Putting Humpty Dumpty Together Again—Major Joint Surgery

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- Surgical Package Definition
  - CPT®/Medicare
  - AAOS Global Service Data Guide
- Joint Surgery Definitions:
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  - Revision
  - Conversion
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- Hip Resurfacing

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- Orthopaedic Concepts
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- Navigation Procedures
- Surgical Modifier Application for Major Joint Surgery

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Surgical Package Definition: CPT vs. Medicare

CPT	Medicare
Subsequent to the decision for surgery, one related E&M encounter on the date immediately prior to or on the date of procedure (including history and physical).	E&M in which the decision is made is separately billable. Visits to perform history and physicals are not separately reportable.
• Immediate postoperative care, including dictating operative notes, talking with the family and other physicians • Writing orders • Evaluating the patient in the post-anesthesia recovery area	• Discussion with patint/family about the nature of the procedure, alternative treatment risks, benefits and other informed consent issues • Scheduling surgery • Writing preoperative admission notes and orders • Dictating the operative record • Writing postoperative orders and postoperative prescribed care

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Surgical Package Definition: CPT vs. Medicare

CPT	Medicare
Postoperative pain management including catheter placement by operating surgeon	Postoperative pain management including catheter placement by operating surgeon
Typical postoperative follow-up care	All follow-up care **including treatment of complications** unless the condition requires a return to the operating room during the global period.

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What is Included in the Surgical Package? CPT vs. Medicare

GLOBAL DAYS: Medicare Reimbursement Concept

- Minor procedure = Zero or ten days Major procedure = Ninety days

Let's take a look at what the AMA says…

Question:

Are preoperative visits billable? If so, what code should be used and what is the time frame before surgery to submit this code?

Answer:

If the decision for surgery occurs the day of or day before the major procedure and includes the preoperative evaluation and management (E/M) services, then this visit is separately reportable. Modifier 57, Decision for Surgery, is appended to the E/M code to indicate this is the decision-making service, not the history and physical (H&P) alone. If the surgeon sees the patient and makes a decision for surgery and then the patient returns for a visit where the intent of the visit is the preoperative H&P, and this service occurs in the interval between the decision-making visit and the day of surgery, regardless of what the visit occurs (1 day, 3 days or 2 weeks) the visit is not separately billable as it is included in the surgical package. Example: The surgeon sees the patient on March 1 and makes a decision for surgery. Surgery is scheduled for April 1. The patient returns to the office on March 27 for the H&P, consent signing, and to ask and clarify additional questions. This visit on March 27 is not billable, as it is the preoperative H&P visit and is included in the surgical package.

Source: AMA CPT Assistant, May 2008/Volume 18 Issue 5, pp. 8, 11.

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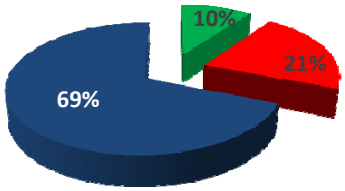
Surgical Package Reimbursement

27130
F RVUs = 42.39
Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft



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AAOS Global Service Data Guide

Global Service Data Guide: CPT Code 27130

Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft

Preoperative services included in the global service package:

1. Local infiltration of medication(s), anesthetic, or combination of agents before, during, or at the conclusion of the operation
2. Surgical approach, with necessary identification, isolation, and protection of anatomic structures, including hemostasis and minor skin excision
3. Obtaining wound specimen(s) for culture
4. Wound irrigation
5. Intraoperative phlebotomy and/or intravenous insertion, excluding arterial catheterization
6. Intraoperative supervision and positioning of imaging and/or monitoring equipment by operating surgeon or assistant(s)
7. Insertion, placement, and removal of surgical drain(s), reinfusion device(s), irrigation tube(s), or catheter(s)
8. Application of initial dressing, orthosis, continuous passive motion, splint, or cast, including traction, except where specifically excluded from global package
9. Preparation and insertion of synthetic bone substitutes, osteoconductive and osteoinductive agents (eg, hydroxyapatite, calcium phosphates, bone morphogenetic proteins), demineralized bone matrix, bone morphogenetic proteins), except where specifically excluded
10. Closure of wound and repair of tissues divided for initial surgical exposure, partial or complete
11. Suture removal by operating surgeon or designee
12. Arthrotomy, hip (eg, 27030, 27033, 27062, 27064)
13. Tenotomy, flexees (eg, 27058)
14. Excision of acetabular osteophytes (eg, 27071)
15. Manipulation of hip (eg, 27275)
16. Trochanteric osteotomy and repair (eg, 27140)
17. Capsular release, repair or reconstruction
18. Synovectomy, capsulectomy, and joint debridement (eg, 27054)
19. Removal of loose bodies (eg, 27033)

Intraoperative services not included in the global service package:

1. Supplies and medication (eg, code 99070, HCPCS Level II codes)
2. Insertion, removal, or exchange of nonbiodegradable drug delivery implants (eg, 11981–11983)
3. Tenotomy, adductors (eg, 27000, 27000)
4. Intramedullary autocatalytic femoral osteotomy (eg, 27165)

Medicare global fee period: 90 days

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Joint Surgery Definitions

What is the definition of:

- Primary?
- Revision?
- Conversion?

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What is NOT reported as a REVISION?

- Removing the implant and inserting nothing or a spacer with the intention of returning later for definitive surgery.

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Shoulder Arthroplasty: Removal/Hemi/Total

CPT Code	Description	NF RVUs	F RVUs
Shoulder			
23330	Removal of foreign body, shoulder; subcutaneous	6.61	4.34
23331	deep (e.g., Neer hemiarthroplasty removal	NA	17.11
23332	complicated (e.g., total shoulder)	NA	25.73
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty	NA	35.52
23472	total shoulder (glenoid and proximal humeral replacement (e.g., total shoulder)	NA	44.01

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Hip Arthroplasty: Removal, Partial, Total, Conversion, Revision

CPT Code	Description	NF RVUs	F RVUs
Hip			
27090	Removal of hip prosthesis; (separate procedure)	NA	24.23
27091	complicated, including total hip prosthesis, methylmethacrylate with or without insertion of spacer	NA	46.96
27125	Hemiarthroplasty, hip, partial (e.g., femoral stem prosthesis, bipolar arthroplasty)	NA	33.16
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft	NA	42.39
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft	NA	49.49
27134	Revision of total hip arthroplasty; both components, with or without autograft or allograft	NA	56.92
27137	acetabular component only, with or without autograft or allograft	NA	43.57
27138	femoral component only, with or without allograft	NA	45.34

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Knee Arthroplasty: Uni/Total, Revision and Removal

CPT Code	Description	NF RVUs	F RVUs
Knee			
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment	NA	32.54
27447	medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	NA	45.31
27486	Revision of total knee arthroplasty, with or without allograft; 1 component	NA	41.43
27487	femoral and entire tibial component	NA	52.01
27488	Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee	NA	35.63

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Hip Resurfacing

- FEMORAL HEAD ONLY:
  - 27125 - Hemiarthroplasty, hip, partial (eg, femoral stem prosthesis, bipolar arthroplasty)
- FEMORAL HEAD and ACETABULUM: *(Both Compartments)*
  - 27130 - Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft

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Orthopaedic Concepts

Grafts (or Implants)

- **Bone Grafts**

  "with or without autograft allograft"

  Example: Patient has a conversion of a hemiarthroplasty for a femoral neck fracture to a total hip arthroplasty, bone is harvested via a separate iliac incision.

  Report: 27132 Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft and 20902-59.

  "includes harvesting the bone graft"

  Example: 27427: Repair, nonunion or malunion, femur, distal to head and neck; with iliac or other autogenous bone graft ***(includes obtaining graft)***

  This code includes the harvest of the graft regardless of the location of the harvest.

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Orthopaedic Concepts

Non-Biodegradable Drug Delivery Implant (antiobiotic impregnated cement spacers)

CPT Code	Description	RVUs
11981	Insertion, non-biodegradable drug delivery implant	(3.04 NF/2.39F RVUs)
11982	Remove, non-biodegradable drug delivery implant	(3.93 NF/2.46F RVUs)
11983	Remove with reinsertion, non-biodegradable drug delivery implant	(4.38NF/2.92F RVUs)

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Fixation/Navigation

Computer Assisted Surgical Navigation

- 20985 Computer-assisted surgical navigational procedure for musculoskeletal procedures; image-less (List separately in addition to code for primary procedure)
- ✚ 0054T Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)
- ✚ 0055T Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)

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Surgical Modifier Overview for Major Joint Surgery

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Modifier 22: Increased Procedural Service

Caution!

Modifier 22: Increased Procedural Service
Attach modifier 22 to the surgical CPT® code
Used to tell the payor that the work performed was substantially greater than typically required.
Dictate a "Findings at Surgery" paragraph to support the substantial additional work. Document reason for additional work including but not limited to increased intensity, time, technical difficulty, severity of patient's condition, physical and mental effort required.
Send the operative note with the CMS 1500 claim form per payor rules. Note: Medicare requires electronic claim submission.
Increase your fee to reflect the substantially greater service.
Monitor your reimbursements closely to ensure payment by payor supports the work.

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Modifier 52: Reduced Services

Modifier 52: Reduced Services
Attach the 52 modifier to the procedure code for the intended surgical or diagnostic procedure.
Use to indicate that the entire CPT® code was not performed or when a service or procedure is partially reduced or terminated.
Submit your entire fee and let the carrier take the discount.
Indicate in your operative note why the intended procedure was not complete.

Scenario		
CPT® Code	Modifier	Description
27486	52	Revision of total knee arthroplasty; with or without allograft; One component

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NOTE: The CPT® Codes/Modifiers illustrated assume the documentation supports the services reported.

Modifier 50: Bilateral Procedures

Modifier 50: Bilateral Procedures
• Use to identify the second of bilateral procedures unless a carrier specifically requires a different format. • Complete the boxes on the CMS 1500 form dependent on carrier policy. • Watch reimbursement closely! • May use RT/LT modifiers if payor (e.g. Medicare) accepts
Submit your full fee for each procedure (unless payor requires you to submit a reduced fee)
Do expect 100% reimbursement on first procedure and 50% reimbursement on second procedure.

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Modifier 50: Bilateral Procedures Non-Medicare

Two Line Submission: CPT Rules

CPT® Code/ Modifier(s)	Description	Units	RVUs Reported	% RVUs Expected
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	1	45.31	100%
27447-50	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	1	45.31	50%

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Modifier 50: Bilateral Procedures Medicare

Single Line Format: Medicare Preference

CPT® Code/ Modifier(s)	Description	Units	RVUs Reported	RVUs Expected
27447-50	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)	1	90.62	150%

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Modifier 51: Multiple Procedures

Modifier 51 Multiple Procedures
Used to tell the payor you did an additional reportable procedure (stand alone procedure) under the same anesthesia.
DO NOT attempt to Add-on or Modifier 51 exempt services.
Submit your full fee for each procedure (unless payor requires you to submit a reduced fee) and put in descending value order.
Decreases reimbursement by 50% 100% first procedure, 50% 2nd, 3rd, 4th, 5th (Medicare Multiple Procedure Payment Formula).

Scenario		
CPT® Code	Modifier	Description
27091		Removal of hip prosthesis; complicated, including total hip prosthesis, methylmethacrylate with or without insertion of spacer
11981	51	Insertion, non-biodegradable drug delivery implant

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Modifier 58: Staged/Related Procedure

Modifier 58 Staged Or Related Procedure Or Service By The Same Physician During The Postoperative Period
Used when you are doing a subsequent procedure that was: 1. Planned or anticipated (staged) ***OR*** 2. More extensive than the first ***OR*** 3. Therapy following a surgical procedure.
Attach to the subsequent surgical procedure.
Protects reimbursement for subsequent procedure during global.
Global period **RESETS** with the date of the subsequent case.

Scenario		
CPT® Code	Modifier	Description
27132	58	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft
11982-58,51	59	Removal, non-biodegradable drug delivery implant

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Modifier 59: Distinct Procedure

Modifier 59 Distinct Procedural Service
Used to tell the payor that this is a special circumstances and procedure is distinct or independent and are not ordinarily reported together but are appropriate under circumstances that might be considered bundled but you met the "special requirement" qualifying for payment... • different session, • different procedure or surgery, • different site or organ system, • separate incision/excision,
Submit your full fee for each procedure (unless payor requires you to submit a reduced fee) and list in descending value order.
Decreases reimbursement by 50% 100% first procedure 50% 2nd, 3rd, 4th, 5th (Medicare Multiple Procedure Payment Formula).

Scenario		
CPT® Code	Modifier	Description
23472		Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))
23412	59	Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic

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Modifier 62: Two Surgeons

Modifiers	62 Co-Surgeon (MD/DO)
Description	2 separate surgeons perform distinct parts of a CPT® procedure. Both surgeons append 62 to the same CPT® code. Each surgeon must dictate his/her own operative note.
Charge Based on Medicare Reimbursement	100%
Reimbursement Impact*	Fee is multiplied by 125% and each surgeon receives 50% of 125% (62.5%).
Operative Note Requirements	Each surgeon dictates the distinct separate part of the same procedure.

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Modifier 62: Two Surgeons

Dr Joint #1		Dr. Joint #2	
27447-62	RT Total Knee	27447-62	RT Total Knee
27447-62, 50	LT Total Knee	27447-62, 50	LT Total Knee

NOTE: The CPT® Codes/Modifiers illustrated assume the documentation supports the services reported.

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Assistant Surgeon Modifiers

Modifiers	80, 81 Assistant Surgeon (MD/DO)
Description	1 surgeon assists another, acting as a "second pair of hands" for "key" portions of the procedure. The assistant appends 80 to the procedure he/she assisted with.
Charge Based on Medicare Reimbursement	25%
Reimbursement Impact*	Primary surgeon receives 100% of fee. Assistant receives 16% of fee (20-25% for private payors) for primary procedure; payment for secondary procedure is based on multiple procedure payment formula.
Operative Note Requirements	Assistant Surgeons do not dictate the operative note. The operative note dictation is the responsibility of the primary surgeon. Primary surgeon's dictation needs to include the medical necessity of needing an Assistant Surgeon; presence for all or part of case; work performed.

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Assistant Surgeon Modifier (Academics)

Modifiers	82 Assistant Surgeon (no qualified resident available) (MD/DO)
Description	1 surgeon assists another in an academic setting when no qualified resident is available.
Charge Based on Medicare Reimbursement	25%
Reimbursement Impact*	Primary surgeon receives 100% of fee. Assistant receives 16% of fee (20-25% for private payors); payment for secondary procedure is based on multiple procedure payment formula.
Operative Note Requirements	Primary Surgeon's dictation needs to include the medical necessity of needing an Assistant Surgeon; presence for all or part of case; work performed.

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Non-Physician Assistant at Surgery Modifier

Payor Alert!

Modifiers	AS; Assistant At Surgery; PA, NP, CNS per Medicare
Description	Non physician provider assists a primary surgeon (MD/DO) with a surgical case because the skills of the NPP are required due to case complexity.
Charge Based on Medicare Reimbursement	20-25%
Reimbursement Impact*	Primary surgeon receives 100% of allowable; NPP receives 13.6% for primary procedure; payment for secondary procedures is based on multiple procedure payment formula.
Operative Note Requirements	Primary Surgeon's dictation needs to include the medical necessity of needing an Assistant Surgeon; presence for all or part of case; work performed.

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Assistant Surgeon Example:

Primary Surgeon		Assistant Surgeon (Non Academic)	
27447	RT Total Knee	27447-80	RT Total Knee
27447-50	LT Total Knee	27447-80,50	LT Total Knee

NOTE: The CPT® Codes/Modifiers illustrated assume the documentation supports the services reported.

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Non-Physician Assistant at Surgery Example:

Primary Surgeon		Physician Assistant at Surgery (Medicare)	
27447	RT Total Knee	27447-AS	RT Total Knee
27447-50	LT Total Knee	27447-AS,50	LT Total Knee

NOTE: The CPT® Codes/Modifiers illustrated assume the documentation supports the services reported.

Some payors may want Modifier 80, 82 in additon to AS modifier

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Modifier 78:

Modifier 78
Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Healthcare Provider Following Initial Procedure for a Related Procedure During the Postoperative Period

- Used when you return the patient to an approved operative suite to treat a complication during the global period
  - Unplanned return.
- Attach to the subsequent unplanned surgical procedure.
- Protects reimbursement for subsequent procedure during global period.
- Global period **STAYS** with the original case.
- Reimbursement is reduced to 50-70% of allowable charge.

Scenario		
CPT® Code	**Modifier**	**Description**
27266	78	Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia

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Modifier 79:

Modifier 79: Unrelated Procedure Or Service By The Same Physician During The Postoperative Period

- Use when the patient has a procedure in the post-op period that is unrelated to the original procedure.
  1. Not for complications
  2. Must have a different diagnosis and make it the primary diagnosis
- Protects procedure from being bundled into the global surgical package.
- Only necessary if the subsequent surgery is within the global period.
- Attach modifier 79 to the unrelated procedural service.
- If the new surgical procedure has a ten or ninety day global period, there will be simultaneous global periods to track.
- Expect reimbursement to be at 100% of the allowable.

Scenario		
CPT® Code	**Modifier**	**Description**
20610	79	RT knee injection during global period of RT shoulder arthroplasty
E&M is not addressed		

NOTE: The CPT® Codes/Modifiers illustrated assume the documentation supports the services reported.

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Thank You!

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