



Major Joint Replacement (Hip or Knee)

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Target Audience: physicians, surgeons, and hospitals

The Hyperlink Table at the end of this document provides the complete URL for each hyperlink.

Major joint replacement or reattachment is one of Medicare's top volume Medicare Severity Diagnosis Related Groups MS-(DRGs). Due to the high volume of these claims, the Centers for Medicare & Medicaid Services (CMS) has had multiple auditing entities, including the Recovery Auditors, Comprehensive Error Rate Testing (CERT) Contractors, and Medicare Administrative Contractors (MACs) review claims for these MS-DRGs. Their findings have demonstrated very high paid claim error rates among both hospital and professional claims associated with major joint replacement surgery.

DOCUMENT MEDICAL NECESSITY TO AVOID DENIAL OF CLAIMS

CMS recognizes that joint replacement surgery is reserved for patients whose symptoms have not responded to other treatments. To avoid denial of claims for major joint replacement surgery, the medical records should contain enough detailed information to support the determination that major joint replacement surgery was reasonable and necessary for the patient. Progress notes should consist of more than just conclusive statements. Therefore, the medical record of the joint replacement surgical patient must specifically document a complete description of the patient's historical and clinical findings. Both physicians and hospitals are responsible for ensuring a complete and accurate record.

The Patient's Medical Record

The **history** should include information such as:

- A description of the pain (onset, duration, character, aggravating, and relieving factors)
- Limitation of specific Activities of Daily Living (ADLs)
- Safety issues (for example, falls)
- Contraindications to non-surgical treatments
- A listing, description and outcomes of failed non-surgical treatments, such as:
 - Trial of medications (for example, Nonsteroidal anti-inflammatory drugs (NSAIDs)).
 - Weight loss.
 - Physical therapy.
 - Intra-articular injections.
 - Braces, orthotics or assistive devices.
 - Physical Therapy and/or home exercise plans.
 - Assistive devices (for example, cane, walker, braces (specify type of brace), and orthotics).

The **physical examination** should describe the joint examination with detailed objective findings, such as:

- Any deformity
- Range of motion
- Crepitus
- Effusions
- Tenderness
- Gait description (with or without mobility aides)

Investigations should include the results of applicable tests (for example, plain radiographs and pre-operative imaging studies).

A statement of **clinical judgment** with reasons for deviating from a stepped-care approach may be included.

The Patient's Hospital Records

The pre-operative portion of the hospital record for the joint replacement surgical patient should include documentation of specific conditions, such as:

- Osteoarthritis (mild, moderate, severe)
- Inflammatory arthritis (for example, rheumatoid arthritis, psoriatic arthritis)
- Failure of previous osteotomy
- Malignancy of distal femur, proximal tibia, knee joint, soft tissues
- Failure of previous unicompartmental knee replacement
- Avascular necrosis of knee
- Malignancy of the pelvis or proximal femur or soft tissues of the hip
- Avascular necrosis of the femoral head
- Fractures (for example, distal femur, femoral neck, acetabulum)
- Nonunion, malunion or failure of previous hip fracture surgery
- Osteonecrosis

The hospital record for the **postoperative** joint replacement surgical patient includes the following:

- Operative report for the procedure, including observed pathology
- Daily progress notes for inpatients
- Discharge plan and discharge orders

MLN Matters® Number SE1236 - Documenting Medical Necessity for Major Joint Replacement (Hip and Knee) (<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1236.pdf>) - provides guidance on documenting medical necessity for major joint replacement. Here are examples of a poor record and a detailed and supportive record from that article.

Example of a medical record that may result in a denied claim.

Mrs. Smith is a female, age 70, with chronic right knee pain. She states she is unable to walk without pain and pain meds do not work. Therefore, she needs a total right knee replacement.

Example of a medical record with more detail and support of medical necessity.

History: Mrs. Smith is a 70-year-old female who is suffering from end-stage Osteoarthritis (OA) of her right knee, worsening gradually over the past 10 years. Treatment has included NSAIDs which have not effectively

relieved her pain/inflammation and which have recently begun to cause her gastric distress. She has also participated in an exercise program/physical therapy for the past 3 months without functional improvement. Sometimes the pain keeps her awake at night. She is using a cane and is no longer able to climb the five steps to her front door. Her knee pain and stiffness limit her ability to perform ADLs. She cannot walk from her bedroom to her kitchen without stopping to rest.

Physical Examination: Vital Signs: 140/90, Heart rate 78, RR 18.

Physical exam: Bilateral varus knee deformity consistent with severe osteoarthritis. Right knee extension reduced to minus 15 degrees and flexion **to less than 100** degrees. Unable to rise from chair unassisted. Full motion of the right hip, no calf tenderness or ankle edema. Antalgic gait noted.

Investigations: X-ray (7/2/11): right knee shows joint space narrowing along with marginal osteophytes.

Impression: Right Total Knee Arthroplasty (TKA) indicated.

Plan/Orders: Discussed risks and benefits of total joint replacement with the patient to ensure the patient understands both. Admit to inpatient care for right TKA. Forward a copy of this note to include in patient's chart along with a copy of the patient's x-ray reports.

KEY POINTS FOR HOSPITAL BILLING CODES

Select the correct MS-DRG code.

The International Classification of Diseases (ICD) 10 MS-DRG codes for major joint replacement or reattachment of a lower extremity, whether hip or knee, are displayed in Table 1.

It is important to select the correct MS-DRG taking into account whether the patient experienced Major Complications or Co-morbidities (MCC) during the hospital stay. Providers need to remain up to date on ICD-10-CM code changes when selecting the correct secondary diagnoses. The provider should code for chronic conditions that are being maintained with medication during the acute episode and code appropriately.

Below is an example from the "[Medicare Quarterly Provider Compliance Newsletter](#)"—Volume 3, Issue 1—October 2012, where a patient was admitted for hip pain with stable treatment to prevent further pulmonary emboli.

Admitting diagnosis (Hip pain): A 66-year-old male was found to have a pathological right hip fracture. After extensive work-up with radiological exams, it was noted that the patient had a pathological subcapital fracture of the right hip that is 4 weeks old.

History and Physical: The patient presented for treatment of the fracture with an arthroplasty with prosthetic implant. Patient has an extensive past medical history hypertension, hyperlipidemia.

Patient's past medical history is significant for multiple pulmonary emboli with placement of an Intravenous Catheter (IVC) filter approximately 4 years ago. Patient is on Coumadin. All radiology reports are negative for acute pulmonary embolism on this admission.

Preoperative diagnosis: Subcapital fracture right hip. Postoperative diagnosis: Same (four weeks old).

Procedure performed: Arthroplasty with Zimmer unipolar prosthesis/13mm stem, 43 mm head, 0 degree neck.

Discharge summary: Patient was treated surgically for a pathological right hip fracture with arthroscopy and replacement of the hip joint. Final diagnosis is pathological right hip fracture. History of lung malignancy with metastasis to the liver and bone; tumor induced Syndrome of Inappropriate Antidiuretic Hormone Secretion (SIADH); hypophosphatemia; **multiple pulmonary emboli and was being maintained on Coumadin and has an IVC filter in place.** Patient was discharged to Skilled Nursing Facility (SNF).

Finding: The Recovery Auditor determined that the patient did not have an acute pulmonary embolism during this admission. Therefore, it was inappropriate to report secondary diagnosis code I26.99 (Other pulmonary embolism without acute cor pulmonale), which is classified as a MCC.

Code correction: The secondary diagnosis was changed to I27.82 (Chronic pulmonary embolism), which is classified as a CC. This resulted in an MS-DRG change from 469 - Major Joint Replacement or Reattachment of Lower Extremity with MCC to 470 - Major Joint Replacement or Reattachment of Lower Extremity without MCC. This resulted in an overpayment.

Table 1: ICD-10 DRG Codes for Major Joint Replacement or Reattachment of Lower Extremity (Hip or knee)(FY 2017)

MS-DRG	SPECIAL PAY DRG?	POST-ACUTE CARE DRG?	DESCRIPTION
469	No	Yes	Major Joint Replacement or Reattachment of Lower Extremity With MCC
470	No	Yes	Major Joint Replacement or Reattachment of Lower Extremity Without MCC
461	No	No	Bilateral or Multiple Major Joint Procedures of Lower Extremity With MCC
462	No	No	Bilateral or Multiple Major Joint Procedures of Lower Extremity Without MCC
466	No	Yes	Revision of Hip or Knee Replacement with MCC
467	No	Yes	Revision of Hip or Knee Replacement with CC
468	No	Yes	Revision of Hip or Knee Replacement without MCC/CC

Note: A list of operating room procedures for the DRGs in Table 1 is available at https://www.cms.gov/ICD10Manual/version34-fullcode-cms/fullcode_cms/P0377.html.

- **These DRGs do not qualify for the special payment methodology.**
- **Submit the correct patient status code to comply with the post-acute transfer policy.**

CMS established a post-acute care transfer policy which pays as transfers all cases assigned to certain DRGs if the patient was discharged to a psychiatric hospital or unit, an inpatient rehabilitation hospital or unit, a Long Term Care Hospital, a children’s hospital, a cancer hospital, a SNF, or a Home Health Agency (HHA). All of the DRGs in Table 1, except code 461 and code 462, are affected by this payment policy.

In order to comply with this policy, hospitals must assign the correct patient status code. A patient status code is a 2-digit code that identifies where the patient is at the conclusion of a health care facility encounter (this could be a visit or an actual inpatient stay) or at the end of a billing cycle (the “through” date of a claim). CMS requires patient status codes if the patient is discharged to the locations listed in Table 2.

Table 2: Patient Status Code and Patient Location

PATIENT STATUS CODE	PATIENT TRANSFER LOCATION
65	Psychiatric hospital or unit
62	Inpatient rehabilitation hospital or unit
63	Long term care hospital
05	Children’s hospital
03	SNF
06	Home (in the care of a HHA)

The patient status code is required on the following type of bills (TOBs):

- Part A Inpatient Claims (Type of Bills (TOBs) - 11X and 12X)
- Skilled Nursing Claims (TOBs - 18X, 21X, 22X and 23X)
- Outpatient Hospital Services (TOBs - 13X, 14X 71X, 73X, 74X, 75X, 76X and 85X) and
- All Hospice and Home Health Claims (TOBs - 32X, 33X, 34X, 81X and 82X)

The patient status code belongs in Field 22 on the UB-92 claim form (or its electronic equivalent) in the Health Insurance Portability and Accountability Act (HIPAA)-compliant, 837 format for all Part A inpatient, SNF, hospice, HHA, and outpatient hospital services. This code indicates the patient’s status as of the “Through” date of the billing period (Form Locator 6 (FL 6)).

For providers who file claims in the Fiscal Intermediary Shared System (FISS), the patient status code is entered on claim page 1. It is important to select the correct patient status code, and if two or more patient status codes could apply, then code to the highest level of care known. Omitting the code or submitting a claim with the incorrect code is a claim billing error and could result in your claim being rejected, or your claim being cancelled and payment taken back.

AIDS TO CORRECT BILLING

CMS publishes Quarterly Provider Compliance Newsletters, which highlight billing issues identified by RACs and CERTs. Here are several issues regarding major joint replacement identified in recent issues.

Information Missing from Hospital Records.

The "[Medicare Quarterly Provider Compliance Newsletter, Volume 1, Issue 1, October 2010](#)", reported that demonstration RACs determined that certain inpatient claims totaling more than \$63 million were made with insufficient documentation submitted. The following example is extracted from the OIG report of July 2010, which is available at <http://oig.hhs.gov/oas/reports/region1/11001000.pdf> on the Internet.

A hospital was paid for total hip replacement surgery. Medicare concluded that the documentation in the beneficiary's medical record was insufficient to support the need for the surgery. Specifically, the record did not contain information on the types of treatment that had been tried before surgery, a pathology note to support statements in the record, or a preoperative x-ray documenting the extent of osteoarthritis of the hip. As a result, payment was denied.

Co-Surgery Not Billed with Modifier 62.

The "[Medicare Quarterly Provider Compliance Newsletter, Volume 3, Issue 4, July 2013](#)", reported that RACs have identified significant payment errors because of failure to appropriately apply the co-surgeon modifier, used when two or more surgeons of different specialties contribute to one operative session and each separately submit claims to Medicare. They found many instances of improper payments when two surgeons performed surgery on the same patient, where one surgeon added the co-surgeon modifier 62 and the other did not.

When two different providers bill the same CPT code, for the same patient and on the same date of service and one of the providers bill with modifier 62, the other provider must also bill with modifier 62. Improper payments exist when two surgeons perform surgery on the same patient: one surgeon added the co-surgeon modifier 62 and the other did not. Note, however, that modifier 62 may only be used when the co-surgeons are of different specialties and are working together on the same procedure.

The "Medicare Claims Processing Manual," Chapter 12, Section 40.8, *Claims for Co-surgeons and Team Surgeons*, provides the following guidance:

Under some circumstances, individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedures and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at-surgery. If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier 62. Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously (for example, heart transplant).

The following billing procedures apply when billing for a surgical procedure or procedures that required the use of two surgeons or a team of surgeons:

- **Modifier 62:** If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier 62. Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously (for example, bilateral knee replacements). Documentation of the medical necessity for two surgeons is required for certain services identified in the Medicare Fee Schedule Data Base (MFSDB).
- **Modifier 66:** If a team of surgeons (more than 2 surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier 66. Field 25 of the MFSDB identifies certain services submitted with modifier 66 which must be sufficiently documented to establish that a team was medically necessary. All claims for team surgeons must contain sufficient information to allow pricing “by report.”
- If surgeons of different specialties are each performing a different procedure (with different CPT codes), neither co-surgery nor multiple surgery rules apply (even if the procedures are performed through the same incision). If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon’s services.
- For co-surgeons (modifier 62), the fee schedule amount applicable to the payment for each co-surgeon is 62.5 percent of the global surgery fee schedule amount. Team surgery (modifier 66) is paid for on a “by report basis.”

To avoid billing errors and improper payments when two surgeons of different specialties are working together on the same procedure, each surgeon shall use Modifier 62 for the procedure. If a team of surgeons (more than two surgeons of differing specialties) are involved in the same procedure, each surgeon shall use Modifier 66 when billing for the procedure.

RESOURCES

FOR MORE INFORMATION ABOUT...	RESOURCE
IPPS tables for FY 2014 Final Rule Table 5 displays the MS-DRGs and the Post-acute DRG and special payments status.	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY-2014-IPPS-Final-Rule-Home-Page-Items/FY-2014-IPPS-Final-Rule-CMS-1599-F-Tables.html
IPPS tables for FY 2015 Proposed Rule Table 5 displays the MS-DRGs and the Post-acute DRG and special payments status.	http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2015-IPPS-Proposed-Rule-Home-Page-Items/FY2015-IPPS-Proposed-Rule-Tables.html?DLPage=1&DLSort=0&DLSortDir=ascending

Resources (continued)

FOR MORE INFORMATION ABOUT...	RESOURCE
The “Medicare Claims Processing Manual,” Pub. 100-04, Chapter 3, Section 20.1.2.4 Transfers	http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf
The “Medicare Claims Processing Manual,” Pub. 100-03, Chapter 12, Section 40.8, Claims for Co-surgeons and Team Surgeons	http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
The “Medicare Quarterly Compliance Newsletter,” Volume 1, Issue 1, October 2010	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN904943.pdf
The “Medicare Quarterly Provider Compliance Newsletter”–Volume 3, Issue 1–October 2012	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN908065.pdf
The “Medicare Quarterly Provider Compliance Newsletter,” Volume 3, Issue 4, July 2013	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN908787.pdf
ML N Matters® Number: SE1236 “Documenting Medical Necessity for Major Joint Replacement (Hip and Knee)”	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1236.pdf

Hyperlink Table

EMBEDDED HYPERLINK	COMPLETE URL
Medicare Quarterly Provider Compliance Newsletter”–Volume 3, Issue 1–October 2012	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN908065.pdf
Medicare Quarterly Provider Compliance Newsletter,” Volume 1, Issue 1, October 2010	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN904943.pdf
Medicare Quarterly Provider Compliance Newsletter,” Volume 3, Issue 4, July 2013	http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedQtrlyComp-Newsletter-ICN908787.pdf

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