Pertinent Insights on Billing and Coding in Foot and Ankle Surgery

While it can be confusing to wade through the sea of acronyms and numbers, correct billing and coding can maximize reimbursement and avoid denials. This author provides a comprehensive guide.

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Billing and coding in foot and ankle surgery can be overwhelming at first. Because we are often billing multiple procedures, it can be complicated at times as well.

Billing and coding is one topic where there is a lack of education during student and resident training. Often, doctors graduate from their residency program and later learn the ins and outs of billing and coding as they work through practice, perhaps relying on more senior doctors or their employer for guidance. For the seasoned practitioner, it is easy to fall into old habits of billing and coding that may have changed. Often, we focus on evaluation and management codes, modifiers, and correct procedural terminology codes (CPT), but we forget the other components to billing and coding.

There are some key areas you can start focusing on to ensure you are maximizing your billing and coding in foot and ankle surgery while hopefully avoiding denials.

What You Should Know About Medically Unlikely Edits

One term to know and understand is medically unlikely edits (MUE). The MUE is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. This value differs per CPT code. If you bill more than the MUE allows without the appropriate modifier when applicable, you may not get paid for any of them. There are multiple resources available to learn about MUE.[1–3] Here are some examples of MUE:

28285—*hammertoe correction (interphalangeal fusion, partial or total phalangectomy).* The MUE for this CPT is 4. If you decide to do bilateral cases and perform more than 4 hammertoe corrections the coding for this based on MUE is only 28285 x4.

28282, 28295, 28296, 28297, 28298, and 28299—these are all bunion correction codes. These codes all have a MUE of 1. If doing bilateral bunions, the appropriate modifier may need to be added when applicable. You cannot in any circumstance bill 2 bunion codes on the same foot. As a rule, you should always pick the CPT codes that most accurately describes the procedure you are performing. This especially applies to bunion correction. I would encourage all practitioners to familiarize themselves with the descriptions of the bunion CPT codes.

28292—*Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method*

28295—*Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method*

28296—*Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method*

28297—*Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method*

28298—*Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method*

28299—*Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method*

28300—*Osteotomy; calcaneus (eg, Dwyer or Chambers type procedure), with or without internal fixation*

Unfortunately, for the surgeon who performs double calcaneal osteotomies, this MUE is 1. I observed discussion throughout 2022 about this MUE possibly changing. To date, this MUE is still 1.

Certainly, there are other CPT codes where you may in a setting perform more than the allowable MUE. I would encourage every surgeon to familiarize themselves with the MUE for the top CPT codes they bill.

CCI Edits and NCCI Policy

I like to refer to the National Correct Coding Initiative (NCCI) and the CCI Edits as the "laws of coding." CCI edits prevent improper payment when incorrect code combinations are reported. NCCI Policy is a Centers for Medicare and Medicaid Services CMS policy. Other insurance companies outside of Medicare may use this policy as well.

The NCCI policy manual can be found on the CMS website.[4] CMS updates the policy once a year. There are currently 13 chapters total. For the foot and ankle surgeon, focus can be directed towards Chapter 1 (General Correct Coding Policies), Chapter 3 (Surgery: Integumentary

System Codes), and Chapter 4 (Surgery: Musculoskeletal System Codes).[4]

While these chapters are/can be monotonous to read through, these policies drive correct coding and ultimately reimbursement. Going through these carefully and writing down pertinent sections on and easily accessible document can provide a guide and alert the practitioner to apply these rules to their coding.

It is important to remember a few key points from these policies. The first is the physician is to report the CPT code that describes the procedure to the greatest specificity possible. Secondly, the physician should not report multiple CPT codes if there is a single CPT code that describes the procedure being performed. It is possible that there may not be a CCI edit between codes; however, the above points take precedence.[4]

Understanding LCDs and MACs

A Medicare Administrative Contractor (MAC) is a private health care company that processes Medicare Part A and Part B medical claims for a region. The MAC does vary based on geographic jurisdiction. Local Coverage Determinations (LCDs) are decisions made by the MAC as to whether to cover particular items or services.[5]

It is important to know what company serves as the MAC in your region. This information can be found on the CMS website.[5] The LCD will provide a list of which ICD-10 codes that are payable for specific CPT codes. If you are noticing denials, turn to the explanation of benefits (EOB). If the EOB makes reference to the LCD for the reason of denial, it may be the ICD-10 you chose is not on the list of payable codes for that CPT. The LCDs are updated periodically; therefore, ICD-10 codes that were once considered payable may change.

The LCD also dictates how frequently or how many times a service is allowed within a given time period. Deviation from these standards can result in nonpayment or denials.

Where to Begin With Billing and Coding in Foot and Ankle Surgery

The earlier you can expose yourself to the world of billing and coding, the more familiar the language and "rules" become. As a resident, spend time in attendings' offices if possible and ask how they approach billing and coding. Additionally, as you are scrubbing cases, ask which CPT codes they are billing. Keeping a notebook of surgeries and CPT combinations can give you a reference guide once you graduate.

Once out in practice, realize that there are constant changes in billing and coding. These changes can come in various forms, including but not limited to, global days, MUE changes, LCD changes, and new or changed NCCI policies. Attending a yearly billing and coding course can help you keep up-to-date on the latest changes. It is important to meet with your practice's billers and coders. Discussing trends in codes that are being denied can alert you to potential flaws in billing. Having an up-to-date coding source is essential. Using the coding book from last year, even though it is only one year old, is likely incorrect in some way. Electronic coding sources are excellent resources, as they show the updates in real time.

Remember, billing and coding is not a "cookbook" or "one size fits all." ■

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