Eli's Rehab Report

ICD-9 Coding Corner: Osteoarthritis and Rheumatoid Arthritis Have Their Own Codes

Physiatrists should be extremely specific when reporting arthritis ICD-9 codes, because many insurers cover procedures for rheumatoid arthritis (714.0) but deny the same services provided to osteoarthritis (715.xx-716.xx) patients and vice-versa.

According to the American Academy of PM&R (AAPMR), more than 40 million Americans have arthritis, most of whom have osteoarthritis. Physiatrists not only treat the actual arthritis pain but also offer injections, therapy and exercise instruction to treat joint injuries and help slow degeneration.

Although most insurers cover certain procedures, such as joint injections (20600-20610) for both osteoarthritis and rheumatoid arthritis (RA), they have approved some drugs only for treating RA. Consequently, if you assign an osteoarthritis ICD-9 code to these claims even accidentally the payer will immediately deny it.

Use Remicade for RA Only

Remicade (J1745) is FDA-approved for treating RA, but the FDA has not approved its use for osteoarthritis patients. "Infusing Remicade takes well over an hour," says **Danielle Ware,** office manager at the Tomkins Joint Center, a six-physician multispecialty practice in Newark, N.J. Tomkins reports 90780 (Intravenous infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; up to one hour) for the first hour of infusion and +90781 (... each additional hour, up to 8 hours [list separately in addition to code for primary procedure]) for each hour thereafter.

Because 90780 applies only when the physician or someone under his or her direct supervision performs the infusion, do not report this code if the physician is off-site. "If the nurse practitioner is with the patient during the infusion, we bill her services incident-to using the physician's number," Ware says.

She notes that the physician always evaluates patients thoroughly before scheduling them for Remicade infusions. "When the patient first comes to our practice, we report an E/M code (**CPT 99201** - **99205**) for their visit with the physician, and we start the Remicade treatments the next time they come in."

During the Remicade treatments, Ware bills only for the drug and the infusion and does not report an E/M code "unless a patient came in for a regularly scheduled infusion and had another problem requiring physician contact." In that case, Ware would append modifier -25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service) to the E/M code.

Carriers Don't Always Pay

Most PM&R practices routinely administer bursa injections (20600-20610) to arthritis patients. Although most insurers cover these injections for both osteoarthritis and RA, some carriers' coverage limitations differ based on the patient's condition.

Because arthritis is a chronic condition, physiatrists often inject multiple sites during the same visit, but carriers such as Utah Medicare limit patients to five injections per service date.

Utah's policy states, "Additional procedures, beyond five, may be allowed when the code is billed with a -22 modifier (Unusual procedural services) and the documentation submitted with the claim adequately explains the patient's history

and the extenuating condition, which would warrant additional coverage."

Claims processors can be very subjective when approving additional injections, says **Tony Ashcroft,** owner of MedOps Billing, an independent coding and billing consultant in Las Vegas. "Sometimes the insurer will be very generous when the patient has generalized osteoarthritis affecting, say, knees, elbows, the back, the shoulders and the hands. Other insurers will always reject any injection after the first five. So it's a matter of really getting your documentation in top shape so you can show them why the additional injections were necessary."

Your ICD-9 codes, both in the documentation and on your claim, should specify the various sites where the patient has arthritis. If you injected the patient's knees, elbows, back, shoulders and hands, as in Ashcroft's example, list 715.09 to denote the patient's generalized arthritis affecting multiple sites.

Therapy, Injections Don't Always Go Together

Physicians universally agree that physical and occupational therapy can help arthritis patients decrease pain and improve flexibility. Insurers, however, don't always support therapy claims for injection patients.

"Most carriers will pay for bursa injections, and most carriers will pay for physical therapy, but not always on the same day," Ashcroft says. "It's not really fair to make an arthritis patient come back the next day for therapy, but it does happen."

According to the medical review policy for TrailBlazer (the Part B carrier for the D.C. Metropolitan area), physical therapy on the same day as a bursa injection (20600-20610) "may be rejected as not medically necessary, unless the specific need and indication are documented." Yet another TrailBlazer policy indicates that 97035 (Application of a modality to one or more areas; ultrasound, each 15 minutes) "is used primarily to treat arthritis" and neuromas.

This dichotomy should be a clear sign that the insurer will probably pay for both the injection and therapy if you send along the chart notes indicating medical necessity, Ashcroft says. "If your documentation shows that the patient has osteoarthritis and that exercises following pain management injections actually improve the patient's flexibility, your insurer will almost always agree that what you're doing is appropriate and medically necessary. It just takes a little bit of extra work to get your documentation together and submit it."