SPECIALTY TIP #20
Knee Procedures

Throughout this series, we have shown that the details of your documentation can make a huge impact on the codes; CPT, ICD-10, and ASA, which are assigned to the cases. Now, even more than before, the emphasis is on specificity to support the medical necessity for every case. With the aging population utilizing health care to maintain their active lifestyle as well as various types of sport injuries, knee procedures have become even more prevalent.

Knee Procedures
In order to avoid miscoding, there are documentation practices that would aid coding to identify how to code and/or add modifiers to get appropriate reimbursement for your services.

- Be sure to document your approach - open versus arthroscopic procedures. Yes, talking about “portals” may seem obvious but it never hurts to state the obvious.
- Is the surgery diagnostic only? This information would be helpful to your anesthesiologist as some of their coding is contingent on this distinction.
- State if an arthroscopic procedure converts to an open procedure.
- Document any separate incision(s) when applicable.
- Document any specimens sent to pathology. Could the diagnosis be impacted based on the findings?
- If using an assistant in surgery, the primary surgeon is responsible for justifying the presence of the assistant, the medical necessity requiring the assistant’s presence, and the work performed.
- Ensure that the procedures performed are dictated in full in the body of the operative note.
- Differentiate between a repair and a reconstruction of the ligaments. The codes are different and reimbursement will be affected if the details of the operative note are not specific.
- Provide adequate history to identify any former surgeries or conditions affecting treatment.
  - Often it is difficult to differentiate whether the current surgery is the initial procedure or is this surgery:
    - A planned, staged procedure (-58 modifier if within the postoperative global period),
    - A repeat surgery (-76 modifier if same surgeon, -77 modifier by a different surgeon),
    - For a different condition (thereby starting the global “clock” for a different condition, -79 modifier),
    - A correction of a defect (different diagnosis noting a complication),
    - An unplanned return to the operating room for a related procedure (-78 modifier)
  - If applicable, when was the last related surgery?
    - Is this within the global period of the previous surgery?
    - What condition has prompted the current surgery? Be sure to add this into the operative report, unless you want to have to provide an H&P with a possible delay in claim submission.

- Bundling – For Medicare payers (and some commercial payers), the end-all, be-all bundling resource is the National Correct Coding Initiative, or NCCI. CMS updates the NCCI each quarter (Jan. 1, April 1, etc.), and posts the complete list of “edits,” as the bundled code pairs are called. Here is where attention to detail in your documentation may or may not impact the billing of your procedures.
  - If additional skill and time are required to do the extra work, then the other procedure may qualify for additional reimbursement. (Example: closure of a surgical opening is part of the surgery. But if the closure is a complex procedure that involves an extensive amount of time and skill, then you may be able to unbundle those services dependent on how the procedure is documented).
    - **NOTE:** There are some instances when some code pairs cannot, under any circumstances, be billed together and the edit cannot be overridden by a modifier. (See example in box below)
  - Bundling can refer to a procedure that had to be done to successfully complete the primary procedure.
  - CPT designates some procedures as “Separate Procedures”. These procedures are considered bundled components when provided with more extensive procedures in the same anatomical location. If performed alone or in a different anatomical location, they can be separately billed.
  - Be sure to clearly state the compartment where the procedure is performed. While some procedures can be performed and billed for different compartment, some cannot (see examples).
Assumptions can be made that may help in the determination of which codes would be appropriate along with some examples of the surgeries to which those codes would apply. The detailed wording in your documentation would determine the codes assigned. No assumptions can be made so without the detail, the lesser coding might be assigned.

### Anesthesia for Knee Surgeries

Anesthesia seems to have increased challenges with the knee area. The following are the knee codes with bolded wording that may help in the determination of which codes would be appropriate along with some examples of the surgeries to which those codes would apply. The detailed wording in your documentation would determine the codes assigned. No assumptions can be made so without the detail, the lesser coding might be assigned.

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
<th>Base Unit Values</th>
<th>Examples of Surgeries</th>
</tr>
</thead>
<tbody>
<tr>
<td>01320</td>
<td>Anesthesia for all procedures on nerves, muscles, tendons, fascia, and bursae of knee and/or popliteal area</td>
<td>4</td>
<td>Biopsy, soft tissue of thigh or knee area, deep (subfascial or intramuscular)</td>
</tr>
<tr>
<td>01340</td>
<td>Anesthesia for all closed procedures on lower one-third of femur</td>
<td>4</td>
<td>Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, without manipulation</td>
</tr>
<tr>
<td>01360</td>
<td>Anesthesia for all open procedures on lower one-third of femur</td>
<td>5</td>
<td>Osteoplasty, femur, combined, lengthening and shortening with femoral segment transfer</td>
</tr>
<tr>
<td>01380</td>
<td>Anesthesia for all closed procedures on knee joint</td>
<td>3</td>
<td>Injection of contrast for knee arthrography</td>
</tr>
<tr>
<td>01382</td>
<td>Anesthesia for diagnostic arthroscopic procedures of knee joint</td>
<td>3</td>
<td>Arthroscopy, knee, diagnostic, with or without synovial biopsy</td>
</tr>
<tr>
<td>01390</td>
<td>Anesthesia for all closed procedures on upper ends of tibia, fibula, and/or patella</td>
<td>3</td>
<td>Closed treatment of patellar fracture, without manipulation</td>
</tr>
<tr>
<td>01392</td>
<td>Anesthesia for all open procedures on upper ends of tibia, fibula, and/or patella</td>
<td>4</td>
<td>Arthroplasty, knee, tibial plateau; with debridement and partial synovectomy</td>
</tr>
<tr>
<td>01400</td>
<td>Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified</td>
<td>4</td>
<td>Capsulotomy, posterior capsular release, knee</td>
</tr>
<tr>
<td>01402</td>
<td>Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty</td>
<td>7</td>
<td>Revision of a total knee arthroplasty, with or without allograft; femoral and entire tibial component</td>
</tr>
<tr>
<td>01404</td>
<td>Anesthesia for open or surgical arthroscopic procedures on knee joint; disarticulation at knee</td>
<td>5</td>
<td>Disarticulation at knee</td>
</tr>
<tr>
<td>01420</td>
<td>Anesthesia for all cast applications, removal, or repair involving knee joint</td>
<td>3</td>
<td>Application of long leg splint (thigh to ankle or toes)</td>
</tr>
<tr>
<td>01430</td>
<td>Anesthesia for procedures on veins of knee and popliteal area; not otherwise specified</td>
<td>3</td>
<td>Repair blood vessel, direct; lower extremity – must designate the site</td>
</tr>
<tr>
<td>01432</td>
<td>Anesthesia for procedures on veins of knee and popliteal area; arteriovenous fistula</td>
<td>6</td>
<td>Repair, congenital arteriovenous fistula; extremities – must designate the site</td>
</tr>
<tr>
<td>01440</td>
<td>Anesthesia for procedures on arteries of knee and popliteal area; not otherwise specified</td>
<td>8</td>
<td>Bypass graft, with other than vein; popliteal-tibial or – peroneal artery</td>
</tr>
<tr>
<td>01442</td>
<td>Anesthesia for procedures on arteries of knee and popliteal area; popliteal thromboendarterectomy, with or without patch graft</td>
<td>8</td>
<td>Thromboendarterectomy, including patch graft, if performed; popliteal artery</td>
</tr>
<tr>
<td>01444</td>
<td>Anesthesia for procedures on arteries of knee and popliteal area; popliteal excision and graft or repair for occlusion or aneurysm</td>
<td>8</td>
<td>Bypass graft, with vein; popliteal-tibial, -peroneal artery or other distal vessels</td>
</tr>
</tbody>
</table>
Key Words
A number of key words are bolded in the knee anesthesia codes that will help to determine the correct choice of code(s).
The following are some of those key words with simplified explanations:

- For open vs. closed vs. diagnostic:
  - Closed = minimally invasive; those that involve no or small incisions.
    - “Scope” surgeries, keyhole surgery, and coronary catheterization.
  - Open = a large enough incision is made that would allow the surgeon unaided vision (possibly with loupes or microscopes).
    - Most cardiac and neuro surgeries, herniated disc surgeries.
  - Diagnostic - is a minimally invasive surgical procedure that allows the visual examination and documentation of internal organs in order to detect any pathology.

- Surgeons will sometimes convert a closed “scope” procedure to an open one. Be sure to note this on your record!!
- Be sure to designate diagnostic vs. open/surgical procedures in your documentation, as there are unit differences in the choices available.
- Fractures:
  - Diagnosis:
    - Open is one in which broken bone fragments lacerate soft tissue and protrude through an open wound in the skin = emergent
    - Closed is one that does not produce an open wound
  - Procedure:
    - Open reduction – realignment of a fractured bone after incision into the fracture site
    - Closed reduction – reduction of a displaced part (as a fractured bone) by manipulation without incision

Diagnosis
- Be sure to designate laterality (right, left, or bilateral).
- Location, location, location... always be site specific and detail anatomical locations.
- For musculoskeletal conditions and injuries, state whether the patient is:
  - In the treatment phase (surgery, Emergency Department, evaluation and treatment by new physician, etc.),
  - In the healing phase (cast change or removal, medication adjustment, aftercare following treatment),
  - Or is this a late effect/sequela of an injury?
- When treating a sequela for an injury, you need to gather information on the mechanism of the injury.
  - Details of the original injury. When did the original injury occur? (Date)
  - What happened? (“driver in an MVA”, “slip and fall in home”, etc.)
- Is this a complication from a previous surgery?
- Coding rules dictate that when coding for multiple conditions, the more severe or acute code is sequenced first with chronic conditions as secondary.
- The diagnostic coding is dependent on the post-operative diagnosis. This is especially important if the coding is dependent
- Coding rules dictate that when coding for multiple conditions, the more severe or acute code is sequenced first with chronic conditions as secondary.
  - Your documentation will determine the coding sequencing
  - Use of descriptive words such as “severe”, “mild”, “stable”, “unstable”, “chronic”, etc. help in the sequencing determination
- Include comorbid and relevant conditions that impact decision making or complicate surgery.
  - NOTE for ANESTHESIA: There is a diagnostic code for a failed or difficult intubation.
- If a patient is pregnant, always include trimester and number of weeks regardless of the setting.
- The only time pregnancy is considered incidental is when it is documented as such. Otherwise it is coded as “Pregnancy complicated by...”
- Dictate additional diagnosis to support the medical necessity of additional procedures based on intraoperative findings.
• Without details surrounding the condition under treatment (i.e., pathological vs. traumatic, current vs. old injury) there is the potential for miscoding. (See how the diagnosis can change in the example below based on detail)

<table>
<thead>
<tr>
<th>Encounter Scenario</th>
<th>Injury vs. Derangement</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meniscus Tear, medial, right knee, undergoing surgery</td>
<td>Current injury, bucket-handle</td>
<td>S83.211A-Bucket-handle tear of medial meniscus, current injury, right knee, initial encounter (active care)</td>
</tr>
<tr>
<td></td>
<td>Derangement, anterior horn due to old tear or injury</td>
<td>M23.211-Derangement of anterior horn of medial meniscus due to old tear or injury, right knee</td>
</tr>
</tbody>
</table>

• It is important to document and link the appropriate diagnosis to specific procedures when performed in different compartments of the knee.
• Arthritis topped the list during abeo’s review for the diagnosis most needing additional information.
• Osteoarthritis is the most common chronic condition of the joints.
  o Primary osteoarthritis, referred to as idiopathic, has no known underlying or predisposing cause.
  o Secondary osteoarthritis has an underlying or predisposing cause (injury, overuse, RA, etc.)
  o Generalized osteoarthritis, also referred to as primary generalized osteoarthritis, is characterized by involvement of 3 or more joints or groups of joints

### Documentation Issues Found During the Provider Review

<table>
<thead>
<tr>
<th>Condition</th>
<th>ICD-10</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis (needs much more specificity)</td>
<td>M--.--</td>
<td>● If meaning osteoarthritis: - Generalized - Primary - Secondary – Specify underlying cause - Post-traumatic ● Specific location? ● Laterality, when applicable ● Due to or associated with: - Infectious - Staphylococcal - Pneumococcal - Streptococcal - Due to other bacteria - Juvenile - Osteoarthritis - Rheumatoid</td>
</tr>
<tr>
<td>Bleeding, post-op</td>
<td></td>
<td>● Specific to intraoperative or postprocedural. ● Specific to system / location.</td>
</tr>
<tr>
<td>Chondromalacia</td>
<td>M94.26-</td>
<td>● Laterality ● Specific anatomical location?</td>
</tr>
<tr>
<td>Derangement of meniscus</td>
<td>M23.--</td>
<td>● Designate type: - Cystic - Degenerate - Detached - Due to old tear or injury - Current would code to an injury ● Medial or lateral? - Anterior horn - Posterior horn - Specified NED - Laterality</td>
</tr>
<tr>
<td>Osteomyelitis</td>
<td>M86.-</td>
<td>● Acute, subacute, or Chronic? ● Laterality when applicable ● Specific anatomical location? ● Hematogenous? - Location - Multifocal</td>
</tr>
<tr>
<td>Plica syndrome (Plica Knee)</td>
<td>M67.5-</td>
<td>● Laterality?</td>
</tr>
<tr>
<td>Synovitis, tenosynovitis</td>
<td></td>
<td>● Designate type: - Due to - Crepitant - Infective - Transient - Syphilitic - Villonodular ● Specific location ● Laterality</td>
</tr>
</tbody>
</table>

The information provided is only intended to be a general summary and not intended to take place of either written law or regulations.