Briefings on APCs

This month's coding Q&A

Reporting total knee arthroplasty in CPT

Q: Is it appropriate to report CPT code 27447 (arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing [total knee arthroplasty]) with modifier -22 (increased procedural services) if hardware removal and/or grafting from a previous surgery is performed?

A: Yes, if the documentation supports that the hardware took an additional amount of time to remove and it is clearly documented what was done. Hardware removal is considered included in total knee replacement. However, if the documentation supports that a significant amount of time was needed to remove the hardware, or grafting is removed, this can be reported with a modifier -22, as it was an increased procedural service.

The operative report should document the extra work and time involved. If that information is there, you should be able to get reimbursed. Now, I'm going to warn you: an appeal usually has to be performed with modifier -22. Either they'll deny the modifier -22 claim line altogether, or they will pen the claim for the information needed to determine that. So, coders will want to make sure that they have information available for auditors or payors when they ask for it.

Editor's note: Lynn Anderanin, CPC, CPMA, CPPM, CPC-I, COSC, *is an independent medical coding education consultant. This question is one of the FAQs she receives from clients. Contact her at codingbones@gmail.com.*

MUE adjudication indicators

Q: I understand that medically unlikely edits (MUE) limit the number of services you can perform on a patient on the same day, but what do the MUE adjudication indicators mean?

A: MUE adjudication indicators (MAI) tell you the nature of the MUE and how carriers will count additional units of the service (UOS) for the same patient on the same day. An MAI of 1 indicates a claim line edit. This is the rarest MAI and it does not apply to any pain management codes. When the UOS on a claim line are greater than the allowed MUE, the carrier will deny all of the UOS on that claim line. When it is appropriate, you may use a modifier to report the second service on a separate line, and you may appeal denials.

An MAI of 2 is a date of service edit—the carrier will tally all of the services on the claim. When the UOS on the claim exceeds the MUE total, it will deny all of those services. These are hard edits and cannot be appealed. CMS has determined that it would be impossible to exceed the allowed number of MUEs. For example, the CPT code for a single level lumbar transforaminal injection (64483) has an MUE of 1 with an MAI of 2 because it is not compliant coding to report a single-level lumbar injection more than once a day.

An MAI of 3 is another date of service edit. It is the most common MAI. You may appeal denials but expect an intense review of your documentation. A carrier might allow an additional unit of service if your documentation clearly shows the medical necessity of the service.

Many nerve blocks have an MAI of 3, including CPT code 64450 (peripheral nerve block) and CPT code 64640 (peripheral nerve destruction).

Remark code N362 (The number of days or units of service exceeds our acceptable maximum) indicates an MUE-triggered denial.

Editor's note: *This question and answer come from the book,* Pain Management Coding Answers, 2023.

Anticoagulation management visits and medical necessity

Q: Can we bill CPT code 99211 (office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional) for an anticoagulation monitoring check when the patient does not see the provider during the visit?

A: You may report CPT code 99211 when the visit is medically necessary, meets incident-to supervision requirements,

and the documentation supports a separately billable visit. When there is no separately identifiable E/M visit — for example, the patient just comes in for a routine test — you should not report the visit with CPT code 99211.

Several Medicare administrative contractors (MAC) give additional guidance on when you may and may not report 99211 for anticoagulation monitoring visits.

Noridian states that "if the patient presents for … anticoagulation monitoring where there is a documented, medically necessary decision by the physician to change or maintain medication dosage, 99211 may be appropriate. In this case the medical record must document that the history and/or exam required a decision and that the physician made the decision, even though the physician does not personally see the patient."

National Government Services' job aid for 99211 includes a checklist with the following item: "For evaluation of patient anticoagulation status, does the patient have new symptoms or a change in medication dosage?" (*See resources, below*.)

CGS Administrators' article on billing anticoagulation management gives a detailed list of dos and don'ts for reporting a visit with 99211. For example, make sure providers document the patient's indication for anticoagulant therapy, current dose, prothrombin time and international normalized ratio (INR) results; assess the patient for signs of bleeding or other adverse reactions to anticoagulation therapy; and identify the ancillary staff who performed the visit and the supervising physician. The list of activities that don't justify a separate E/M visit include repetitive education that isn't customized for the individual patient; the supervising physician is not treating the condition that requires the anticoagulant therapy; or "when the only documentation would be vital signs, the patient's current and future dose of anticoagulant, and when lab work is to be repeated," CGS writes.

Editor's note: *This question and answer originally appeared on Part B News.*

These answers were provided based on limited information. Be sure to review all documentation specific to your own individual scenario before determining appropriate code assignment