ADVANTUM HEALTH

REVENUE CYCLE INTELLIGENCE

JULY 2026 · QUARTERLY CLINICAL & REVENUE UPDATE

Ortho Revenue Report

Clinical shifts and revenue-cycle risk for orthopedic practices, distilled for the people who run them.

IN THIS ISSUE — FOUR BRIEFINGS

The rise of shoulder replacement

Not long ago, shoulder replacement was a niche procedure: technically demanding, limited in patient pool, and overshadowed by the volume and policy infrastructure built around hips and knees. That is changing fast. Shoulder arthroplasty is now one of the fastest-growing joint procedures in orthopedics, driven not by a single trend but by several forces converging at once.

MARKET ADOPTION PHASE

Early adoption	Expansion	Maturity
past	now — validated by outcomes	ahead

CONVERGING DRIVERS OF VOLUME GROWTH

Reverse shoulder arthroplasty (RSA)

The turning point. For decades a successful replacement required an intact rotator cuff, leaving patients with cuff tear arthropathy, complex fractures, or failed prior surgeries with few options. RSA redesigned the biomechanics so the deltoid takes over where the cuff failed.

A larger, earlier patient pool

An aging population is pushing more degenerative shoulder disease into practices, and patients are less willing to accept lost function. Surgeons are operating earlier and expanding into fracture and revision cases once managed conservatively.

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CONVERGING DRIVERS OF VOLUME GROWTH

Technology catching up

3D preoperative planning, patient-specific instrumentation, and improved glenoid fixation are addressing the classic failure modes — loosening, instability, and malalignment — that once made surgeons hesitant.

The outpatient shift

Shoulder arthroplasty suits ambulatory surgery centers well: lower blood loss than hip or knee, less physiologic stress, and effective regional anesthesia. As cases migrate to ASCs, cost and throughput incentives reinforce growth.

> *"In orthopedics, good results scale volume."*
>
> **Andrea Utterback**
> VP Enterprise RCM Operations

KEY TAKEAWAY

The shoulder arthroplasty market is firmly in its expansion phase: past early adoption, validated by outcomes, and broadening in both patient population and care setting. The patterns driving it are a preview of what is happening across orthopedics.

One caveat worth tracking: whether patient selection keeps pace with expanding indications, especially on long-term implant durability where the data is still maturing.

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The post-operative revenue window

Routine post-op follow-up is bundled into the global surgical package. What gets missed is the legitimate, separately billable work that happens in that same period when care extends beyond routine recovery. The global period is not a billing blackout; it is a framework with specific rules, and documenting to them is the difference between recovering revenue and writing it off.

MODIFIER QUICK REFERENCE

-24
Unrelated E/M during the global period

-25
Distinct, separately identifiable E/M on the same day as a procedure

-54
Surgical care only, when the operating surgeon will not provide post-op management

-55
Post-operative management only, when a receiving provider assumes follow-up

-78
Return to the OR for a related complication during the global period

-79
Unrelated procedure during the global period

WHERE REVENUE COMMONLY LEAKS

Unrelated conditions at post-op visits

A separate issue (hypertension, a new musculoskeletal complaint) is reportable, but only if the note identifies it as distinct. Generic "post-op follow-up" language does not support it.

Separately identifiable E/M

A new diagnosis, significant status change, or complex decision-making beyond standard recovery assessment can support a separate E/M, if the record differentiates it.

Complications beyond normal recovery

Surgical site infections, thromboembolic events, or wound dehiscence requiring substantial decision-making or a return to the OR may qualify for separate reporting.

Transfer of care & outside providers

Modifiers 54 and 55 split reimbursement when the surgeon will not manage recovery, but require documented transfer. Hospitalists and consultants on unrelated conditions can bill independently.

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DENIAL EXAMPLE · CONTRALATERAL JOINT INJECTION DURING THE GLOBAL PERIOD

A patient recovering from total hip arthroplasty receives a corticosteroid injection to the contralateral knee at a follow-up visit.

WHY IT WAS DENIED

The note read “post-op follow-up,” with no distinct knee diagnosis, no laterality, and no stated medical necessity. Without those elements and Modifier 79, the payer bundled the injection into the surgical package.

THE FIX

A separate diagnosis for the knee, a note identifying the injection as unrelated to the hip surgery, documented laterality, and **Modifier 79**. The same service becomes separately billable.

THE PATTERN

Post-op revenue is lost less because a service is non-billable and more because documentation does not clearly separate unrelated care from routine recovery. Intentional documentation is the fix.

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Injection & E/M billing: what payers are watching

If the post-op window is about revenue you can recover, injection and E/M billing is about revenue you can lose. Payer scrutiny of orthopedic injections billed alongside E/M has increased sharply over the past year. Commercial carriers including Highmark BCBS and UnitedHealthcare have expanded payment-integrity initiatives, and the consequences are real: downcoding, denials, retroactive recoupments, and pre-payment audits.

HIGH-PRIORITY INJECTION SERVICES UNDER REVIEW

Corticosteroid injections

The highest-volume injection, and the highest-volume audit target. When the E/M and the injection look indistinguishable in the record, Modifier 25 cannot be supported.

Joint aspiration & injection

Frequently bundled with a same-date E/M. The record must show a separately identifiable evaluation, history, assessment, and decision-making independent of the procedure note.

Trigger point injections

Standing trigger point visits billed consistently with higher-level E/M codes are drawing audit attention.

Hyaluronic acid (viscosupplementation)

The most stringent LCD requirements of any ortho injection: documented conservative treatment failure, specific OA diagnosis coding, and appropriate trial periods.

CPT 76942 **Ultrasound-guided injections.** When guidance is billed, the note must support why guidance was medically necessary for that patient and site. Templated language does not meet the standard.

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RISK LEVEL BY DOCUMENTATION PATTERN

HIGH RISK	E/M not separately identifiable from the injection, reading as one bundled encounter
HIGH RISK	Insufficient documentation to support Modifier 25
WATCH	Standing injection visits billed with higher-level E/M without supporting complexity
WATCH	Hyaluronic acid claims without documented failed conservative therapy and qualifying diagnosis
REVIEW	Ultrasound guidance billed without site- and visit-specific necessity language

The Level 5 E/M auto-downcoding problem

Both UnitedHealthcare and many BCBS plans now apply claim edits that automatically reduce Level 5 E/M services (99215 established, 99205 new) to Level 4 when billed on the same date as a procedure, regardless of whether the documentation supports Level 5 complexity. The payer rationale is that E/M complexity is “not separately supported” alongside a procedure. That logic ignores the record: medical decision-making or time can support a Level 5 independent of a same-day procedure, and the American Medical Association has formally resolved to oppose unilateral E/M downcoding by insurers — a resolution that specifically names the Cigna and Aetna programs — holding it is never acceptable to downcode a claim without reviewing the medical record. A second pattern works differently: Cigna's E/M Coding Accuracy policy (R49), effective October 1, 2025, reviews physicians whose coding runs high against their peers and can drop a visit one level, with appeal rights when the record supports it.

LEVEL 5 E/M

99215 · 99205

documented complexity

AUTOMATED CLAIM EDIT →

DOWNCODED TO

Level 4

regardless of the record

Same-day-procedure edits fire on co-billing; peer-pattern reviews (e.g., Cigna R49) fire on billing patterns — in both cases the documented MDM or time can support a Level 5 that the edit ignores.

For orthopedics, this hits hardest in complex new-patient visits, post-op evaluations with significant complications or comorbidities, and high-MDM established-patient encounters where a procedure also happens. The impact compounds fast across high-volume practices.

WHAT PROVIDERS CAN DO

When a Level 5 is clinically justified, the documentation has to make that case explicitly, through MDM elements (number and complexity of problems, data reviewed, risk) or clearly documented total time. A note that reads like a Level 3 will not survive a downcode appeal, whatever the actual complexity of care. Build the record to reflect the work.

Sources: UnitedHealthcare E/M Services Policy (commercial reimbursement policies); Cigna E/M Coding Accuracy Policy R49, effective October 1, 2025; BCBS regional guidelines published by Highmark and affiliates in provider manuals, with Federal Employee Program references at fepblue.org/providers. AMA position: American Medical Association, advocacy and guidance on E/M downcoding (ama-assn.org).

AI-driven denial defense at Advantum Health

Traditional denial management is reactive by design: a claim goes out, a denial comes back, and a team works to recover it. It is a workflow built around failure. Advantum Health is building the opposite — an intelligence-led approach that treats prevention as the goal and recovery as the fallback. Our platform pairs Denial AI and MedReasoning to analyze claims before submission, flagging the ones most likely to be denied or downcoded while the cost of fixing them is still low.

TRADITIONAL · REACTIVE

Claim goes out

↓

Denial comes back

↓

Team works to recover

A workflow built around failure.

ADVANTUM · INTELLIGENCE-LED

Analyze before submission

↓

Flag denial & downcode risk

↓

Fix while cost is low

Prevention is the goal; recovery is the fallback.

WHAT THE PLATFORM DOES

Pre-submission risk identification

We flag correctable coding, documentation, and downcode-risk issues before the claim goes out, improving first-pass yield.

Evidence-based appeal support

When denials occur, we prioritize the highest-impact cases and generate audit-ready, compliant appeals grounded in payer policy and coding standards, with human oversight at every step.

Root-cause insights

Continuous analytics surface recurring denial drivers so organizations can strengthen upstream documentation and coding.

Payer policy monitoring

We track edit-policy changes from UHC, BCBS affiliates, and other carriers and alert clients before an unexpected denial is how they find out.

WHY IT MATTERS FOR ORTHOPEDICS

Ortho carries some of the highest denial rates in specialty care, driven by complex modifiers, global-period rules, injection bundling scrutiny, and now systematic E/M downcoding. These tools are built to address those patterns before revenue is lost, not after.

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LET'S TALK

Ready to see this applied to your practice?

Whether you are managing a coding backlog, adjusting to new payer rules, or working to reduce denials across your revenue cycle, our team is ready to help. Schedule a conversation with an Advantum Health specialist to find where your greatest orthopedic revenue opportunities are and how we can support your goals.

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Schedule a conversation

NEXT ISSUE Is robotic surgery actually improving outcomes, or just selling them?