Focused," "Expanded," "Detailed," and "Comprehensive," when referring to the History and Physical Examination key components and "Straightforward," "Low," "Moderate," and "High" when referring to the MDM key component[2]. These terms are listed in the tables provided in Appendix 1, but in the examples in this paper, they are simplified to levels of service. Portions of the steps below were summarized in a previous report[4], with relevant updates now added.

Step 1

Determine whether an office visit should be coded as that of a new patient, an established patient, or a consultation. Tables 1 and 2 in Appendix 1 are divided into columns corresponding to the level of E/M service and E/M code[2-6,15].

Step 2

Review the History key components. Every note needs a CC. For the HPI section, score 1 "bullet" for each descriptive element recorded in Table 3 in Appendix 1. For the ROS, score 1 bullet for each system described. To receive credit for a system documented on a questionnaire, there must be an individual entry of a positive or negative response for each system. For the PFSH, score 1 bullet for each history area described: past history, family history, and social history. The number of bullets scored determines which coding level, or column of the table, is utilized for the History key component (Tables 1 and 2 in Appendix 1). The criteria for each section—CC, HPI, ROS, and PFSH—must be met or exceeded for the History component to qualify for a given code level. For example, the minimum requirement for a detailed (99203) new patient History requires documentation of a CC, 4 elements under the HPI, 2 systems under the ROS, and 1 area under the PFSH. Remember, medical necessity must be present to include elements of the ROS for all patient encounters.

Step 3

Review the Physical Examination key component using the Musculoskeletal Exam Bullet Counter (Table 4 in Appendix 1)[2-6,15]. The minimum requirement for a comprehensive examination requires documentation of all 4 bullets (inspection/palpation, range of motion, stability, and strength) and assessment of the skin in 4 of 6 possible body areas as well as all other examination elements highlighted in gray in the table. If you evaluate the involved extremity as well as the contralateral extremity for comparison, you should document this appropriately. Documentation of multiple joints in the same extremity or body area is scored as 1 bullet for each part of the examination. However, range of motion in 6 different body areas (right shoulder, left shoulder, right knee, left knee, neck, and back) counts as 6 bullets. The number of bullets scored determines which coding level or column of the table is met for the Physical Examination key component (Tables 1 and 2 in Appendix 1). For example, a comprehensive examination of the right upper extremity (RUE) necessary for a 992x5 code could be "R elbow non-tender without effusion, no abrasions or ecchymosis, ranges actively and passively from 0 to 120 degrees of flexion without crepitation, stable to varus and valgus stress without subluxation, 5/5 strength in flexion and extension." Remember, there must be medical necessity to support performing an examination on a body part outside of the area of complaint[9]. In addition, it is important to recall that examination of the shoulder, elbow, and wrist on the involved side would all fall within the same RUE examination.

Step 4

Review the MDM component (Tables 1 and 2 in Appendix 1). Two of the 3 parts (Data, Diagnosis, and Risk) need to be met or exceeded to determine the level of service. This is made easier to understand by referring to Examples 1 to 5 in Appendix 2.

In the Data part, points are given for several data-gathering/reviewing tasks. These are listed in Tables 1 and 2 in Appendix 1. Add up the points to determine the level of complexity. For example, documentation of the review of a radiographic report is 1 point, and documenting independent interpretation of outside images is 2 points, for a total of 3 points for Data. Note, ordering multiple radiographs—knee, hip, and ankle—only scores 1 point for ordering imaging. Likewise, reviewing and summarizing old records, whether 1 page or 100 pages, scores the same 2 points. The Diagnosis part is similarly scored on the basis of the complexity of the diagnosis. Finally, the Risk part of the MDM is a representation of the morbidity or mortality associated with the management options selected, diagnostic procedures ordered, and presenting problems[8]. Orthopaedic examples of these, extracted from the CMS Evaluation and Management Services guidelines[2], are listed in Tables 1 and 2 in Appendix 1. The highest level of risk from any 1 category (management options selected, diagnostic procedures ordered, or presenting problem) determines the overall risk.

Step 5

Determine the appropriate code. This is illustrated by Examples 1 to 5 shown in Appendix 2. For a new patient visit or a consultation, documentation of all 3 of the key components must meet or exceed the coding level for the code to qualify. The left-most of the columns indicating the level of service are used to determine the code.

For a visit with an established patient, documentation of only 2 of 3 key components must meet or exceed the level for the code to qualify. The left-most column of the 2 key components chosen determines the code level.

Finally, the level of service reported must reflect appropriate medical necessity as it relates to the problem. Although not required, consideration should be given to making the MDM 1 of the 2 contributing components in follow-up visits.

Time may also be used as a stand-alone factor in determining the level of service. Minimum time and required documentation are specified in Tables 1 and 2 in Appendix 1. If time is used as the determining factor for coding level, and all rules are met for reporting a service on the basis of time, then the appropriate time column demonstrates the level of service and code.

CMS Proposed E/M Change

According to CMS, it launched its "Patients Over Paperwork" initiative to reduce the burden caused by Medicare documentation requirements[1,12]. In keeping with this idea, CMS suggested multiple changes to E/M services, including collapsing the payments from the current 5 levels (99201 to 99205, 99211 to 99215) for new and established patients into 2 levels. CMS proposed 1 payment for Level-1 codes 99201 and 99211, and 1 payment for all other levels (99202 to 99205, 99212 to 99215). Required documentation only needs to support a Level-2 visit to justify the new blended payment. More than 15,000 comments were submitted regarding this change. Due to the comments, CMS will continue to recognize all 5 levels of outpatient E/M services for new (9920x) and established patients (9921x).

Appendix

Supporting material provided by the authors is posted with the online version of this article as data supplements at jbjs.org (http://links.lww.com/JBJSREV/A630), (http://links.lww.com/JBJSREV/A631).

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