

Sports Medicine Practice Economics

Part 2: Consultations, Modifiers, and Other Codes

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In Brief: Physicians face numerous challenges related to sports medicine practice economics, including coding and billing for consultations. Some of this difficulty stems from a lack of widespread recognition of sports medicine as a specialty. To further complicate matters, many insurance companies refuse to recognize dual credentials in both family medicine and sports medicine. Physicians can better position themselves for appropriate reimbursement from third-party payers by becoming familiar with modifiers and related codes for various sports medicine services, including fracture care, injections and arthrocentesis, and osteopathic mobilization.

This is the second article in a three-part series about economics issues encountered in a sports medicine practice. The authors are not certified coding experts, and the articles are not meant to serve as a definitive guide to billing and coding in sports medicine, but rather to provide insight into this poorly understood and complex area of medicine that can make or break a practice. The first article, on coding basics, appeared in May.

Consultations are a significant component of many sports medicine practices, and a practitioner should bill as a consultant when appropriate. Fees for office consultations are much higher than fees for new and established patients at similar code levels, with the exception of confirmatory consultations, which reimburse less than do standard consultations. Physicians should familiarize themselves with fee schedules for their areas of expertise.

Primary care providers often serve as consultants, especially to surgeons, when they provide preoperative clearance of patients and management of postoperative complications. Despite this, some insurance companies refuse to reimburse sports medicine physicians for sports consultations, because they claim these providers are not specialists. According to the definition of a consultation, however, specialty designation does not matter when billing for a consultation.

Sports medicine physicians charge for consultations in two main settings: referral from within the primary care provider's office and referral from another office (a lateral referral). Sports medicine physicians are usually credentialed with insurance companies as family physicians or as sports medicine physicians/orthopedists, or are dual-certified as both family medicine and sports medicine providers.

Sports medicine physicians who practice only in their primary care office are usually credentialed with local insurance companies as family medicine practitioners, because the need to seek dual credentials as a sports medicine physician rarely arises. (This is likely because reimbursements for consultations are usually collected under the umbrella of the primary care office.) Patients rarely see an unlisted primary care physician (the sports medicine specialist) after seeing their primary care physician (in a different office), because patients who see a sports medicine specialist usually do so in the office where their primary

care provider practices. The ideal setting for this type of consultation is where a sports medicine specialist partners with primary care providers who have minimal interest in sports medicine and refer patients in need of sports medicine care.

Sports medicine specialists who work primarily in an orthopedic setting are usually credentialed in sports medicine or orthopedics instead of family medicine, especially if they provide primarily musculoskeletal care and work only in the sports medicine or orthopedic office. In this situation, consultations from lateral referrals are successfully reimbursed, because the specialist is not listed as a primary care provider (ie, family medicine). Occasionally, a physician may be listed as sports medicine or orthopedics in an orthopedic practice and as family medicine in a family practice office, and bill under two separate tax codes and credentials specific to each office. This may occur when sports medicine physicians see patients in both a primary care office and an orthopedic office.

From a consultation and reimbursement standpoint, the most challenging setting is that in which a sports medicine specialist practices solely in a primary care office but sees lateral referrals. Unless the sports medicine physician is dual-credentialed in family medicine and sports medicine with individual insurance companies, the referral likely will not be reimbursed as a consultation—or at all—because a patient usually cannot be referred to a primary care practice that is not listed on the individual payer contract. This is particularly true in health maintenance organization– or managed care–driven environments. According to the definition of a consultation, insurance companies should reimburse for such patient visits, but some refuse to pay sports medicine physicians in this situation, because they maintain that a patient may not be evaluated at two primary care offices. Many sports medicine providers have failed to enlighten certain insurance companies that this seems inappropriate, and thus have had difficulty collecting reimbursement. Some providers have tried to find middle ground by negotiating for dual credentials in family medicine and sports medicine with individual payers.

Sports medicine physicians have met varying success in becoming dually credentialed. Insurance company approaches to such certification are highly individualized, both within geographic regions and in different parts of the United States. Physicians often point out that the American Board of Medical Specialties recognizes sports medicine as a specialty. Some insurance companies see the obvious and legitimate need for dual certification, and these companies assist sports medicine physicians in becoming dually credentialed. Yet, other insurance companies treat dual-credentialing as impossible, likely because it entails having to reimburse physicians at higher rates. One author (CM) has heard various, often comedic reasons offered by insurance companies to sports medicine specialists who are attempting to obtain dual certification (table 1). The reasons are inconsistent, brief, invalid, lack any sound basis, and almost always benefit the insurance company.

TABLE 1. Responses From Insurance Companies to Sports Medicine Physician Queries About Dual Credentials*

"You can't be dually credentialed because you can't be both a family medicine specialist and a sports medicine specialist. We do not allow that."

"We will allow you to be a 'family medicine specialist' and a 'sports medicine specialist,' but because that eliminates you from the 'family medicine' category, your office visits for family medicine issues must be cosigned by your partners."

"We do not have a mechanism in place that allows dual credentials."

"We are going to stop reimbursing all of your visits because you misled us by charging as a sports medicine specialist, and we found out you are a primary care physician. We [also] are going to stop reimbursing your partner, who has been doing this for 10 years." (Response to two family medicine–trained sports medicine physicians, one of whom was recently hired, who practiced in an orthopedic office as sports medicine specialists.)

Insurance negotiator: "Sports medicine is not recognized as a medical specialty."
 Physician: "Yes, it is. The American Board of Medical Specialties recognizes it."
 Insurance negotiator: "Oh, but it's not a specialty."

No response from insurance company to physician attempts at communication.

*Source: Chris Madden, MD, oral communications

Unfortunately, the burden to obtain dual credentials from an unreasonable third-party payer currently rests on the individual physician's shoulders. However, sports medicine physicians are starting to pool their ideas at the national level, and with the advent of the orthopedic sports medicine qualification, physician strength in fighting dual-credential battles may gain momentum in the near future. No two insurance companies are the same, and one of our favorite quotes from a sports medicine physician mentor who went on to work in the insurance industry sums it up well: "When you have seen one insurance company, you have seen one insurance company."

Consultation Definitions and Requirements

A consultation is a service provided by a physician whose opinion or advice regarding evaluation or management of a specific problem is requested by another practitioner (eg, physician, physical therapist, nurse practitioner, physician assistant). Many sports medicine and preoperative exams qualify as consultations. No specialty requirement is stated, which is significant for third-party payers.

Consultation requirements include documentation of a written or verbal request from the referring practitioner, documentation of the consultant's evaluation and opinion, and written communication from the consultant to the referring practitioner.¹

Confirmatory consultations are a unique service provided by a physician who is aware that he or she is giving a second or third opinion. The consultation may be patient- or family-driven or may be requested by a third-party payer (the latter requires use of modifier -32). The consultation may involve an opinion or advice.¹ Confirmatory consultations cannot be coded on the basis of time. Follow-up visits after both types of consultations use nonconsultation current procedural terminology evaluation and management (CPT E/M) codes. Refer to table 2 for E/M requirements for consultations.

TABLE 2. Evaluation and Management Coding Requirements for Consultations

Patient or Visit	Code	History	Exam	Medical Decision Making	Time (min)
Consultation	99241	PF	PF	SF	15
	99242	EPF	EPF	SF	30
	99243	D	D	L	45
	99244	C	C	M	60
	99245	C	C	H	80
Confirmatory consultation	99271	PF	PF	SF	N/A
	99272	EPF	EPF	SF	N/A
	99273	D	D	L	N/A
	99274	C	C	M	N/A
	99275	C	C	H	N/A

PF = problem focused; SF = straightforward; EPF = expanded problem focused; D = detailed; L = low complexity; C = comprehensive; M = moderate complexity; H = high complexity

Modifiers

Modifiers are numbers added to the primary E/M code to indicate that a procedure or service was altered by some circumstance but was not changed in definition or code.³ Modifiers are intended to make it hard for insurance companies to ignore extra services or to inappropriately bundle two E/M codes and pay the lesser of the two.⁴ Modifiers signify that special services or services above and beyond those performed in a normal visit were rendered. The most commonly used modifier in sports medicine is -25 (used for a significant, separately identifiable E/M service performed on the same day as another procedure or service), yet it is often misinterpreted and underutilized by physicians and professional nonphysician coders.

Individual insurance company responses to modifiers vary, and, despite its appropriately frequent use, modifier -25 is often ignored or omitted by third-party payers.^{3,4} It is important to note that both the separately identifiable E/M service and the procedure or service performed above and beyond the initial service may be related to the same diagnosis.³ Unless physicians create a tracking system, they will not be able to identify cases to appeal to insurance companies and will leave money on the table as a result. A detailed list of modifiers is provided in table 3.

Modifier	Procedure or Service
-21	Prolonged E/M services (99358 prolonged E/M, 30 min above highest level; usually a 99215 or a preventive care visit) Maximum billable time for nonconsultation E/M visit (before adding 99358) is 45 min
-24	Unrelated E/M service by same physician during postoperative period; may prevent unrelated problems that arise during global period from being lumped into global care package
-25	Significant, separately identifiable E/M service (eg, injections, casting, taping) performed on same day as procedure or other service; most common sports medicine modifier
-32	Mandated services: services related to mandated consultation (eg, third-party payer requests additional opinion or confirmatory consultation)
-50	Bilateral procedures
-51	Multiple procedures
-52	Reduced services
-59	Distinct procedural service (eg, casting of sprained wrist as well as fractured ankle)

E/M = evaluation and management

In 2004, the "starred" procedure (minor surgery without associated preoperative and postoperative services) was eliminated from the CPT protocol. It was reimbursable in addition to the primary CPT E/M service performed on the same day,⁵ but the use of certain modifiers negates the need for the starred procedure.

Sports Medicine Procedures and Other Codes

Diversified sports medicine physicians can provide a broad spectrum of care that may generate significant income when such services are coded properly. Fracture care, casting, splinting, taping, arthrocentesis and injection, and rehabilitation programs are components of most sports practices. Additional areas of special interest may include orthosis fittings; application of durable medical equipment (DME), such as braces, splints, and cast boots; compartment pressure measurement; KT-1000 arthrometry; osteopathic mobilization; spirometry; exercise treadmill testing; and skin lesion and wart treatment.

Fracture Care

Fracture care application and supply codes pertinent to sports medicine are listed in table 4. International classification of diseases (ICD-9) fracture codes are easy to access using a cheat sheet or computer program, so they are not provided in this article. Fracture codes carry higher reimbursements than those for routine visits, but they provide one-time-only reimbursement. The first cast or splint is included in the global fracture-care fee, but additional splints or casts may be charged at follow-up visits. Some sports medicine physicians predict the number of follow-up visits needed and then determine whether to charge globally or for individual visits after reviewing the reimbursement provided for each.

Code	Procedure or Service
29125	Short arm splint
29075	Short arm cast
29105	Long arm splint
29065	Long arm cast
29440	Add walker, prior cast
29730	Windowing cast
29470	Wedging cast
29405	Short leg cast
29425	Short leg walking cast
29435	Long leg cast
29355	Long leg walking cast
29505	Long leg splint
29515	Short leg splint
29130	Static finger splint
29131	Dynamic finger splint
A4590	Cast supplies*
A4570	Splint supplies*
Q4005	Medicare (cast or splint)*

*Assign dollar amount to code.

It may seem more appropriate to simply code and charge for fracture care when treatment is initiated. However, this is not always possible, particularly when the initial fracture is in question (eg, a fracture is suspected but unconfirmed) or when a physician provides only initial care to stabilize a fracture before referring the patient to an orthopedist. These initial visits may be more appropriately coded as 99214 (based primarily on the level of risk), with supporting visit documentation.

Patients pay x-ray charges at follow-up visits for fracture care. An important consideration is when patients present other problems (new or follow-up) during these visits. Insurance companies may inappropriately lump E/M charges from independent problems that arise during this period into the global fracture-care fee. When an independent problem arises during a follow-up fracture-care visit, some physicians charge for a nonconsultation E/M visit by adding modifier -25 to the cast fee if the visit includes a scheduled cast change. Other physicians use a nonconsultation E/M code and add modifier -24 if a cast charge is not incurred (eg, the visit occurs between scheduled cast changes). It is important that physicians document their work and appeal to the insurance company when appropriate.

Casting and Splinting

Casting and splinting generates a separate billable fee in addition to the visit fee, except for initial fracture care, in which the initial fee is built in to the global fracture-care fee. Except for initial fracture care, physicians should use modifier -25 if casting or splinting is performed in addition to evaluation and management of a problem. Follow-up fracture care may require only cast or splint codes if the patient has no other complaints. Many sports medicine physicians do not realize that cast and splint supplies may be charged for in addition to fees for cast and splint application. These supply codes require a dollar amount assigned to them. Physicians should note which codes are reimbursed by which insurance companies. Table 4 lists common cast, splint, and supply codes.

Taping and Strapping

Taping and strapping is used more in some sports medicine practices than others. These procedures may be needed for immediate postfracture care, for athletes who have minimal access to athletic trainers or physical therapists, and in offices where certified athletic trainers perform rehabilitative and other services. Taping and strapping is billable, and using modifier -25 if additional services (eg, musculoskeletal evaluation) are provided will likely increase the chance for successful reimbursement. Table 5 lists common taping and strapping codes.

Code	Body Part or Region
29540	Ankle/foot
29503	Knee
29550	Toes
29220	Lower back
29280	Hand/finger
29260	Elbow/wrist
29249	Shoulder
29520	Hip
29799	Unlisted casting/strapping procedure

Injections and Arthrocentesis

Diagnostic and therapeutic injections are performed in most sports medicine practices. Common procedures include trigger-point injections, joint or ganglionic cyst aspiration, and corticosteroid injections into joints, bursae, and tendon sheaths. If these services are performed in addition to evaluation and management of a problem (independent of the primary problem), modifier -25 should be added to the primary E/M visit code. If the sole purpose of the visit is the procedure, only the procedure code should be used.⁶ Like cast and splint codes, supply codes should be listed with a specific dollar amount. However, reimbursement amounts for supplies used with injections are usually only a few dollars. Table 6 lists common injection and arthrocentesis codes.

Code	Procedure or Service
20600	Small joint or bursa, fingers, toes

20605	Intermediate joint or bursa, acromioclavicular, wrist, elbow, olecranon, ankle
20610	Major joint or bursa, shoulder, subacromial, hip, knee
20550	Injection(s); single tendon sheath, ligament, or aponeurosis*, plantar fascia
20551	Single tendon origin or insertion*
20526	Injection; therapeutic, carpal tunnel
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscles
20553	Injection(s); single or multiple trigger point(s), 3 muscles
20610	Aspiration or injection of ganglionic cyst(s), any location
Code	Injected Substance†
J1100	Dexamethasone
J2920	Methylprednisolone
J3301	Triamcinolone
J2001	Lidocaine hydrochloride/bupivacaine hydrochloride
17315	Sodium hyaluronate
17320	Hylan G-F 20
*Changed for the year 2004. ¹	
†Assign dollar amount to code. Bill for number of units, in mL, of injected substance (eg, J110031 unit and J200135 units).	

Sports medicine physicians who use prolotherapy should be aware of its healthcare common procedural system (HCPCS) code (M0076), but it is not covered by Medicare. No CPT code is designated for prolotherapy; physicians may be able to use the CPT code for ligament or tendon injection if the location meets CPT criteria. However, some third-party payers may view prolotherapy as an investigational procedure and may consider the use of a ligament or tendon injection code misleading.⁷ It may be best to check with individual payers before coding for prolotherapy.

Other Sports Medicine Codes and Ancillary Services

Sports medicine physicians may perform a variety of additional services on the basis of patient need and physician interest. Modifier -25 should be added to the primary E/M code for most of these services.

Therapeutic exercise (97110) programs are billable when administered by a physician or physical therapist. This code is defined as a "therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion, and flexibility." A practitioner is required to have direct patient contact to use 97110.¹ The code is reimbursed by many insurance providers, but because it is a physical therapy code, charges may be applied to the patient's deductible or may affect the patient's total number of annually allowable physical therapy visits.

Osteopathic mobilization (98925, 98926, 98927) is offered by various sports medicine providers. Areas include the head, cervical region, lumbar region, sacral region, pelvic region, lower extremity, upper extremity, rib cage region, and abdomen and viscera region. Modifier -25 should be added to the primary E/M code to obtain reimbursement for mobilization. Individual reimbursement varies. Some plans do not reimburse for mobilization, whereas others may reimburse only if the physician is a doctor of osteopathy. Physicians should review the explanation of benefits (EOB) and track the charges.

Orthoses are constructed by many sports medicine physicians, and there are a few ways to charge for them. If orthoses are covered in the EOB of an individual insurance policy, then a physician may charge the insurance company. However, insurance companies may apply high deductibles, place certain restrictions (eg, required diagnoses, dictate who can build orthoses),

and set predetermined allowable reimbursement amounts for orthoses. This may vary greatly among individual companies. If physicians bill insurance companies for orthoses, they should track their reimbursement closely. In some situations, reimbursement may be less than the cost of the supplies incurred by the physician. Patients usually cannot be billed additional fees by physicians when orthoses are covered in the EOB, because this typically violates the contract between the physician and the insurer.

The easiest way to obtain reimbursement for orthoses is when they are not covered in the insurance company EOB, which is most of the time. In this situation, physicians may directly charge patients. It is wise to provide patients with a contract that states that orthoses are not covered by insurance, lists the cost of orthoses, and sets the expectation that fees will be collected on the same day that services are rendered.

If a patient presents with a problem that requires evaluation (eg, pes cavus and foot pain, plantar fasciitis), a physician may charge the insurance company for the E/M service provided during the visit, even if orthoses are discussed. A physician may take a mold or order appropriate materials at the initial visit and fit the orthosis during a follow-up visit. This allows the physician to bill the insurance company for the E/M service provided at the follow-up visit and the patient for the orthotic service provided. L-codes are used for orthoses and shoe modification, and a few examples are listed in table 7. Orthotic codes may be reviewed in more detail in the HCPCS manual.⁸

Code	Service
L3000-L3031	Shoe inserts, removable
L3040-L3060	Arch support, removable
L3300-L3334	Lift, shoe modification
L3340-L3420	Wedges, shoe modification
L3430-L3485	Heels, shoe modification

Durable medical equipment (DME) may include anything from crutches to home oxygen. DME commonly used in sports medicine includes premanufactured splints and braces, cast boots and walkers, and stiff surgical shoes.

Distribution of DME is a lucrative business. Physicians need to strike a balance between not violating insurance contracts if they charge patients and being reimbursed appropriately if they charge insurance companies. DME reimbursement is highly variable among insurance companies, and benefits frequently change. Thus, it can be challenging to keep up with specific coverage, and charging for DME may be difficult for physicians. Furthermore, individual insurance companies may "shake hands" with specific DME suppliers, and physicians who supply DME to patients insured by these companies may unwittingly breach contracts. Finally, DME is often subject to high copays (which creates more billing and collection work and fees), so even if physicians are able to legitimately supply their patients with equipment, they are lucky to break even financially.

To sidestep these problems, many sports medicine physicians rent space (eg, closet, cabinet) to DME suppliers who stock offices with requested items and bill patients separately from the physician office. Even with this setup, physicians should be aware of individual insurance contracts so that patients are not surprised by a large bill from a DME supplier that is not contracted with their insurance company. Physicians may want to develop waivers that clarify patients' insurance and related options. Many patients may opt to avoid hassles and further appointments with the DME supplier by signing the waiver and purchasing DME at their initial

visit. Physicians should check with individual insurance companies before using waivers to ensure that doing so does not violate insurance contracts.

Quality DME is increasingly available through Internet-based companies. Under the guidance of a physician, patients can purchase almost any brace, splint, cast boot, cryotherapy cuff, or other rehabilitative item. Internet companies often have a broader selection of items, and the prices are usually cheaper compared with local DME suppliers. DME codes commonly used in sports medicine are listed in table 8. Other codes and details may be reviewed in the HCPCS manual.⁸

TABLE 8. Common Sports Medicine Durable Medical Equipment (DME) Codes

Code	Service
L0120	Cervical, flexible, nonadjustable (foam collar)
L0140	Cervical, semirigid, adjustable (plastic collar)
L0450-L0490	Thoracolumbosacral orthoses, flexible
L1000-L1520	Scoliosis orthotic devices (including Milwaukee)
L3650	Shoulder orthosis, figure of eight, fabricated
L3651	Shoulder orthosis, single shoulder, elastic, prefabricated, includes fitting and adjustment
L3907	Wrist/hand/finger orthosis, elastic, prefabricated (may include thumb spica)
L3908	Wrist/hand orthosis, wrist extension control (cock-up), nonmolded, prefabricated
L3917	Hand orthosis, metacarpal fracture orthosis, prefabricated (eg, Galveston splint), includes fitting
L3956	Addition to joint upper extremity orthoses, any material; per joint
L4350	Ankle-control orthosis, stirrup style, rigid, any type of interface (eg, pneumatic, gel), prefabricated, includes fitting
L4360	Walking boot, pneumatic, with or without joints, prefabricated, includes fitting
L3486	Walking boot, nonpneumatic, with or without joints, prefabricated, includes fitting
L4398	Foot-drop splint, prefabricated
L1800	Knee orthosis, elastic with stays, prefabricated, includes fitting
L1830	Knee orthosis, canvas longitudinal immobilizer, prefabricated, includes fitting
K-codes	Various DME (eg, wheelchair devices); not often used in sports medicine

Supplies other than those normally included in a patient visit may be billed when the items (eg, tension bands, slings, compression wraps) are distributed, but the code (99070) is often ignored by individual contractors who reason that the supplies are supposed to be included as part of the primary CPT E/M visit code or are not covered in the contract.

Testing Procedures

Some sports medicine offices offer compartment pressure measurement (20950) to evaluate possible compartment syndromes. KT-1000 arthrometry (97750) may be used to measure anterior cruciate ligament laxity, but its code is a physical therapy code and may be applied to a patient's deductible or to a limited number of annual physical therapy visits allowed by a third-party payer.

Supplementary Codes

V-codes are used when circumstances arise other than disease or injury classifiable to ICD-9 codes 001-999. They are reported as the diagnosis and *take the place of an ICD-9 code*. Insurance companies may not pay for these services, and the patient may be responsible for the bill. V-codes pertinent to sports medicine are listed in table 9.

TABLE 9. Sports Medicine V-Codes

Code	Service
V65.41	Exercise counseling
V65.42	Substance abuse/use counseling
V65.43	Injury prevention counseling
V70.0	General medical exam
V70.3	School or sports exam
V70.5	Occupational or preemployment exam

E-codes are used to classify environmental events, circumstances, and conditions as causes of injury, poisoning, and other adverse effects. They are *added to ICD-9 codes* that describe diagnoses. E-codes are used with motor vehicle, motorcycle, machinery, and watercraft accidents.⁹

Comprehensive Coding

Coding in a sports medicine practice that offers diverse services may be challenging. Consultation codes and modifiers need to be used consistently and accurately in appropriate circumstances. Fracture care, joint injections, and rehabilitation are part of most sports medicine practices; physicians with special interests may provide other services. Please refer to the appendix (below) for examples using CPT codes for new patients, established patients, and consultations, along with modifiers and other procedure and service codes. Understanding coding specifics for this broad range of patient care is an important step toward achieving a financially successful practice.

Disclaimer: This review is for educational uses only. The authors are not coding and billing experts and are not responsible for any consequences resulting from the misuse of this review. THE PHYSICIAN AND SPORTSMEDICINE is not liable for any information found in this material.

APPENDIX 1. Examples Using CPT E/M Codes for New Patients, Established Patients, and Consultation Visits With Modifiers and Other Procedure and Service Codes*

New Patients

ACL tear: new (99203 or 99202), follow-up (99213)

New patient with chronic back pain without neurologic symptoms: review patient records, independently review films (99204)

Established Patients

Anterior knee pain with rehabilitation, new (99214)

Follow-up of MCL sprain not responding to treatment and URI with prescription drug management (99214)

Asthma exacerbation and URI with prescription drug management (99214)

Multiple plantar warts: initial (99212 or 99213-25 and 17000 and 17003), follow-up (17000 and 17003), follow-up with other problem (appropriate level [99213]-25 and 17000 and 17003)

Acute back pain with radiculopathy and sensory loss: review patient records, independently review films; nonconsultation (99215)

Eating disorder in established patient, takes 10 min because patient is resistant (99124)

Eating disorder and depression evaluation in established patient, takes 75 min (99215-21 and 99358)

Triangular fibrocartilage complex or sprained wrist in established patient: cast placed, NSAID prescribed (99214-25 and 29075 and A4590)†
Thumb UCL sprain: cast placed, NSAID prescribed; plantar warts treated (99214-25 and 29075 and A4590† and 17000)
New rotator cuff tendonopathy in established patient: requires physician-taught rehabilitation program; patient does not want to undergo physical therapy (99214-25 and 97110)
New bilateral trochanteric bursitis in established patient who wants two corticosteroid injections, NSAID prescribed (99214-25 and 20610-50 and 20610)
Consultations
Preoperative exam for meniscal tear (99242, 99243, or 99244, depending on complexity)
Colleague asks you to evaluate a patient's knee (99242 or 99243)
Physical therapist refers patient with elbow pain (99242 or 99243)
Fractures
Fracture of right radius, lunate-triquetral sprain of left wrist: casts placed on both (25560-59 and 29075 and A4590)†
Patient mentions high cholesterol during fracture care follow-up (99213 or 99214-25 and 29075 and A4590)†
*Suggested codes for visits that meet all qualifications for specific E/M levels; all details are not included. Suggestions are for educational purposes only. †Assign dollar amount to code. CPT E/M = current procedural terminology evaluation and management; ACL = anterior cruciate ligament; MCL = medial collateral ligament; URI = upper respiratory infection; NSAID = nonsteroidal anti-inflammatory drug; UCL = ulnar collateral ligament

References

1. American Medical Association: Current Procedural Terminology CPT 2004, Standard Edition, Chicago, AMA Press, 2003
2. Herbst MR: CPT and HCPCS coding: the modifier fiasco. Health Manag Technol 1998;19(11):73-74
3. Yoder L: Using CPT modifier -25 for professional billing. J AHIMA 2000;71(1):21
4. Scichilone RA: Clarifying selected CPT modifiers. J AHIMA 2000;71(4):69-73
5. Moore KJ: CPT: what's in store for 2004? Fam Pract Manag 2004;11(1):18-21
6. Moore KJ: Coding and documentation answers to your questions. Fam Pract Manag 2004;11(5):29
7. Moore KJ: Coding & documentation answers to your questions. Fam Pract Manag 2002;9(9):23
8. The Medical Management Institute: HCPCS Healthcare Common Procedure Coding System Level II Codes, ed 11. Alpharetta, Georgia, Medical Management Institute, 2003
9. The Medical Management Institute: Professional ICD-9-CM Volumes 1 & 2. Alpharetta, Georgia, Medical Management Institute, 2003

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