Eli's Rehab Report

Get in the Swing of Coding For Common Golf-related Injuries

This is the time of year when PM&R practices begin seeing many more patients with medial epicondylitis (726.31), rotator cuff tendinitis (726.10), plantar fasciitis (728.71) and low back strain (846.9) and that means golf season has arrived again. Many of these golfing-related conditions create tricky coding scenarios because the patient is often treated for more than one symptom at a time, causing the coder to submit claims for E/M visits, cortisone injections and therapy all at the same time. Knowing the ins and outs of coding for these treatments can help coders avoid common pitfalls when submitting claims for commonly treated golf injuries.

Education Is Part of the Evaluation?

"The vast majority of golf injuries that I see are repetitive strain, overuse injuries due to the nature of the sport," says **Gregory Mulford, MD, FAAPMR, FAAEM,** chairman of the department of rehabilitation medicine at Morristown Memorial Hospital in New Jersey. "In my practice, far less than 5 percent of golf-related injuries require surgery," so most of these injuries can be handled in the office or with the help of a physical therapist.

Physiatrists cannot determine the extent of a patient's injury without a thorough evaluation (99211-99215 for an established patient). If the injury is not very serious, the physician usually gives the patient tips regarding how long to rest and what types of anti-inflammatory medications he or she can use to ease the pain. In addition, the physician may provide information concerning how to avoid future problems by stretching and moving more effectively to remain injury-free. But are exercise tips and demonstrations of strengthening and stretching movements included in the physiatrist's E/M code, or are they separate, counting as therapeutic exercise (97110, Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility)?

"This is a mistake sometimes made by coders who are new to PM&R they see the therapeutic exercise code listed in the PM&R section, and they assign it whenever the physiatrist works on strengthening exercises with the patient," says **Dennis Marks,** owner of Rivers Coding and Billing, a reimbursement firm in Tallahassee, Fla. "This is not what **CPT 97110** was intended for, and you can't ever bill it this way."

Because 97110 should be billed as part of a patient's overall treatment plan, and a code does not exist for a patient whose injury is being evaluated for the first time, this code should not be billed in this situation. Instead, include the physiatrist's review of exercising as part of the E/M code that best fits the visit.

Coding Cortisone Injections

Medial epicondylitis and rotator cuff tendinitis often benefit from cortisone injections to reduce inflammation and pain. Because cortisone injections are coded using 20550*-20551 or 20600*-20610* (depending on the location of the injection), the "starred procedure" rules apply, which may prevent the practice from billing an E/M visit with the injection.

This is because "starred procedures" are surgical procedures, and insurers are allowed to determine what is included in the "global" package billed with the starred code. Most payers bundle the office visit into the injection as part of that global package, assuming that all services done before and after the injection should be included in that code. Each starred procedure is paid differently by Medicare carriers and private insurers, so before billing for cortisone injections, ask the patient's insurer exactly what services are included.

"When a patient initially presents with an injury and the doctor gives him or her the cortisone injection on that first visit, we bill for both the injection and the E/M visit with modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service)," says **Dawn O'Keefe,**

who handles the billing at Seacoast Area Physiatry, a four-physiatrist practice in Portsmouth, N.H. "After that first visit, we still bill for the E/M, but generally it doesn't get paid. Medicare just reimburses for the injection and denies the visit."

The rationale for this is that the first visit requires a comprehensive and detailed examination of the patient's new injury to determine how it would best be treated, and therefore, the injection can be billed with the E/M code (as long as modifier -25 is appended).

You should remember to specify the site injected by using the -LT (Left side) or -RT (Right side) modifiers with the injection code. Or, if bilateral injections are performed, append modifier -50 (Bilateral procedure) to the injection code. In addition, the "J" code indicating the medication injected should be included on the claim. O'Keefe says that her practice most commonly bills J3301 (Injection, triamcinolone acetonide, per 10 mg) as the drug code, although other commonly billed codes include J1030 (Injection, methylprednisolone acetate, 40 mg) and J0702 (Injection, betamethasone acetate and betamethasone sodium phosphate, per 3 mg).

For example, a patient presents with pain in both shoulders after a weekend golfing trip, and it is a new injury that the physiatrist has never seen before. The patient states that he felt pain in his shoulders halfway through the weekend but continued to golf anyway, with increased pain upon every swing. The physician performs a detailed examination and decides that the overuse, particularly that which occurred after the patient began feeling the pain, resulted in rotator cuff tendinitis. The physiatrist recommends cortisone injections in both shoulders, which he then performs using triamcinolone acetonide. The visit would be coded as follows:

1. 20610* (Arthrocentesis, aspiration and/or injection; major joint or bursa [e.g., shoulder, hip, knee joint, subacromial bursa]) with modifier -50 appended to indicate that both shoulders were injected.

2. 99214 (Detailed established patient E/M visit) with modifier -25 appended to demonstrate the medical necessity of the visit.

3. J3301 for the medication.

4. 726.10 to denote the patient's condition of rotator cuff tendinitis.

If the patient returns the following week for additional injections into the shoulders, the office visit for that day should not be billed. Only the injection code and the drug code should be submitted. The exception to this rule is if the patient presents for his or her cortisone injections and complains of a separate problem at the visit. For instance, before the physiatrist injects the patient's shoulders, the patient complains of pain in his feet, which worsens on the golf course. The physiatrist examines the patient's feet and discovers a bunion (727.1) problem exacerbated by poor-fitting golf shoes and excessive walking, and completes a referral to a podiatrist for treatment.

The physiatrist can bill for the cortisone injections as 20610-50 with J3301 and 726.10. In addition, he or she can bill the appropriate E/M code for evaluating the bunion with modifier -25 and 727.1.

Billing for Physical Therapy

Mulford says that some golf injuries require traditional physical therapy stressing modalities, manual therapy, therapeutic exercises, and balance issues. For instance, if the patient suffered from medial epicondylitis, the physiatrist initially may refer the patient for pain relief therapy in the elbow, progressing into more therapy for rehabilitation of the elbow, as well as strengthening exercises for the back.

The patient's initial meeting with the therapist would include a thorough evaluation, for which the therapist would bill

97001 (Physical therapy evaluation) or 97003 (Occupational therapy evaluation). The therapist would write a treatment plan, which, when approved by the treating physiatrist, may include cold packs (97010, Application of a modality to one or more areas; hot or cold packs), muscle-strengthening and stretching exercises for the forearm extensor muscles (97110), counterforce wraps (97140, Manual therapy techniques [e.g., mobilization/manipulation, manual lymphatic drainage, manual traction], one or more regions, each 15 minutes) and massage (97124), among other therapies.

If the physiatrist sees the patient in the morning for a cortisone injection, and the patient goes to the therapist for a therapy session later in the afternoon, the cortisone injection and the therapy can be billed on the same day, even if the same practice performs both, because there are no Correct Coding Initiative edits disallowing the submission of both claims on the same day. You should document in the patient's record exactly what was performed during the therapy session and how much time was spent on each modality or exercise so the insurer can clearly see the breakdown between different modalities if your records are ever requested.