AAPC

CRHC™

Certified Rheumatology Coder

STUDY GUIDE

2026

2026

Specialty Study Guide: CRHC™

RHEUMATOLOGY

Contents

2026 Specialty Study Guide: CRHC™ Introduction

The *Specialty Study Guide: CRHC™* is designed to help rheumatology coders, billers, and other medical office professionals prepare for the CRHC™ examination. This guide is by no means comprehensive. Your primary resource for the examination will be your years of hands-on experience in coding for rheumatology.

Healthcare in the 21st century is complex and requires expertise in proper coding to obtain payment for procedures, services, equipment, and supplies. Becoming a CRHC™ shows your expertise in rheumatology coding. Membership in AAPC lends integrity to your credentials, provides a large network of coders for support, and gives you access to continuing education opportunities. The *Specialty Study Guide: CRHC™* is designed to provide an overall review of coding and compliance information for the more experienced coder, as well as for someone preparing for the CRHC™ examination.

We will review the importance of using the coding guidelines within ICD-10-CM and CPT®, as well as emphasize the importance of correct evaluation and management (E/M) leveling. You will need 2026 versions of ICD-10-CM, CPT®, and HCPCS Level II code books for the study guide and the CRHC™ examination.

ICD-10-CM Coding

Proper diagnostic coding not only reports the medical necessity of procedures performed, but also contributes to data that determines health policies for tomorrow. Because physicians have traditionally been paid by CPT® code values, coders have sometimes given little importance to correct ICD-10-CM coding. Regulatory trends show that diagnoses will play a larger role in reimbursement in the future. It is important to code correctly so you are prepared for that day.

We will discuss the major topics of diagnosis coding for rheumatology. The examinee must become familiar with the Official Coding Guidelines for ICD-10-CM. The examinee must know how to select the appropriate ICD-10-CM codes as well as the proper sequencing of diagnosis codes when more than one diagnosis code is required to report a patient's condition(s). This year's ICD-10-CM guidelines can be found at https://www.cms.gov/files/document/fy-2026-icd-10-cm-coding-guidelines.pdf. The examinee must understand the conventions, general coding guidelines, and chapter-specific guidelines in the ICD-10-CM code book.

Evaluation and Management (E/M) Coding

Office visits consume much of the physician's time in most practices, and consequently represent the largest revenue source. Compliance is an increasing concern at practices, and the E/M material will focus on the E/M services for rheumatology and underscore the importance of modifier use. An understanding of the AMA E/M guidelines and subsection notes is an important foundation for accurate code selection that is provided in your CPT® codebook.

An E/M calculator is provided for the online exam (https://www.aapc.com/codes/em-calculator) and your CPT® code book provides a Medical Decision Making (MDM) table to level an E/M service.

CPT® Coding

Surgical procedures specific to rheumatology will be discussed in the Rheumatology CPT® coding chapter. Special attention is given to the guidelines and parenthetical phrases associated with procedures. Understanding CPT® coding conventions will be helpful as well. The examinee must be able to select the appropriate CPT® codes and sequence the codes correctly when multiple procedures are performed. CPT® codes are sequenced based on the most complex or labor-intensive procedures. The codes with the highest relative value units are sequenced first.

Top 10 Missed Coding Concepts

In the chapter, Top 10 Missed Coding Concepts, we will review the top 10 missed coding concepts for the CRHC™ certification examination. The list is not presented in any specific order. The information is determined after an evaluation by the AAPC examination department of the commonly missed questions on the examination.

Practice Examination

The practice examination and the examination itself are written by coders with extensive experience in rheumatology. The practice examination mimics the format and structure of the CRHC™ certification examination.

AAPC has developed specialty credentials to enable coders to demonstrate superior levels of expertise in their respective

specialty disciplines. Here is information on the CRHC™ credential:

- CRHC™ stands alone as a certification with no prerequisite that the examinee holds a CPC® or COC® credential.
- Examinations aptly measure preparedness for real-world coding by being entirely operative/physician-note based. These operative (op) notes are redacted op notes from real rheumatology practices.

The CRHC™ examination tests your knowledge of coding concepts, anatomic principles, and coding guidelines only. When you sit for this examination, remember that individual payer rules are not a consideration when choosing the right answer. Unless it is specifically stated in the case note or examination question that Medicare covers the patient, you should follow the CPT® coding guidelines.

The examination tests competency. The candidate most qualified to pass the examination will be proficient in understanding the following:

- Medical terminology and anatomy
- Medical physiology
- Teaching physician guidelines
- Incident-to guidelines
- Shared/Split services
- Health Insurance Portability and Accountability Act of 1996 regulations
- Proper use of Advanced Beneficiary Notice
- ICD-10-CM coding
- E/M code selection using the AMA CPT® E/M guidelines
- CPT® coding for common procedures
  - 20000 Series
  - 30000 Series
  - Laboratory and Pathology
  - Radiology
  - Medicine
  - Category III codes
- CPT® and HCPCS Level II modifier usage
- HCPCS Level II coding

Familiarity with practical coding and the coding books is essential, as time is an important element in successfully completing the examination. You should approach the examination as you would approach your work—by demonstrating coding abilities essential to success. This is not a general aptitude test, and each question has a specific goal for measuring your competency. The practice examination within the *Specialty Study Guide: CRHC™* course is highly representative of the subject matter and level of difficulty you will encounter in the full-length examination.

Test Answers and Rationales

The final chapter in the book contains the answers to the practice examination. Accompanying each answer is a rationale that explains the coding guidelines contributing to selecting the right answer. These rationales should help you understand what is needed to successfully approach and answer questions on the real examination, because they allow you to have a glimpse into the minds of the test's creators.

Examinees that pass the CRHC™ certification examination will receive recognition in AAPC's monthly magazine, *Healthcare Business Monthly,* and receive a diploma suitable for framing.

About AAPC

AAPC was founded in 1988 in an effort to elevate the standards of medical coding by providing training, certification, ongoing education, networking, and recognition.

AAPC provides medical coding certification exams for coders in physician practices and the outpatient/facility environment. AAPC has expanded beyond outpatient coding to include training and credentials in documentation and coding audits, inpatient hospital/facility coding, regulatory compliance, and physician practice management. The purpose of AAPC coding certifications is to test an examinee's knowledge of coding principles and proficiency in coding accurately and efficiently. AAPC examinations measure a coder's skill of both coding accuracy and efficiency.

AAPC Member Code of Ethics

Members of AAPC shall be dedicated to providing the highest standard of professional service for the betterment of healthcare to employers, clients, vendors, and patients. Professional and personal behavior of AAPC members must be exemplary.

It shall be the responsibility of every AAPC member, as a condition of continued membership, to conduct themselves in all professional activities in a manner consistent with ALL of the following ethical principles of professional conduct:

- Integrity
- Respect
- Commitment
- Competence
- Fairness
- Responsibility

Adherence to these ethical standards assists in assuring public confidence in the integrity and professionalism of AAPC members. Failure to conform professional conduct to these ethical standards, as determined by AAPC's Ethics Committee, may result in the loss of membership with AAPC.

Introduction to ICD-10-CM Coding Guidelines

The National Center for Health Statistics developed International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) in consultation with a technical advisory panel, physician groups, and clinical coders to ensure clinical accuracy and utility. ICD-10-CM coding guidelines are developed by the Centers for Medicare & Medicaid Services (CMS) and the National Center for Health Statistics. Healthcare providers must begin using the most recent ICD-10-CM code revisions on October 1 of each year, with no "grace period" to transition to the changes.

All versions of the ICD-10-CM code book typically include the *ICD-10-CM Official Guidelines for Coding and Reporting*. These guidelines are an invaluable source for diagnosis coding information and provide instruction supplemental to that found in the Tabular List and the Alphabetic Index within the ICD-10-CM code book.

ICD-10-CM codes are utilized to facilitate payment of health services, to evaluate utilization patterns, and to study the appropriateness of healthcare costs. Case-by-case success in achieving these goals requires an open line of communication between the coder and the documenting physician.

The Official Guidelines note, "A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures." Each ICD-10-CM code assigned must be supported by documentation linked to that claim (individual dates of service must "stand alone"). Coders must be mindful not to assume or extrapolate information from the medical record, for example, coding a condition as "chronic" when it is not documented as such.

The Official Guidelines are divided into four sections:

- Section I lists ICD-10-CM Conventions, General Coding Guidelines, and Chapter Specific Guidelines.
- Section II explains the Selection of Principal Diagnosis. The Uniform Hospital Discharge Data Set defines the principal diagnosis as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."
- Section III gives rules for Reporting Additional Diagnoses in addition to the principal diagnosis that affect the patient's care.
- Section IV provides Diagnostic Coding and Reporting Guidelines for Outpatient Services. These include information about coding signs and symptoms, when to report chronic diagnoses, ambulatory surgery, routine outpatient prenatal visits, and more.

General Tips for Using ICD-10-CM

Use the Alphabetic Index and Tabular List of the ICD-10-CM code book together to determine the diagnosis code. Begin by searching for the main term—such as lesion, burn, and so on—in the ICD-10-CM Alphabetic Index. Follow all cross-references and "see also" entries. When you have located the code you are seeking, turn to that code in the Tabular List. Pay close attention to disease definitions, footnotes, color-coded prompts, and other instruction. Read all supplemental information completely to be certain you are choosing the correct code. Always select a diagnosis to the highest level of specificity supported by the available documentation.

The first listed diagnosis should describe the most significant reason for the procedure or visit. The first-listed diagnosis will be reflective of the patient's chief complaint. Relevant coexisting diseases and conditions, as well as related history or family history conditions, are reported as secondary diagnoses. When coding preexisting conditions, make sure the assigned diagnosis code identifies the current reason for medical management. Do not report conditions that no longer exist or do not pertain to the visit.

Many patients will have numerous chronic complaints. Report a chronic complaint diagnosis only when that chronic condition is treated or becomes an active factor in the patient's care.

Always select ICD-10-CM codes to the highest level of specificity supported by documentation. For example, diagnosis coding for fractures of the wrist and hand requires a 5th code character (which specifies location), a 6th code character (which specifies the laterality and whether the fracture is displaced or nondisplaced), and a 7th code character (which specifies the episode of care). If this information is not documented, appropriate code selection is impossible. You should work with your provider to ensure that the information necessary for proper coding is always noted.

Diseases of the Musculoskeletal System and Connective Tissue

Most of the codes within Chapter 13 in the ICD-10-CM code book have site and laterality designations. The site represents the bone, joint, or the muscle involved. For some conditions where more than one bone, joint, or muscle is usually involved, such as osteoarthritis, there is a "multiple sites" code available. For categories where no multiple site code is provided and more than one bone, joint or muscle is involved, multiple codes should be used to indicate the different sites involved. ICD-10 uses "blocks" of code categories to group related conditions:

M00-M02	Infectious arthropathies
M04	Autoinflammatory syndromes
M05-M14	Inflammatory polyarthropathies
M15-M19	Osteoarthritis
M20-M25	Other joint disorders
M26-M27	Dentofacial anomalies [including malocclusion] and other disorders of jaw
M30-M36	Systemic connective tissue disorders
M40-M43	Deforming dorsopathies
M45-M49	Spondylopathies
M50-M54	Other dorsopathies
M60-M63	Disorders of muscles
M65-M67	Disorders of synovium and tendon
M70-M79	Other soft tissue disorders
M80-M85	Disorders of bone density and structure
M86-M90	Other osteopathies
M91-M94	Chondropathies
M95	Other disorders of the musculoskeletal system and connective tissue
M96	Intraoperative and postprocedural complications and disorders of musculoskeletal system, not elsewhere classified
M97	Periprosthetic fracture around internal prosthetic joint
M99	Biomechanical lesions, not elsewhere classified

Many codes have been relocated from other chapters in ICD-10-CM to Chapter 13 in ICD-10-CM (for example, gout, osteomalacia, malocclusion, dislocation of the knee, etc.).

For certain conditions, the bone may be affected at the upper or lower end, (for example, M87 *Osteonecrosis*, M80 *Osteoporosis with current pathological fracture*, M81 *Osteoporosis without current pathological fracture*). Though the portion of the bone affected may be at the joint, the site designation will be the bone, not the joint.

Many musculoskeletal conditions are a result of previous injury or trauma to a site or are recurrent conditions. Bone, joint, or muscle conditions that are the result of a healed injury are usually found in Chapter 13. Recurrent bone, joint, or muscle conditions are also usually found in Chapter 13. Any current, acute injury should be coded to the appropriate injury code from chapter 19. Chronic or recurrent conditions should generally be coded with a code from Chapter 13. If it is difficult to determine from the documentation in the record which code is best to describe a condition, query the provider.

Osteoporosis is a systemic condition, meaning that all bones of the musculoskeletal system are affected. Therefore, site is not a component of the codes under category M81, *Osteoporosis without current pathological fracture*. The site codes under category M80, *Osteoporosis with current pathological fracture*, identify the site of the fracture, not the osteoporosis.

Category M81, *Osteoporosis without current pathological fracture*, is for patients with osteoporosis who do not currently have a pathologic fracture due to the osteoporosis, even if they have had a fracture in the past. For patients with a history of osteoporosis fractures, status code Z87.310, *Personal history of (healed) osteoporosis fracture*, should follow the code from M81.

Category M80, *Osteoporosis with current pathological fracture*, is for patients who have a current pathologic fracture at the time of an encounter. The codes under M80 identify the site of the fracture. A code from category M80 (not a traumatic fracture code) should be used for any patient with known osteoporosis who suffers a fracture from a minor fall or trauma, only if that fall or trauma would not usually break a normal, healthy bone.

Enthesopathies are disorders of peripheral ligamentous or muscular attachments. Peripheral enthesopathies and allied syndromes (conditions described with the suffix "-itis"), describe inflammation. Osteomyelitis is now classified by type, acuity, specific site, and laterality.

M75.01	Adhesive capsulitis of right shoulder
M25.722	Osteophyte, left elbow
M70.11	Bursitis, right hand
M76.12	Psoas tendinitis, left hip
M70.51	Other bursitis of knee, right knee
M77.42	Metatarsalgia, left foot

Evaluation and Management Coding for Rheumatology

This chapter examines the documentation requirements for the evaluation and management (E/M) codes used by physicians and non-physician practitioners (NPPs) to bill for their services.

The E/M documentation requirements chapter is designed to provide a detailed approach to the accurate identification of documentation elements as they are defined by the American Medical Association (AMA) Guidelines for E/M services. The goal of this material is to offer the necessary insight to develop proficiency and correct technique to accurately select levels of E/M services for the exam. This material is not meant to influence policy, rather to refer to as coding guidelines for the CRHC™ exam.

This chapter should be reviewed with the CPT® guidelines for E/M services found in the current CPT® code book. This guide is a general summary that explains commonly accepted aspects of selecting E/M codes. The goal is that, after completing your training, you will be confident that you will not under or over code a visit.

An Introduction to the Documentation Requirements Associated with E/M Services

The E/M Documentation Guidelines (DGs) have perhaps inspired more discussion than any other non-clinical topic based in the industry. In an ever-increasing effort to ensure that correct payments are made for visits and consultations, Medicare and the AMA have been working together for well over a decade. In 1992, Medicare transitioned to the Resource-Based Relative Value Scale (RBRVS) physician payment system and the AMA introduced E/M codes in CPT® to report visits and consultations.

By 1994, in response to confusion and the inaccurate interpretation of the codes, the Office of Management and Budget mandated that Medicare adopt DGs to expand the definition that was, at that time, only provided by CPT®. Medicare and the AMA jointly developed this initial set of E/M DGs which were deployed in 1995 and became known as the 1995 Documentation Guidelines or DGs. As auditing showed a pattern of continued misuse of the E/M Codes, the 1995 DGs were criticized as unfair to specialists because they seem to account for extended single system examinations with as much weight as limited multiple system exams.

Within two years, the E/M DGs were revised to improve physician and provider understanding and payment accuracy by extending the definitions to include specialty specific guidance. This set of DGs was scheduled to replace the 1995 DGs and became known as the 1997 DGs. The only problem was that the physician community loudly objected to the 1997 DGs. They were criticized as burdensome with documentation requirements that were too detailed and very difficult to achieve. Medicare decided to not replace the 1995 DGs but to instead allow physicians and providers to choose between the 1995 and the 1997 DGs.

In 2021, in an attempt to simplify the guidelines, the AMA changed the descriptions of the Office or Other Outpatient E/M Services codes 99202-99215. In addition, guidelines for the use of these codes were printed in the CPT® code book. The guidelines added in the 2021 CPT® code book were specific to Office or Other Outpatient E/M Services. In 2023, the AMA expanded the use of the guidelines introduced in 2021 to other E/M categories, eliminating the need for the 1995 and 1997 DGs.

Documentation Guidelines

There are three general principles regarding documentation to ensure credit can be thoroughly verified. It is important to follow these rules of thumb:

1. Documentation should be legible to someone other than the documenting physician or provider and their staff.
2. The date of service, name of the patient, and the name of the provider of service should be easily demonstrated by the documentation.
3. The documentation should support the nature of the visit and the medical necessity of the services rendered.

For most E/M visits, the provider performs three main components: history, exam, and medical decision making (MDM). The history directs the provider to troubleshoot the chief complaint based on an interview with the patient. The exam portion is the provider's physical exam and evaluation of the patient. The MDM includes the provider's assessment and plan.

The guidelines for E/M Services, along with the code descriptors, indicate that a "medically appropriate history and/or physical examination, when performed" is included in the service. While the history and exam should be documented, they are not used in the determination of the level of the code.

The guidelines also include pertinent definitions for terms necessary to understand when determining the level of MDM. You should read through the definitions provided in your CPT®

code book and refer back to them as we go through the MDM components below.

The E/M guidelines provide instructions for selecting the appropriate level of service based on either of the following:

1. The level of the MDM as defined for each service; or
2. The total time for E/M services performed on the date of the encounter.

The provider can determine to support the E/M level of the visit based on MDM or time on a case-by-case basis. Regardless of which element is used to determine the level of visit, documentation should support the medical necessity of the visit. Payers may also have regulations on when MDM or total time is used.

Determining the Medical Decision Making (MDM)

The MDM most accurately reflects the amount of work a provider performs during an E/M service. Four levels of MDM are recognized: straightforward, low, moderate, and high. The level of MDM directly correlates to a level of service.

EXAMPLE: OFFICE VISIT MDM TO CODE CORRELATION

New Patient Code	Established Patient Code	Level of MDM
	99211	N/A 99211 is reported for services that typically do not require the presence of a provider. As such, the concept of MDM does not apply to code 99211.
99202	99212	Straightforward
99203	99213	Low
99204	99214	Moderate
99205	99215	High

To adequately determine the level of visit, the MDM is selected based on three components:

1. The number and complexity of problems addressed at the encounter;
2. The amount and complexity of data to be reviewed and analyzed; and
3. The risk of complications and/or morbidity or mortality of patient management.

To determine the levels of these components appropriately, the definitions provided in your CPT® code book must be understood. Using a grid method, we will discuss each component. Be sure to refer back to the definitions listed in the E/M Guidelines as needed.

Number and Complexity of Problems

The number and complexity of problems identifies the nature of the presenting problem and is based on the relative difficulty level in making a diagnosis. For the problem to be considered in the number of problems, the problem must be addressed within that encounter.

Per CPT®, symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Multiple problems of lower severity may, in aggregate, create higher risk due to interaction.

The final diagnosis alone does not determine the complexity or risk to the patient. The documentation should be reviewed for comorbidities or underlying diseases that are addressed that increase the level of risk to the patient. Simply listing a chronic illness in the documentation is not sufficient. The documentation should indicate that the provider addressed the conditions during the encounter or that the condition contributed to the severity of the case.

When a patient sees multiple providers for different aspects of their care, you may see a physician document the condition is being managed by another provider. When the documentation only states that the patient has the condition and that it is being treated by another provider, it is not considered for the leveling of the visit. If there is additional documentation showing assessment or care coordination regarding that diagnosis, other than the statement of the condition being treated by another provider, it is then considered toward the level of service.

TESTING TECHNIQUE

Read through the entire note to get an understanding of the conditions that are addressed and analyzed during the visit. Simply relying on the chief complaint will not always give an accurate description of the number and complexity of problems for the encounter.

There are four levels identified under the number and complexity of problems addressed; minimal, low, moderate, and high. As demonstrated by the table below, the level of Number/Complexity of Problems Addressed increases as the difficulty of the patient's health increases.

Introduction

In this chapter, we will discuss the procedures commonly performed in rheumatology practices. We will also cover CPT® coding guidelines and HCPCS Level II codes and modifiers.

Trigger Point Injections

Trigger point injections are focal, discrete spots of hypersensitive irritability identified within bands of muscle. These points cause local or referred pain. Trigger points may be formed by acute or repetitive trauma to the muscle tissue, which puts too much stress on the fibers. The provider identifies the trigger point injection site by palpation or radiographic imaging and marks the injection site. The needle is inserted into the muscle and the medication is injected into the trigger point. The codes are selected based on the number of muscles injected, not the number of injections performed. CPT® 20552 is used to report injection of single or multiple trigger points in one to two muscles. CPT® 20553 is used to report single or multiple trigger points in three or more muscles.

Arthrocentesis

Arthrocentesis describes sticking a needle into a joint for aspiration, or for injection of a medication. These injections are performed for diagnostic and therapeutic services. The diagnostic injection is commonly done in addition to an evaluation and management (E/M) service, especially for new patients presenting with pain and swelling of the joints and being treated for the first time. During that first encounter, the physician may decide to perform an arthrocentesis to get the swelling down. In that instance, when a separately identifiable E/M service is performed, bill for both the E/M service and the arthrocentesis performed on the same day. If the patient returns for additional arthrocentesis services (not in conjunction with a new problem or E/M service), only the arthrocentesis is reported. If the provider performs an aspiration and injection in the same joint, the procedure code is reported only once. If the service is performed in more than one joint, report the appropriate procedure code for each joint.

The following codes report arthrocentesis:

- 20600 Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes); without ultrasound guidance
- 20604 Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting
- 20605 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance
- 20606 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting
- 20610 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa); without ultrasound guidance
- 20611 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

Documentation for arthrocentesis should include the following:

- The patient's history
- Any extenuating circumstances
- The specific diagnosis codes
- The drugs injected (separately billable in office setting)
- The specific sites of each injection
- The medical necessity for giving the injections
- The expected outcome of the treatment
- Permanent recording and reporting in medical record when ultrasound guidance is utilized

Medications provided by the provider can also be reported using the appropriate HCPCS Level II codes.

Venipuncture

Venipuncture is the collection of venous blood. The collection of the specimen by venipuncture is not considered an integral part of the laboratory procedure performed. For reporting the performance of the lab test only, do not include the collection of the specimen via venipuncture, which is 36415 *Collection of venous blood by venipuncture*, or finger/heel/ear stick, which is 36416 *Collection of capillary blood specimen (eg, finger, heel, ear stick)*.

In addition, 99000 *Handling and/or conveyance of specimen for transfer from the office to a laboratory* should be reported when the physician's office centrifuges the specimen, separates the serum and labels, or packages the specimens for transport to the laboratory.

If venipuncture is performed in the office to obtain a blood specimen, report 36415 *Collection of venous blood by venipuncture*. Many payers bundle this service with E/M codes, so always check your payers' policies.

Facet Joint Injections

The goal of facet joint injections is to aid in finding a diagnosis for the pain and to provide the patient with pain relief.

There are two primary codes and four add-on codes for these services. CPT® code 64490 is an injection of the paravertebral facet joint or facet joint nerve in the cervical or thoracic spine, and this is a single level. This joint consists of the bony spaces between the vertebrae that articulate with each other.

In coding this service, you first need to determine how many spaces are being injected. For instance, an injection between C3 and C4 and C4 and C5 involves two levels and two separate joints. For the first level, report 64490 and for the second level, report 64491. Report 64492 for the third and any additional levels (this code can only be reported once per day). Fluoroscopy or computed tomography guidance is included with these codes and should not be reported separately.

The next codes for your facet joint injections are: 64493, for the lumbar or sacral single level; 64494 for the second level; and 64495 for the third and additional levels. The clinician must document the location of the spine where the facet joint injections were performed, and the number of levels injected for proper code selection. If ultrasound guidance is performed, report a code in the 0213T-0218T range, depending on the region of the spine and number of levels.

Modifiers

Modifiers are appended to procedure codes to identify a procedure that has been altered in a specific way without changing the code description itself. Modifiers can be informational or effect reimbursement. Proper modifier use is crucial for appropriate reimbursement.

There are two types of modifiers: pricing and informational. Whenever multiple modifiers apply to a service, list the pricing modifiers first so payers process the claim appropriately. For example, if you are reporting services that are typically bundled, report modifier 59 first before other modifiers, such as LT, so the payer knows that a distinct procedure was performed.

Modifier 24

Apply this modifier when a patient presents with a new problem within the global period of a procedure. A different diagnosis is necessary to indicate that the E/M service within the global period is not related to procedure. Non-Medicare payers may accept this modifier for a patient visit due to complications from the previous procedure.

Modifier 25

Modifier 25 is used when a significant and separately identifiable E/M service is performed by the same physician or other qualified healthcare professional on the same day of the procedure or other service. It's important that the documentation supports the separate service. How do you know if it is significant and separately identifiable? If the documentation can stand alone from other services, then it is significant and separately identifiable.

For example, an arthrocentesis is scheduled to be performed. The provider examines the patient's knee and then performs the procedure. Each minor procedure has a component of E/M included. Because the provider is planning to perform a minor surgery, examining the area of the procedure is included in performing the procedure. Examining the patient's knee is not a significant and separately identifiable E/M service for the arthrocentesis.

There are some common reasons for denial when modifier 25 is used: excessive use of modifier 25; unbundling procedures included with an E/M visit (some insurance carriers bundle E/M services with minor procedures); and incorrect placement of the modifier (modifier 25 is appended to the E/M service, not the minor procedure code). It's important to know what your payer contracts include.

Modifier 26

Modifier 26 is used most commonly in offices that have the capability of performing radiology services vs offices that do not have the capability of performing radiology services. Modifier 26 is used to report the professional component of procedures that have a professional and technical component. X-rays, for example, have a professional component which is the interpretation of the X-ray and a technical component which includes the use of the equipment, and the service of the technician who takes the X-ray. When your physician is only performing the professional component, bill for the X-ray code with modifier 26 to alert the payer that you are only performing the professional component. This occurs when the patient is sent to an outpatient hospital facility or an X-ray facility. The patient goes to have the X-ray performed and the physician is only going to interpret (read) the actual X-ray for diagnosis. For this example, select the appropriate CPT® code for the X-ray and append modifier 26. If your practice owns the X-ray

Top 10 Missed Coding Concepts on CRHC™ Examination

The tips provided below are based on the AAPC examination department observations of the most missed coding concepts.

1. **Infusions:** Infusion codes are selected based on the type of medication administered and the duration of the infusion. Hydration codes should not be reported when normal saline is infused with another medication. The supply drug for saline is not billed separately unless medically necessary hydration is provided. For infusions lasting up to one hour, report 96365 for therapeutic infusions (such as Benadryl) and 96413 for chemotherapy or other highly complex medications (such as Remicade). Only one initial code is reported per encounter unless the patient requires two distinct intravenous access sites. Any additional infusions are billed using the appropriate add-on codes. The selection of the initial infusion code is based on the primary purpose of the encounter.
2. **Modifier 50:** Modifier is not reported on codes that indicate the words bilateral or both in the code description. For example, 73050 *Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction*; modifier 50 is not reported for this code.
3. **Split/Shared Visits:** A shared/split visit occurs when an NPP and physician are involved in the same patient case. Shared/split visits does not apply in the office setting, only in the facility setting. If performed in the office setting, refer to incident-to requirements. In the facility setting, if the physician and NPP in the same group performs a face-to-face encounter or non-to-non-face-to-face time, the service is billed by either physician or the NPP depending on which one performs the substantive portion (more than half) of the visit. CPT® defines substantive portion when code selection is based on time will need to be more than half of the total time or two out of three elements when the level is based on MDM.
4. **AMA Guidelines for Number and Complexity of Problems Addressed at the Encounter:** CPT® guidelines indicate, "stable" is defined by whether the patient has met their individual treatment goals, not simply by whether the condition is unchanged. A chronic condition is not considered stable if the patient has not reached the desired therapeutic target, even when the condition shows no recent progression and there is no immediate threat to life or function.

   For instance, a patient whose blood pressure remains consistently above goal is not considered stable, even if they feel well and their readings are not worsening. Similarly, a rheumatology patient with rheumatoid arthritis whose symptoms persist and whose inflammatory markers remain above target despite current treatment is also not stable, because the patient has not achieved the treatment goals necessary to prevent long-term joint damage and morbidity.
5. **Incident-to Guidelines:**
   - The physician must be physically present in the office suite to provide direct supervision; they do not need to be in the same room with the patient.
   - To bill services as incident-to, the care must follow the physician's established treatment plan for an established patient.
     - Example: An established patient who returns for follow-up under the physician's treatment plan and is seen by a PA or NP may be billed incident-to under the physician if the physician is in the office suite.
   - If the physician is not in the office—for example, seeing patients at the hospital—incident-to billing cannot be used because supervision requirements are not met.
   - Incident-to billing is not allowed in facility settings (e.g., hospitals, skilled nursing facilities).
6. **New vs. established patient determination:** If the patient is seeing a provider in the same group practice but of a different specialty for the first time, the encounter is coded as a new patient. APRNs and PAs working with physicians of a certain specialty are considered to be of that same specialty.
7. **Consultation rules according to CPT® and CMS:** According to CPT® guidelines, a consultation requires all of the following:
   a. A documented request for the consultation from a physician or other qualified healthcare professional.

b. An evaluation and opinion provided to offer recommendations for a specific problem or to determine whether the consultant should assume ongoing management of all or part of the patient's care.

c. A written report of the consultant's findings and recommendations sent back to the requesting provider.

If any of these elements are missing—such as the absence of a documented written report—the service cannot be billed as a consultation. Because CMS no longer reimburses consultation codes, office/outpatient E/M codes or hospital care codes must be reported when the patient is covered by Medicare. Do not assume Medicare coverage based on the patient's age; on the exam, Medicare status will always be clearly indicated in the case note or question.

8. **AMA E/M Guidelines for Selecting the Level for the Amount and/or Complexity of Data to be Reviewed:** When assessing the *Amount and/or Complexity of Data* in MDM, determining whether a test—such as a radiology study (e.g., ultrasound), laboratory test (e.g., CRP), or medicine test (e.g., EMG)—counts toward data depends on whether the test is separately reportable. If a diagnostic test is ordered, performed, or interpreted during the visit and the provider bills a CPT® code separately for the professional interpretation, that test does not count toward the E/M data element as a unique test. Tests that do not require a separate interpretation—such as laboratory studies reported only by their immediate results (e.g. dipstick urinalysis)—may be counted as ordered or reviewed towards the MDM. At a follow-up visit, reviewing the results of a test that was ordered at a previous encounter is not counted again because credit was already given at the time the test was ordered.

9. **AMA E/M Guidelines for Selecting the Level for the Risk of Complications and/or Morbidity or Mortality of Patient Management:** Risk is assessed based on the provider's judgment of the patient's likelihood of becoming ill, developing complications, or experiencing morbidity or mortality between this visit and the next planned encounter. E/M guidelines clarify that the *risk of patient management* is separate from the *risk of the underlying condition*. The level of risk reflects the management decisions made by the reporting provider during the encounter. For example, prescribing a medication that must be filled by a pharmacist is considered moderate risk because it involves prescription drug management. If the prescription is changed in dosage or the provider stops the medication that is also considered prescription drug management. In contrast, recommending an over-the-counter medication represents low risk, as the patient can obtain the medication without a prescription.

10. **ICD-10-CM code selection for suspected or probable diagnosis:** Conditions documented as suspected, rule out, versus, or probable are not coded. While this information is important clinically and should remain in the documentation, it is not reported as an ICD-10-CM diagnosis. Instead, report the patient's signs or symptoms.

AAPC continuously evaluates and enhances our certification exams throughout the year. As AAPC continues to enhance the certification exams, we are beta testing the inclusion of a fill-in-the-blank item type on our certification exams. To prepare you for both item types (multiple choice and fill-in-the-blank), we have provided two versions of this practice exam. The same questions are on both versions of the Test Your Knowledge practice exam; however, the last three cases on this version of the practice exam are fill-in-the-blank. If you prefer to test using the multiple-choice item type for all the cases, use practice exam B.

The following questions will test your comprehension of the information covered in this study guide. The answer key is used for both versions of the Test Your Knowledge practice exams.

Version A

CASE 1

Chief Complaint: Multiple joint pains.

History of Present Illness: Dr. X, the patient's primary care physician, requested I see the patient for further evaluation of multiple joint pains. He states to me that his symptoms started about 4 months ago, affecting his shoulders, knees, and then both his wrists and hands. He describes to have 2 to 3 hours of morning stiffness. He feels somewhat better when taking a hot shower and after he takes medications. He states that six months ago he had a motorcycle accident and had dislocated hip and broken ribs. He gradually improved and started to exercise. After a few weeks, his multiple joint pains started. He was put on Celebrex for 3 weeks, which initially helped, and then it did not. He was given Naproxen without any relief in his symptoms. He is currently taking aspirin, 325 mg, 2 tablets every 4 hours on an as-needed basis, alternating with Tylenol, 2 tablets every 4 hours. He had multiple blood tests done within the past few weeks including herpes virus 6 antibody that yielded negative results; uric acid is normal; and complete blood count (CBC) is within normal limits, except slightly elevated white blood cell (WBC) at 11.6 and platelet count at 464. RPR was nonreactive. Complete metabolic panel was normal, except slightly elevated alkaline phosphatase. He had Lyme tests done last week. The results are not available to us. He was put on doxycycline for presumable Lyme disease on September 28. He reports that he had multiple insect bites a week before the pain started. He denies any tick bites or any rash.

Past Medical History:

1. Hypercholesterolemia
2. History of colon cancer, status-post surgery in 1997
3. Gastroesophageal reflux disease

Medications:

1. Doxycycline 100 mg p.o. bid
2. Aspirin pm
3. Tylenol pm
4. Crestor 30 mg p.o. daily
5. Prevacid 30 mg p.o. daily

Allergies: NKDA

Social History: He is a retired military officer. He quit smoking in 1969. He drinks alcohol very occasionally.

Family History: Father had prostate cancer. Mother had breast cancer. No siblings

Review of Systems: He denies any constitutional symptoms, except intentional weight, on military diet. He denies any eye or ear symptoms, cardiovascular, respiratory, gastrointestinal (GI), or genitourinary symptoms. He has physical disability because of pain. He has joint pain and stiffness and difficulty with making fists. He also has a numbness and tingling sensation in his right hand. No rashes or itching.

Physical Examination: He is an elderly male in no acute distress. Vital signs: blood pressure (BP) 138/80 mm Hg, temperature 98.0°F, pulse 80 beats/min

HEENT: Examination reveals no conjunctival injections or scleral icterus. There are oral mucosal ulcers. Chest: Is clearly bilaterally, without any crackles or wheezing. Equal air entry. Heart: Examination is unremarkable, with SI, S2 regular. There is no murmur. Abdomen: Benign. Soft, no masses or tenderness. Normal spleen. Neurologic: Oriented and alert ×3. Normal motor and sensory function.

Musculoskeletal Examination: No tenderness on both shoulders, with normal range of motion (ROM). There is no swelling or tenderness on his elbows. He has tenderness on his right wrist with swelling. There is no swelling on his left wrist. He has a slight limited ROM with flexion on both wrists, more on the right side. He has synovitis across all metacarpophalangeal joint (MCP) joints on his right hand, with no tenderness. There is a subtle synovitis on his few PIP joints on both hands. There is a mild synovitis on his few MCP joints as well. He is unable to make a fist on both his hands, more pronounced on the right one. He has a loss of the distal portion of his 3rd and 4th fingers at the PIP level on the left hand. He has full ROM of the hips, without any pain. There is no effusion on his both knees. There is no increased warmth or swelling. There is no tenderness on his ankles. Skin: Examination is unremarkable, without any nodules or rash. Warm/dry, no diaphoresis.

Assessment and Plan: This is a 64-year-old gentleman with inflammatory arthritis multiple sites, most likely rheumatoid arthritis. I would like to obtain a rheumatoid factor, anti-CCP antibody, erythrocyte sedimentation rate, and C-reactive protein (CRP). I would like to put him on prednisone, 10 mg in the morning, 5 mg at night for 1 week, then decrease it to 5 mg p.o. bid until I see him. He will be seen in 2 weeks for further management.

He had Lyme tests done last week. The result is not available to me. He is on doxycycline, I do not have any clinical suspicion for Lyme disease, although I would rather wait for lab results before we decide on doxycycline at this point.

Please make sure Dr. X receives my written recommendations.

1. The evaluation and management (E/M) section for this encounter is as follows:

   A. Office consultation
   B. Established patient
   C. New patient
   D. Preventive medicine

2. What is the level for number and complexity of problems addressed at the encounter?

   A. Minimal
   B. Low
   C. Moderate
   D. High

3. What is the level for amount and/or complexity of data to be reviewed and analyzed?

   A. Minimal or None
   B. Limited
   C. Moderate
   D. Extensive

After reviewing the answers and rationales, if you have further questions, please send them to: mct@aapc.com

CASE 1

Chief Complaint: Multiple joint pains

History of Present Illness: Dr. X, the patient's primary care physician, requested I see the patient for further evaluation of multiple joint pains. [1] He states to me that his symptoms started about 4 months ago, affecting his shoulders, knees, and then both his wrists and hands. He describes to have 2 to 3 hours of morning stiffness. He feels somewhat better when taking a hot shower and after he takes medications. He states that six months ago he had a motorcycle accident and had dislocated hip and broken ribs. He gradually improved and started to exercise. After a few weeks, his multiple joint pains started. He was put on Celebrex for 3 weeks which initially helped, and then it did not. He was given Naproxen without any relief in his symptoms. He is currently taking Aspirin, 325 mg, 2 tablets every 4 hours on an as-needed basis, alternating with Tylenol, 2 tablets every 4 hours. He had multiple blood tests done within the past few weeks including herpes virus 6 antibody, which showed a negative result; uric acid is normal; complete blood count (CBC) is within normal limits except slightly elevated white blood cell (WBC) at 11.6, and platelet count 464. RPR was nonreactive. Complete metabolic panel was normal except slightly elevated alkaline phosphatase. He had Lyme tests done last week. The results are not available to us. He was put on doxycycline for presumable Lyme disease on September 28. He reports that he had multiple insect bites a week before the pain started. He denies any tick bites or any rash.

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Assessment and Plan: This is a 64-year-old gentleman with inflammatory arthritis multiple sites, most likely rheumatoid arthritis. [2] I would like to obtain a rheumatoid factor, anti-CCP antibody, erythrocyte sedimentation rate, and C-reactive protein (CRP). [3] I would like to put him on prednisone, 10 mg in the morning, 5 mg at night for 1 week, then decrease it to 5 mg po bid until I see him. [4] He will be seen in 2 weeks for further management.

He had Lyme tests done last week. The result is not available to me. He is on Doxycycline. I do not have any clinical suspicion for Lyme disease, although I would rather wait for lab results before we decide on Doxycycline at this point.

Please make sure Dr. X receives my written recommendations. [5]

[1] Request from physician.

[2] Chronic illness with exacerbation

[3] Four unique tests (labs) ordered

[4] Prescription management

[5] Written report to the referring provider

1. **Answer:** A. Office consultation

   Rationale: Requirements for a consultation include the following: request from a physician, render an opinion, and written report to the requesting physician. For this encounter, the requirements for a consultation have been met.

2. **Answer:** C. Moderate

   Rationale: Chronic illness, with exacerbation, progression, or side effects

3. **Answer:** C. Moderate

   Rationale: Physician ordered four unique lab tests.

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