

**Orthopaedic Coding Seminar
CA Orthopaedic Assoc.**

**Coding, Documentation, Reimbursement
& Compliance Issues
for Physician Practices & ASCs**

Speaker

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2012

ICD-9 AND SUMMARY OF UPCOMING CHANGE TO ICD-10

In January of 2009, CMS decided they wanted to change the diagnosis and hospital procedural coding system from ICD-9 to the ICD-10 system, which was related to the provisions of the Health Insurance Portability and Accountability Act (HIPAA) passed by Congress in 1996 to standardize health care information. While the original effective date for the change to the ICD-10 system for providers was originally supposed to be October 1, 2013, CMS has put a hold on that date and has not yet stated what the new implementation date will be. The following provides a comparison between the ICD-9 and ICD-10 coding systems out of the Federal Register 49802 from 2008.

Comparison of ICD-9 to ICD-10 Systems	
<u>ICD-9-CM</u>	<u>ICD-10-CM</u>
Diagnosis codes 3-5 digits	Diagnosis codes 3-7 characters
Approximately 14,000+ codes	Approximately 69,000+ codes
1st character can be Alpha or Numeric Followed by 2-5 Numeric characters	1 st character is Alpha; characters 2 & 3 are Numeric; characters 4-7 can be Alpha or Numeric
Limited space for addition of new codes	Flexible for addition of new codes
Coding system lacks detail	Coding system is very specific
Coding system lacks laterality	Coding system includes laterality
Coding system is difficult to analyze data due to non-specificity of codes	Specificity improves coding accuracy and ability to collect data
Coding system is non-specific - codes do not provide detail of diagnoses necessary for medical research	Detail of coding improves accuracy of data useful for research
Coding system not used in countries outside of the U.S.	Coding system allows exchange of data between the U.S. and other countries

One thing that hasn't changed - the PURPOSE of ICD-10 diagnosis codes is still to provide the Medical Necessity of WHY the procedure was performed or the services were rendered by the provider – just using more detail. This is why documentation is more important than ever!

Ways to Prepare for Change to ICD-10

- Identify key staff responsible for implementation and training at the practice/ASC.
- Set a budget for system upgrades and provider/staff training.
- Set aside a savings cushion for paying bills/payroll during first month or two after ICD-10 implementation since “glitches” are likely with your system, clearinghouse and/or with payors.
- Check in with your billing system vendor and clearinghouse on their readiness and keep in close contact with them about changes and readiness. Allow plenty of time for testing.
- Train coders, business office staff and physicians/extenders on coding changes, the ICD-10 system and the need for more detailed documentation on the part of physicians and other providers.
- Be sure any certified coders on staff are thoroughly trained on ICD-10 in a timely manner and that they take their coding tests on ICD-10 to keep his/her coding certification.
- Expect a possible decrease in physician and staff productivity during implementation and the first month or two after the entity is under the new ICD-10 system.
- Revision of the practice superbill and other business office forms may be necessary.

Other Considerations/Information

- Once ICD-10 is implemented, the ICD-9 system will be discontinued – this includes Medicaid and Workers’ Compensation carriers.
- Warn physicians and other providers if they do not provide the detail needed in their documentation, they will have more medical record addendums to deal with and inquiries from coding and billing staff before coding can be done and claims can go out – slowing down the practice/ASC revenue stream.
- It is more important than ever for physicians to make it clear in the documentation whether an orthopedic condition was an acute traumatic injury or a chronic problem (not involving a specific injury).

Ortho Examples and Information

- Instead of using E-codes as we do currently for how accidents occurred, under ICD-10, these situations will be much more detailed and will be in the V and Y sections.
- Instead of using V-codes under ICD-9, these codes will be found in the section with Z-codes.

Comparison of Format of Codes

Current ICD-9 Diagnosis codes can only have a maximum of 5 digits total.

ICD-9 Code Example: 123.45

Numbers 123 represent the Category. The numbers 4 and 5 represent the Etiology, Anatomic Site and Manifestation.

Under ICD-10, diagnosis codes can be 7-digits, as follows:

ICD-10 Code Example: 123.456 7

Numbers 123 represent the Category. Numbers 456 represent the Etiology, Anatomic Site or Severity, and Number 7 represents the Extension of the code.

- Many of the diagnosis codes for orthopedic conditions under ICD-10 address site and laterality - they state upon which side the leg, wrist, etc. was having the surgery (i.e., the Left Leg, the Right Wrist, etc.).
- The ICD-10 book will still contain an Alphabetic Index and a Tabular List section of codes similar to ICD-9. As with ICD-9, never code from the Alphabetic Index without verifying your code choice in the Tabular List.
- You can purchase software or books to help you with “mapping”, which is a method to convert an ICD-9 code into an ICD-10 code.
- Example of an ICD-10 diagnosis code for a Nonunion of a Fractured Tibia (at the shaft) of the Left Leg which had previous (unsuccessful) treatment would be initially coded as 582.25 for a 1) Fracture, 2) Traumatic, 3) Tibia (shaft), 4) Nonunion, 5) Left Tibia, 6) the Sequela is a Late Effect, which would have the coding completed as 582.252S.
- Recommended References for ICD-10 Information:
 1. *Principles of ICD-10-CM Coding – AMA*
 2. *Principles of ICD-10-CM Coding Workbook – AMA*
 3. *Preparing for ICD-10: Making the Transition Manageable – AMA*

CODING AND BILLING ISSUES FOR PHYSICIANS & ASCs

It is very important to code correctly, to assure you are not leaving any money on the table, while avoiding compliance problems. This seminar will update your coding knowledge and skills and provide you with specific tips you can use for the most common procedures performed in your ASC or physician practice.

Billing Issues

- Billing non-covered CPT codes for services with CPT codes for services which do not properly describe the procedure performed.
- Billing for new procedures (which do not have an existing CPT code) with a code for a procedure that does not fit [to be paid]. Carefully check out advice on coding for new technology or equipment you get from salespeople and equipment reps. – if they give you flawed advice and you code incorrectly, YOU are still responsible.
- Upcoding of CPT procedure or diagnosis codes.
- Unbundling of CPT procedure codes.
- Failure to refund Credit Balances in a timely manner.
- Medical Necessity issues.
- Billing inappropriately for Anesthesia Services.
- Scope of Practice violations.
- Billing improperly for “cancelled cases” vs. “terminated cases” in an ASC facility.
- Transforaminal Injections are a target area of the OIG due to their increased billings to Medicare by 130% between 2003 and 2007. Medical Necessity must be proven to give these injections. Be sure that for patients receiving multiple transforaminal injections over time there is documentation of improvement from these injections in the medical record.
- Facet Joint Injections are a RAC Audit issue related to billing for more than 3 levels, billing separately for use of Fluoroscopy in the procedure, or not following the diagnosis coding list on the Medicare LCD medical policy.
- Place of Service errors on claim forms. Physicians performing cases in ASC facilities must use POS 24 as the Place of Service on their claims for procedures performed at the ASC facility, rather than POS 11 for their office. If surgical procedures are performed at their office, they are reimbursed at a high rate than when they are performed at the ASC, which is a fraud issue.
- Changing the Date of Service on claims to correspond with coverage dates.

What is Fraud?

The Federal Government defines Fraud as willingly or knowingly engaging in a scheme to defraud or obtain by false or fraudulent pretenses money or property from a health care benefit program.

What is Abuse?

The Federal Government defines Abuse as involving actions that do not involve intentional misrepresentations in billing, but which result in improper conduct.

General Billing Basics and Tips

- Read the ENTIRE OP Report before coding the claim. Do not just code from or rely on the summary statements/listing of the surgery titles at the beginning of the report, do not code from a Superbill/Chargeticket document, and never code from the ASC's surgery schedule.
- Sometimes with surgical procedures, the physician utilizes a "Canned" Operative Report in the record, instead of doing an individualized OP Report tailored to that patient and the procedure performed. Many times, "canned" OP Reports do not contain all of the information necessary for proper documentation of the service performed. Sometimes the reports have no Pre- or Post-operative diagnosis tailored to the patient, the detail of the report for the procedure may contain no language tailored to the patient's surgery (to include noting any actual occurrences of problems during the procedure, etc.), and at times, they may not even list the procedure performed and/or indicate upon which side (Left or Right) the surgical procedure was performed. Using a canned OP Report can save time for the surgeon, but it is neither an advisable nor an acceptable way to document procedures. Medicare and other payors frown on the use of "canned" OP Reports (which they refer to as "Cloned Records"). If some sort of template is used for an OP Report (where similarities in procedures occur), it must still be tailored enough *to each patient's individual surgery* and circumstances for use, and not appear to be "canned". Also, any deviations from the normal during surgery (in the form of a complication with the patient, something going wrong with the surgery, or a change in something for just that patient's procedure, etc.), must appear in the report. If the report is not accurate, detailed and individualized as required by the payor, it can cause providers to have to refund money to the payor, it can cause an issue with the ASC's state survey (for the ASC's licensure), and/or it could be a potential malpractice issue for both the surgeon and the facility.
- Be sure each service billed is properly documented PRIOR to billing it. Medicare expects OP Reports to be complete and in the patient record within 30 days of the surgery date of service.

- If you will spend the time to review payor EOBs for denial reasons, they will provide you with a wealth of information of what is being done incorrectly with the insurance verification processes, the coding, and the billing at your office.
- Always check CCI Unbundling material when coding multiple procedures. Keep the CCI material current (updated quarterly).
- Be sure OP Reports properly identify that the ASC facility is the Place of Service where the surgery was performed. When surgeons dictate OP Reports on their own office stationary or at the hospital, it can be unclear that the POS *was* at the ASC facility.
- Read and carefully check Medicare Bulletins monthly for changes to existing policies/rules and new policies that affect billing for procedures you perform and those procedures performed in your ASC (e.g., Pain Management procedures, etc.).
- Be aware of any Medicare Local Medical Review Policies (LMRP) or Local Coverage Determination (LCD) policies that affect procedures done, services provided, or implants, supplies/equipment used. These policies list covered diagnoses for the procedure, which must be followed carefully to assure proper reimbursement. Remember – any diagnosis not listed in the LCD used on a claim will usually result in a claim denial for “Medical Necessity” reasons. However, you cannot use a diagnosis from the LCD list which the patient does not have. If you cannot find a supporting diagnosis in the OP Report, review the H&P and/or Pathology Report for a symptom or path. result that is covered on the LCD list.
- Use the *Post-operative Diagnosis* listed on the OP Report for coding the billing, rather than coding from the Pre-operative Diagnosis. If you can’t find a suitable diagnosis for billing in the OP Report, it is acceptable to draw diagnosis or symptom information from the Path. Report and/or the H&P.
- If any procedure performed involves the use of Implants in an ASC, check into whether or not billing them to the payor is allowed (if they are not inherently included in the CPT code billed). Review the HCPCS book for possible codes for use. The L8699 code is frequently used for those implants not having a specific code.
- X-rays and the use of Fluoroscopic Guidance are usually not billable services by the ASC (not reimbursed by Medicare or BC/BS, in most cases), when done in the ASC setting, however, physician practices can usually bill for those services using the -26 modifier. ASCs should bill fluoro. charges to Workers’ Comp. and to those payors who may reimburse for them (those payors with whom the ASC does not have a contract and those payors who do

not specifically prohibit billing of radiology in their contract). Use the –GZ Non-covered Modifier if you are trying to bill everyone the same.

- Bill multiple procedures at Full Fee – do not cut the fees on line items beyond the initial charge. The payors have a mechanism to arrive at the correct fee, but you will be under-paid if you cut your fee on these charges.

General Coding Basics

ICD-9-CM DIAGNOSIS CODING

- Diagnosis codes are the mechanism for providing payors with the “what” and “why” the service(s) was necessary. They describe diagnoses, signs, symptoms, chronic and acute problems, and conditions. They provide the tools to report the *Medical Necessity* of the services provided to patients.
- Diagnosis codes justify the service/procedure provided. They are VERY IMPORTANT!!! Over 85% of claim denials for “Medical Necessity” reasons are a result of incorrect or non-specific diagnostic coding.

Basic Steps for Selecting a Diagnosis Code

1. Locate the main diagnosis from the medical records.
2. Identify the main term(s) in the diagnosis that describes the patient’s condition (Main Terms in the ICD-9 are printed in bold face type). Look for words like disease, syndrome, disorder, a person’s name, and nouns describing the main conditions containing word parts, such as “-osis”, “-iasis”, “-opathy”, “-itis”, “-ia”.
3. Look up the main term(s) in Volume 2, the Alphabetic Index of Diseases.
4. Select a provisional code from the Volume 2 Alphabetic Index. You are not done! DO NOT CODE FROM THE ALPHABETIC INDEX!!!!
5. Turn to the Volume 1 Tabular List and verify the accuracy of the selected code. Code to the greatest level of specificity known, always using 4th or 5th digits, when required.
6. Review and carefully follow any instructional notes given, and always assign a diagnosis code from the Tabular (not Alphabetic) List.

Tips for Appropriate Diagnosis Code Assignment

1. List on claims as the first code the diagnosis that is the reason *chiefly responsible* for the surgery or services provided, with subsequent diagnoses listed in descending order of importance. Be sure to observe the diagnoses listed in LMRP/LCD policies for Medicare patients, where applicable. If there is a Medicare LCD for the procedure and you are filing a Medicare claim, be sure the first diagnosis code listed on the claim is on the LCD list of covered diagnosis codes.
2. The use of Unspecified Codes and other general terms is discouraged, as they do not clarify the Medical Necessity of the procedure performed. Terms indicating an Unspecified diagnosis code include NEC and NOS in the ICD-9-CM book.
3. Do not code directly from the Alphabetic Index (Volume 2), without verifying code choices in Volume 1.
4. If a patient has a condition that is both Acute (which is defined as 6 months or less) and Chronic (which is defined as after 6 months from the injury), code both separately and list both codes on the claims, with the acute code listed first.
5. For ambulatory surgery, code the diagnosis for which the surgery was performed. If a post-op diagnosis is different from the pre-op diagnosis, select the post-op diagnosis for coding, except in the situation you have to go by a Medicare LCD and the post-op diagnosis is not on the LCD, but a pre-op symptom is on the LCD.
6. It is very important to LINK the “what” (procedures/services provided) and the “why” (diagnosis/condition) for each on the claim.
7. It is very important to purchase new coding books every year and keep all coding and billing materials up-to-date. The new ICD-9-CM books are usually released in late Summer and are effective on October 1st of each year, which is when you must be using the ICD-9 codes for the new year on all of your claims. Review the revisions, additions, and deletions of applicable codes and add them to your system as soon as they are effective.

V-Codes

1. By ICD-9-CM book definition, the V-Codes for a Personal History of a disease/condition are to be used to indicate that a patient has had the disease in the past but the medical condition no longer exists (i.e., it is no longer active) and the patient is not receiving any treatment, however, the disease has the potential for recurrence and may require continued monitoring.

2. Use V-Codes for encounters for reasons other than injury or illness (i.e., patient history, family history, diagnostic tests, attention to devices, some symptoms, etc.).
3. Use for planned care or treatment of a patient with a condition that is resolving.
4. Use for the following situations:

<ul style="list-style-type: none"> -Aftercare -Attention to -Admission/encounter for -Administration (prophylactic) -Contraception -Sterilization -Evaluation -Examination -Follow-up -Supervision 	<ul style="list-style-type: none"> -Personal & Family History of -Management -Observation for -Problem with -Procedure -Screening -Status-post -Suspected condition -Vaccinations -Testing
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Examples of some pertinent V-codes for Orthopedics

- V45.4 for Arthrodesis Status
- V58.61 for Long-Term use of Anti-Coagulants
- V50.1 for Other Plastic Surgery for Unacceptable Cosmetic Appearance
- V54.01 for Encounter for Removal of Internal Fixation Device
- V54.09 for Other Aftercare Involving Internal Fixation Device
- V54.89 for Other Orthopedic Aftercare
- V54.9 for Unspecified Orthopedic Aftercare
- V64.41 for Laparoscopic Surgical Procedure Converted to an Open Procedure
- V64.43 for Arthroscopic Surgical Procedure Converted to an Open Procedure

E-Codes

1. Used to classify external causes, such as:
 - Environmental events
 - How an accident happened
2. Commonly used on Workers' Comp. claims
3. Do NOT use E-codes on Medicare claims
4. Do not use an E-code as a primary diagnosis
5. Use E-codes in addition to codes identifying the trauma or condition
6. E-Codes may be located in the Alphabetic Index under the following terms:
 - Admission for
 - Complications of
 - Disease/disorder/condition
 - Observation

- Status-Post
7. E-Codes beginning in the E929 section can be used for *Late Effects* of accidental injury, causing conditions which persist for a year or more after the original injury.

Coding Neoplasms

1. Codes for Neoplasms are located in the Neoplasm Table in Volume I and are located according to site or anatomic location.
2. Begin location of a neoplasm code by looking up the name/diagnosis first in the Alphabetic Index.
3. If the diagnosis does not indicate whether the tumor is primary or secondary, code it as primary.
4. Unless the coding book indicates otherwise, assume the following are usually secondary (metastatic) sites: Bone, brain, meninges, peritoneum, pleura, spinal cord, and retroperitoneum.
5. When a diagnosis is stated in terms such as “Metastatic Colon Cancer”, it means the Colon Cancer is the *Primary Site* and the Cancer has Metastasized to other (usually multiple) locations. Unless you know *where* the secondary sites are to which the Cancer has traveled, you cannot specifically code them. You can use the Neoplasm for the Primary Site as your first code and the 199.0 code (for Metastasis to Multiple Sites NEC) to cover all of the Secondary Sites.
6. **Wait until the path report comes back prior to coding the claim** for those surgery situations that look like a malignant process might be involved (i.e., a Breast tumor, patients with previous cancer who have a new growth, etc.), as the exact diagnosis is needed for correct coding of a neoplasm condition.
7. Remember: V-Codes for a Personal History of Cancer are to be used to indicate that a patient has had the disease in the past but the medical condition no longer exists (i.e., it is no longer active) and the patient is not receiving any treatment, however, the disease has the potential for recurrence and may require continued monitoring. If the patient is **STILL** receiving any kind of treatment for the malignancy, use the diagnosis code for the current Cancer condition.
8. **Terms for Neoplasms:**
 - Malignant – Cells which spread/multiply with an invasive nature to other parts of the body
 - Primary Site – The area of the body or organ that was the original site of the neoplasm
 - Secondary Site – The area of the body or organ to which the tumor has metastasized or spread and implanted or grown. This can include local spread or direct extension and distant spread (metastasis)
 - Ca. In Situ – A pre-malignant condition where a tumor is undergoing malignant changes, but is still localized at the point of origin
 - Benign – Cells that grow, but are non-invasive in nature and do not spread to distant sites

Uncertain Behavior – Neoplasms which are changing in nature, and which is neither malignant nor benign at the time of diagnosis. It may undergo malignant changes/ behaviors at a future time

Unspecified Nature – The diagnosis statement does not specify the behavior of the neoplasm as malignant or benign.

Diagnosis Coding for Plastics, Nail, Lesion Removal Procedures

- Other Plastic Surgery for Unacceptable Cosmetic Appearance – Code V50.1
- Lipoma of other Skin and Subcutaneous Tissue – Code 214.1
- Benign Lesions – alphabetic in Neoplasm Section of ICD-9 book
- Malignant Lesions – alphabetic in Neoplasm Section of ICD-9 book
- Lipodystrophy – Code 272.6
- Localized Adiposity – Code 278.1
- Keloid Scar – Code 701.4
- Unspecified local Infection of Skin and Subcutaneous Tissue – Code 686.9
- Other Abnormal Granulation Tissue – Code 701.5
- Other specified Hypertrophic and Atrophic Condition of Skin – Code 701.8
- Actinic Keratosis – Code 702.0
- Other Seborrheic Keratosis – Code 702.19
- Pilonidal Cyst with Abscess – Code 685.0
- Pilonidal Cyst without mention of Abscess – Code 685.1
- Hidradenitis – Code 705.83
- Onychia and Paronychia of Toe – Code 681.11
- Ingrowing Nail – Code 703.0
- Unspecified Disease of Nail – Code 703.9
- Post-OP Hemorrhage – Code 998.11
- Post-OP Hematoma – Code 998.12
- Infected Post-OP Seroma – Code 998.51
- Post-OP Seroma – Code 998.13
- Disruption of wound, unspecified – Code 998.30
- Disruption of internal operation (surgical) wound – Code 998.31
- Disruption of external operation (surgical) wound – Code 998.32
- Disruption of traumatic injury wound repair – Code 998.33
- Other postoperative infection – Code 998.59

Diagnosis Coding in Orthopedics

Removal of Hardware procedures have different diagnosis codes, depending on the reason the hardware/implant is being removed. Use diagnosis code 996.78 for the removal of painful hardware. Use code V54.01 for the removal of hardware in the absence of symptoms.

Arthropathies

Arthropathies include disorders of the joint. Codes are 5-digits in the 716 section. They do not include injuries to the joint. These codes do not include any disorders of the spine.

Arthropathy Associated with Infections

Inflammation of the joints is a common complication of infectious disease and other disorders. In these codes the underlying disease must be coded first with the arthropathy as a secondary code. Codes are in the 711 section and are 5-digits. Exception - pyogenic arthritis, where you need to code the infectious organism as an additional code.

Traumatic Arthropathy

Arthropathy may be related to previous injuries. In this instance, the coder will first code the arthropathy and then add an additional code to show that this is a late effect of an injury. Codes are 5-digits in the 716.1X section. It was not necessarily an injury to the joint.

Internal Derangement of the Knee

Degeneration, ruptures, and old tears of the knee are coded from category 717 for Chronic problems and the 836 section for Current Injuries. The coder must clarify if this is a Current Injury, or treatment for a previous condition/Chronic problem.

Bucket Handle Tears

Bucket Handle Tears are coded 836.0 for a Current Injury Tear of the Medial cartilage or Meniscus of the Knee. Chronic problem Bucket Handle Tears are coded 717.0 for a Medial Meniscus Tear or 717.41 for a Lateral Meniscus Tear.

Chondromalacia

Chondromalacia of the Patella is coded 717.7. For Chondromalacia occurring in the Medial or Lateral Compartment of the Knee, use code 733.92, which would also be the code for use for the Chondromalacia condition occurring in joints other than the Knee.

Hypertrophy of Fat Pad

When a patient has the condition of Hypertrophy of the Fat Pad in the Knee use code 726.91.

Ankylosis

Ankylosis refers to a condition involving the immobility or loss of flexibility of a joint. Codes are 5-digits in the 718 section.

Degenerative Spine Disorders

In coding degenerative disorders of the spine, first note which part of the spine is involved. Code from the 722 section. Myelopathy indicates spinal cord involvement, and although the physician might not specifically state “myelopathy,” certain terms

suggest spinal cord involvement, such as sciatic nerve pain, paralysis, paresis, numbness, or foot drop.

Pathological Fractures

Pathological fractures occur because of some underlying disease or condition, not because of an injury. Osteoporosis, bone cysts, and tumors of the bone are common causes. Look under “fracture” in the index, and then go to “pathological,” and code. Codes are 5-digits in the 733 section.

Malunion/Nonunion

Occasionally, fractures fail to heal or heal improperly and require additional attention. Each of these codes should be accompanied by a “late effect” code, showing that the principal diagnosis is the result of a previous fracture. Use code 733.81 for a Malunion occurring anywhere in the body. Use code 733.82 for a Nonunion occurring anywhere in the body.

Valgus vs. Varus

The knees, toes, and feet can be deformed and turn inward (varus = to the middle) or outward (valgus = to the side). If this is a congenital anomaly, the condition should be coded from the congenital anomaly codes, but if it is acquired, use the code for an Acquired Deformity (if there is one).

Injuries

The ICD-9 chapter on Injuries contains many fifth digit sub-classifications to identify anatomical sites, states of consciousness, severity, etc., which can be useful for orthopedic coding. Code for the organ site involved, rather than the type of injury. When a primary injury results in minor damage to peripheral nerves or blood vessels, list the primary injury first, with additional codes from categories 950-957, injury to blood vessels.

Avoid Upcoding of Injury Diagnosis Coding

It is very important, when coding Injury claims, not to “Upcode” the diagnosis codes for these cases. Upcoding of the diagnoses occurs when you choose a diagnosis code from the 800-section, which are codes for CURRENT Injuries, when the injury is an old injury or the problem is Chronic in nature. The codes for CHRONIC Injuries are in the 700-section, which should be used if the injury occurred more than 6 months prior to the surgical procedure being performed. Six months is only a “rule of thumb” to have some guide to go by. When coding, if you cannot derive the age of the injury from the OP Report, review the H & P for this information and if it is still not clear, consult the physician’s office for the Date of Injury (DOI) they have on file in their records. The Exception: It is usually necessary to continue using the Current Injury codes from the 800-section on an ongoing basis for Workers’ Comp. claims.

Multiple Injury Coding

When a patient is seen with multiple injuries, the general rule is that each component should be coded separately, (with the exception of lacerations). When coding multiple injuries, such as fractures of the tibia and fibula, assign separate codes for each injury, unless a combination code is available. The ICD-9 Index will provide codes for “multiple injuries,” but these codes should be used **only** when there is insufficient information to code more specifically or when a limited number of codes can be used. The multiple-site codes may be used to show involvement of several areas within the category.

Fracture of Vertebra

With vertebral fractures, the fourth digit of the diagnosis code indicates which area (Lumbar, Thoracic, Cervical, etc.) has been affected. In the OP Report, physicians frequently use a letter followed by a number to pinpoint the spinal level (i.e., L-4 for the 4th Lumbar vertebra). In addition, you must determine whether the spinal cord has also been involved in the injury. Paralysis, paraplegia, quadriplegia, and spinal concussion are some terms that suggest spinal cord injury. These codes are in the 805-806 section.

Multiple Fractures

For multiple unilateral or bilateral fractures of the same bone(s) and different parts of the bone are involved, code each individually by site.

Fracture of the Radius and Ulna

In the ICD-9 book, the term *and* means “either” or “both.” Whereas the term *with* means “both.” These codes are 5-digits in the 813 section.

Dislocation

Determine whether the injury is a “closed” or “open” dislocation. The dislocation codes are only used with current injuries. If the condition is old, recurrent or pathological, the code will be found in the other musculoskeletal system diagnosis codes.

Sprains and Strains

Sprains and strains may be referred to by other terms in the ICD-9 book, including avulsion, tear or rupture, if it is involving a joint capsule, ligament, muscle, or tendon.

Sequencing

In situations where there are multiple injuries, the most serious injuries need to be coded first. If there are several serious injuries, look to see what procedures were done.

Coding Sports-Related Injuries

Muscle Tears

Although muscle tears can occur anywhere, they tend to happen more often in muscles that cross two joints, such as the hamstrings. Tears can be partial or complete and sometimes involve the fascia (the sheet of fibrous tissue covering the

muscle). An important word to note when coding muscle tears is “sprain”. For example, an acute injury to a ruptured supraspinatus muscle is coded as 840.6. To locate this code, look in the ICD-9-CM alphabetic index under the main term “Sprain” and the subterm “supraspinatus.” Under 840, sprains and strains of shoulder and upper arm, code 840.6 is for the supraspinatus (muscle) (tendon). This same code would be used for a rupture, tear or avulsion of the supraspinatus tendon, as well.

Rotator Cuff Conditions

1. Impingement Syndrome, which occurs when swelling of the rotator cuff and subacromial bursa causes a narrowing of the space between the humeral head and the acromion process and ligament that lie above it. Assign ICD-9 code 726.2, for Other Affections of the Shoulder Region, not elsewhere classified.
2. **Current** Rotator Cuff Tear/Rupture - Can be coded as 840.4, if the condition is a CURRENT Traumatic Injury (appears in the 840 section, sprains and strains of the Rotator Cuff Capsule). Use code 840.5 for a Current Injury to the Subscapularis area. If that Current Injury is to the Supraspinatus Tendon, use code 840.6.
3. **Chronic** Rotator Cuff Problems – Use new code 726.13 for a Chronic Partial Tear of the Rotator Cuff. For *Complete* Nontraumatic Rotator Cuff Ruptures, which are CHRONIC in nature, use code 727.61. This code can only be used when the OP Report is detailed about the extent of the injury and at least 3 of the 4 rotator cuff tendons are involved. For Chronic Rotator Cuff Syndrome, use code 726.10 for Disorders of Bursae and Tendons in the Shoulder Area, Unspecified.
4. Tendinitis and Shoulder Bursitis can also be coded using ICD-9-CM code 726.10, for Disorders of Bursae and Tendons in the Shoulder Region, Unspecified.
5. Use code 726.0 for Adhesive Capsulitis of the Shoulder.
6. Little League Shoulder (which can occur from throwing balls) is caused by friction around the epiphysis. Assign ICD-9-CM code 718.81, for Shoulder Joint Derangement, for this condition. This code is also used for Instability of the Joint.

SLAP Lesion

Superior Glenoid Labrum Lesion (SLAP Tears or SLAP Lesions), which is a detachment injury of the superior aspect of the glenoid labrum (the ring of fibrocartilage attached to the rim of the glenoid cavity of the scapula) is coded 840.7 for a Current Injury and use code 726.2 for a Chronic SLAP problem. The 718.01 code can be used for an Articular Cartilage Disorder of the Shoulder Region.

Dislocations of the Shoulder Joint

Coding for shoulder joint dislocations depends on whether the injury is open or closed, followed by what area of the shoulder is affected. Shoulder dislocations may be recurrent and shoulder joints also may experience Subluxation (also called anterior

capsular insufficiency), from repetitive stretching. Assign code 718.31 for a Recurrent Dislocation of the Shoulder Joint.

For a Closed Acromioclavicular Separation or Dislocation, use code 831.04 for a Closed Dislocation of the Acromioclavicular Joint. For an Open injury, assign code 831.14 for an Open Dislocation of the Acromioclavicular Joint.

Glenohumeral Joint Dislocations usually are the result of falling on an arm that is extended. ICD-9-CM code 831.09 is assigned for a Closed Glenohumeral Dislocation.

Bankart Lesions

A Bankart Lesion in the Shoulder involves an instability or dislocation of the joint. A Chronic problem is coded 718.31 and a Current Injury is coded 831.01 for an Anterior Dislocation of the Humerus or 840.5 for a Subscapularis Sprain/Strain.

Tennis Elbow

Tennis Elbow (also, Golfer's Elbow) is the inflammation of the tendinous origin of the muscles of the forearm. It is caused by strong, repetitive gripping motions. Assign ICD-9-CM code 726.32 for Lateral Epicondylitis of the Elbow for this condition.

Trigger Finger

Trigger Finger is an irritation of the sheath which surrounds the flexor tendons that prevents the tendons from gliding smoothly. This condition is coded 727.03 for Trigger Finger, Acquired.

Other Ortho./Neuro. Diagnoses

deQuervain's Syndrome is a condition brought on by irritation or swelling of the tendons running along the thumb side of the wrist. This condition is coded 727.04 for Radial Styloid Tenosynovitis.

Dupuytren's Contracture is a hereditary condition involving a thickening of the fascia that lies just below the skin and can pull the fingers towards the palm. This condition is coded 728.6 for Contracture of the Palmar Fascia.

Synovitis involves the inflammation of the synovial lining that keeps foreign matter out of joints and produces joint fluid for lubrication of joints such as the knee, shoulder, hip, elbow, wrist, or ankle. The usual type of Synovitis conditions found, for which orthopedic procedures are commonly performed (Synovectomy procedures or Plica Resections) are coded with the 727.00 Synovitis or Tenosynovitis code. If the Synovitis condition occurs in the hand or wrist area, use code 727.05. If the Synovitis condition occurs in the foot or ankle regions, use code 727.06.

Villonodular Synovitis conditions sometimes seen should not be confused and coded for most Synovitis conditions, as that is another condition (where there is pigmentation

of the tissue and the joint lining swells, retaining fluid), which should be coded from the 719.2X section – that is only to be coded when the OP Report or Path. Report specifically states the patient has the *Villonodular* Synovitis condition.

Plica Syndrome is coded 727.83.

Orthopedic Terms and Abbreviations

Arthroplasty – Surgical formation or reformation of a joint, which involves a plastic surgical repair.

Avulsion – The tearing away of a structure or part.

BK – Below the Knee.

AK – Above the Knee.

Bunion – A subluxation lateral deviation of the first metatarsal head.

Carpal – Relating to the Wrist.

CTS – Carpal Tunnel Syndrome (Arthroscopic repair procedure is coded 29848/Open repair is coded 64721).

Caudal – Towards the Feet. Refers to the Lower Lumbar region.

Chondroplasty – Repair, Debridement or plastic surgery of a cartilage.

Cruciate – Shaped like a cross.

Cruciate Ligament Repair – Ligament is sutured or stapled to promote healing.

Cruciate Ligament Augmentation – When a Hamstring Tendon is placed alongside the ligament as a splint.

Cruciate Ligament Reconstruction – Where an Allograft, synthetic ligament, hamstring, or patellar tendon is used to replace the injured ligament.

Decompression – The Release or Removal of pressure.

Exostosis – A Benign protuberance from the long bone surfaces of flat bone.

Fascia – Sheet of connective tissue that covers, supports, and separates the muscle.

Glenoid – Resembles a pit or pocket.

Malleolus – One of the bony constraints of the ankle joint.

Meniscus – Crescent-shaped fibrocartiliginous structure found in the knee, shoulder and temporomandibular joint.

Ossicle – Little bone.

Osteo – Bone.

Reduction – An alignment of the bone back to normal.

Rotator Cuff – The musculotendinous covering of the humeral head.

Synovectomy – Surgical removal of the lining of the joint or tendon cavity.

Talus – Ankle.

Tendon – Strong fibrous band of tissue that attaches muscle to bone.

Tendodesis – Freeing-up of a tendon.

Tenotomy – Transection of a tendon.

Diagnosis Coding in Pain Management/Spine Procedures

It is very important for Pain Management procedures to code these complicated conditions as specifically as possible and to not use the 724.2 Low Back Pain symptom code (or something as equally as general and non-specific) to code every claim. If you

cannot locate the patient's true condition in the Procedure Report, review the H & P for this information.

Spinal Stenosis

Spinal Stenosis is the narrowing or stricture of the spinal canal. Cervical Spinal Stenosis is code 723.0. Thoracic Stenosis is coded 724.01. There were changes to the Lumbar Spinal Stenosis codes for 2010 – use code 724.02 for Lumbar Stenosis without Neurogenic Claudication and use code 724.03 for Lumbar Stenosis with Neurogenic Claudication.

Radiculitis

The inflammation of the root of a spinal nerve, particularly that portion of the nerve root lying between the spinal cord and the intervertebral canal. Pain from this disorder is called Radicular Pain, and it can also be referred to as Radicular Neuritis. Use code 724.4 for Lumbosacral or Thoracic Radiculitis and code 723.4 for Cervical Radiculitis.

Spondylosis

Spondylosis is a degenerative change of a vertebral joint due to osteoarthritis. Coding is based on whether or not Myelopathy (a disease affecting the spinal cord) is involved. Use code 721.90 for Spondylosis (Unspec. site) without Myelopathy and code 721.91 for Spondylosis with Myelopathy. Use code 721.3 for Lumbar Spondylosis without Myelopathy and code 721.0 for Cervical Spondylosis without Myelopathy.

Enthesopathies

Enthesopathies are degenerative disorders of the peripheral ligaments or muscles and tendon attachments to the bones. Common areas of involvement are the shoulder, the elbow, the wrist, the hip, and the knee.

Postlaminectomy Syndrome

Some patients have chronic pain following back surgery, which is also called Postlaminectomy Syndrome or Failed Back Syndrome. This problem may require Pain Management Procedures or further Spine Procedures. Use code 722.81 for the Cervical Region and code 722.83 for the Lumbar Region.

Displaced or Herniated Disc

Use code 722.0 for the Displacement of a Cervical intervertebral disc without myelopathy, code 722.10 for a Displaced Lumbar disc without myelopathy, code 722.11 for a Displaced Thoracic disc without myelopathy and code 722.2 for a Displaced intervertebral disc at an Unspecified site, without myelopathy.

Degenerative Disc Disease

Use code 722.4 for Degeneration (DJD) of a Cervical intervertebral disc, code 722.51 for DJD of a Thoracic or Thoracolumbar disc, code 722.52 for DJD of a Lumbar or Lumbosacral disc and code 722.6 for DJD of an Intervertebral Disc of an Unspecified site.

Disorders of the Sacrum

When Pain Management procedures are performed in the Sacral (SI Joint Injections), they are usually performed for either Sacroiliitis (code 720.2) or other Disorders of the Sacrum (code 724.6).

Spondylolisthesis

This condition involves the forward displacement of one vertebra over another. If it is a Congenital condition, it is coded 756.12, which is also referred to as Displastic Spondylolisthesis. When the condition is Acquired, it is coded 738.4. This condition can be pathological, degenerative, traumatic or caused by a spinal lesion.

Cervicalgia

Neck Pain is coded 723.1.

Diagnosis Coding for Foot Conditions

Tenosynovitis

Tenosynovitis is an inflammation of a tendon and its synovial sheath. These codes fall into the 727.0X section of the diagnosis coding book. It is also referred to as Tendosynovitis, Tenonothecitis, Tenontolemmitis, and Tendinous Synovitis.

Bunions

Bunions are coded as 727.1. This condition is a localized enlargement at the first metatarsal head caused by either malposition of the metatarsal or by overgrowth of the metatarsal. Bunions occurring on the medial aspect are associated with Hallux Valgus (where the Great Toe turns towards the Second Toe).

Bursitis

Bursitis is coded as 727.3, for Other Bursitis. This is an inflammation of the fluid-filled sac which cushions a bony prominence.

Ganglions

Ganglions and cysts of the synovium, tendon, and bursa are coded from the 727.4X section. These are thin-walled cystic lesions containing thick, clear, mucinous fluid. Their etiology (cause) is unknown. They usually occur on the hands and feet only.

Paget's Disease

Paget's Disease (also called osteitis deformans) is coded as 731.0. This disease involves the slow and progressive enlargement and deformity of multiple bones and the resorption of bone. In the initial phase, bones become enlarged, sponge-like, weakened and deformed – followed by the second phase where the bones have deposition and resorption, and they then come thick and dense. The etiology of this disease is unknown.

Osteochondropathies

These disorders are coded from the 732.X category, and this condition primarily affects children from 3 to 10 years of age. The etiology of this disease is unknown.

Flat Foot

Flat Foot is coded 734 and is a condition where one or more of the arches of the foot have flattened. Acquired Pes Planus and Talipes Planus are included in this category. There are several kinds of flat foot, including congenital, rigid, and spastic flat foot. Congenital Flat Foot is coded 754.61.

Other Common Foot Conditions

Hallux Valgus (Acquired) – code 735.0

Hallux Varus (Acquired) – code 735.1

Hallux Rigidus/Hallux Limitus – code 735.2

Hallux Malleus – code 735.3

Hammertoes (Acquired) – code 735.4

Claw Toe (Acquired) – code 735.5

Procedure for Sequencing CPT Codes for surgical procedure(s) performed in Freestanding ASC Facilities for the ASC facility:

1. Review the OP Report(s) for the surgical case.
2. Code out the CPT procedure code(s) for all surgical procedures performed.
3. Look up each pertinent CPT procedure code(s) with all of the other pertinent CPT procedure code(s) in the CCI material to determine Unbundling for the case.
4. Determine if those procedures designated as “Separate Procedures” in the CPT book and those CPT codes which are Unbundled in the CCI material are billable using the -59 Modifier or they should not be billed. Arrive at the final CPT procedure code(s) that can be billed for the surgery(s) performed.
5. Look up each CPT code to be billed on the Medicare ASC List for the associated fee.
6. Sequence the CPT codes for billing from Highest to Lowest fee listed on the Medicare ASC List.
7. Those CPT codes to be billed which are NOT listed on the Medicare ASC List are not covered by the Medicare program and should be billed using the –GY Not Covered Modifier in the last position.

Procedure for Sequencing CPT Codes for surgical procedure(s) for Physician Practices:

1. Review the OP Report(s) for the surgical case.
2. Code out the CPT procedure code(s) for all surgical procedures performed.
3. Look up each pertinent CPT procedure code(s) with all of the other pertinent CPT procedure code(s) in the CCI material to determine Unbundling for the case.

4. Determine if those procedures designated as “Separate Procedures” in the CPT book and those CPT codes which are Unbundled in the CCI material are billable using the -59 Modifier or they should not be billed. Arrive at the final CPT procedure code(s) that can be billed for the surgery(s) performed.
5. Sequence the CPT codes on claims from Highest to Lowest RVU weight – regardless of the practice’s fee schedule amount.

HCPCS CODING FOR PROCEDURES, SERVICES AND SUPPLIES

HCPCS codes provide the explanation of “what” was done for the patient.

Level I HCPCS codes are the CPT Codes most often used to code procedures, services and Evaluation & Management (E&M) visit codes.

Level II HCPCS codes are those codes appearing in the HCPCS coding books. They are used for dental procedures, supplies, implants, DME, rehab., orthotics and prosthetics, and injectable medications, among other things. These codes are 5-digits and begin with a letter. Injectable meds. fall in the J-code section.

Level III HCPCS codes are local Medicare carrier-assigned codes specific to the geographic area, and are only accepted by the carrier who created them. They are 5-digits and usually begin with a letter (G-codes, L-codes, etc.). They change often and are listed in the Medicare Bulletins, but are less seldom used now – they are mainly used by Medicaid programs.

Coding Tips:

- It is VERY IMPORTANT to purchase NEW ICD-9-CM, CPT and HCPCS coding books every year, and keep updated CCI Unbundling material (usually updated quarterly with important changes) for billing and coding staff.
- In the CPT book, certain words and descriptions will make a substantial difference in reimbursement and your audit liability. The selection of the appropriate code for the situation is, of course, dependent on the medical record documentation supporting the higher paying code chosen.

Similar words and phrases that can alter your reimbursement are as follows:

Closed vs. Open	Each (for example, each digit)
Simple vs. Complicated	One or More Sessions
Benign vs. Malignant	Separate Procedure
Unilateral vs. Bilateral	List/Charge in Addition To
Deep vs. Superficial	Charge or List Separately
Excision vs. Destruction	

Unlisted Procedure Codes

ASC facilities want to avoid performing cases in the ASC involving an Unlisted Code for the only or primary procedure on Medicare patients, since Medicare does not reimburse for Unlisted Codes and you cannot bill the patient (in most circumstances). Sometimes, you have no alternative but to use an Unlisted procedure code, when an exact code cannot be found. When an Unlisted procedure code is used, the service or procedure should be described. In the CPT book, identifying words for these codes are “Unlisted” service or code and “Special Report”. Drop the claim to paper and submit the claim with medical record documentation (the OP Note) to justify the procedure performed and explain what was done. An example of a procedure that must be billed using an Unlisted CPT code for ortho. is 29999 for an Arthroscopic Debridement of the ACL.

Bilateral Procedures

Physician practices don't have as many rules to go by for billing Bilateral Procedures as do ASC facilities. All providers need to inquire about payor requirements and follow them, if they do have specific rules about modifier usage. If a surgical procedure is by (CPT) definition unilateral, and is performed bilaterally, the provider should report the CPT code on the claim form in a bilateral manner. The policies each payor has for the use of modifiers for reporting bilateral procedures can vary widely, so the ASC facility should check with each payor to which they submit claims for their preferred method of billing Bilateral procedures. Modifier -50 identifies a procedure performed identically on the opposite side of the body (mirror image). Some payors prefer the use of the -RT Anatomic Modifier on one code and the -LT Modifier on the other. Don't mix the use of -50 and -RT or -LT Modifiers on the same code. Be consistent in the method used for claims going to a particular payor. If the surgical code is by definition bilateral, the CPT procedure code is reported once (with no modifier), even if the procedure is performed on both sides. If the procedure is often performed bilaterally, but is performed only unilaterally for a surgery, the usual fashion is to bill using an -RT or -LT Modifier on the CPT code.

The five usual methods for the billing of Bilateral procedures for ASC facilities include:

- Bill the same code as two line items, using the -RT Modifier on one code and the -LT Modifier on the other (same) code. (***)Medicare
 - 64483-RT \$700.00
 - 64483-LT \$700.00
- Bill the bilateral procedures as two line items with no Modifier on the 1st code and a -50 Modifier on the 2nd line item (same code).
 - 64483 \$700.00
 - 64483-50 \$700.00
- Bill the procedure as a single line item on the claim form with a -50 Modifier on the procedure code. Be sure if you use this method to double the facility fee.
 - 64483-50 \$1,400.00
- Bill the same code as two line items with no Modifiers. (***)Medicare
 - 64483 \$700.00
 - 64483 \$700.00

- Bill the procedure as a single line item on the claim form with no Modifier on the procedure code and put a “2” in the Units column on the claim. Be sure if you use this method to double the facility fee. (***)Medicare)
 - 64483 2 Units \$1,400.00

*****Billing methods allowed on Medicare ASC claims. Do NOT use the -50 Modifier on Medicare claims, unless your Medicare MAC specifically requires you to do so.**

Multiple Procedures

Modifier –51, which designates multiple procedures, (other than Evaluation and Management services), is used for procedures which are rendered on the same date of service, at the same operative session, and commonly at the same surgical site by the same provider. When a procedure is performed with another appropriate or separately-identifiable procedure, the highest valued code is listed as the primary procedure and additional procedures are appended with the modifier –51. *This modifier is for use on physician claims only. ASC’s should not use this modifier* on their claims, unless the payor specifically requires its use.

Add-on Codes

For some multiple procedures, “Add-on” codes should be used, when required. “Add-on” codes are identified with a “+” notation. These can be seen in Pain Management claims for Injections done at subsequent levels. Do not list an Add-on code first on the claim form. List the code for the main procedure/first level procedure first, followed by the subsequent level Add-on codes.

Separate Procedures

Those procedures designated as “Separate Procedures” in the CPT book must be treated differently from other procedures. If these procedures are not coded and billed correctly, the facility can experience a denial from the payor similar to a CCI Unbundling denial – even if the codes are not Unbundled in the CCI Unbundling material. A “Separate Procedure”, by definition, is a component of a more complex service and is usually not identified separately. These services are typically an integral component of a more extensive service. When these services are performed alone, or not as part of a larger or more inclusive procedure, then the “separate procedure” should be reported. When the “separate procedure” is carried out independently or distinctly from other procedures, it may be reported by itself or with the -59 modifier, in some instances (i.e., separate site or by a separate incision). The separate procedure designation indicates that a certain procedure or service may be:

- Performed independently;
- Unrelated or distinct from other procedure(s)/service(s) provided at that time; or
- Considered an integral component of another procedure/service.

Codes designated as Separate Procedures may be billable with the use of the –59 modifier, to indicate that the procedure is not considered a component of another procedure, but a distinct, independent procedure, such as the following:

- Different session or patient encounter;
- Different site or organ system;
- Separate incision/excision;
- Separate compartment;
- Separate lesion; or
- Treatment of a separate injury (or area of injury in extensive injuries).

UNBUNDLING

To define, Unbundling is the practice of breaking out each individual part of a procedure and billing for it separately. This is most frequently done with surgical procedures. **It is an unethical practice.** Unbundling is to be avoided, as it can flag an audit from a payor. The individual components, or incidental services of a surgical package, should not be coded when the primary procedure code includes these components. This is referred to as *Unbundling*.

To avoid Unbundling, check each procedure code to be billed with every other procedure code to be billed in the current CCI Unbundling material to see if any of them are components of another code. Pay close attention to code selection by coding with the most accurate and complete code available for use, using CPT guidelines. If there is a doubt, check with the physician as to what the main procedure is and what might be included.

In some (very few) cases, even though one code is Unbundled from another listed procedure, it can be billed anyway using a –59 Modifier. If the procedure was done in a separate area, by a separate incision, etc., it might be billable. Check the OP Note and the procedure book descriptions carefully, assess correct modifier usage, and contact the Medical Review or Coding department at the payor for guidance. This situation would not occur very often. Usually, if it is Unbundled, it is not billable.

Fragmenting

Fragmenting of claims is billing CPT codes for the same patient, on the same date of service, performed by the same service provider (surgeon), and during the same episode of care on *separate* claim forms to the same payor. It is considered fraudulent, and is to be avoided. Bill services on the same claim form and only use a second claim form when the maximum number of procedure lines are full on the first claim form. Also, print the word “Continued” on the bottom of the first page of the first claim form, or the claim might not process correctly. If two completely different procedures were performed by two different primary surgeons on the same patient during the same case, you can bill on two different claim forms, as long as you have 2 separate complete OP Reports.

Modifiers

Modifiers (usually 2-digits) are added to the main procedure code to signify that the procedure has been altered by a distinct factor. Modifiers are accepted by most payors. Modifiers can increase or decrease reimbursement. They can also cause claims not to pay properly or deny if used incorrectly or not used, when necessary. Some Modifiers are for use by physician practices only (P), some for ASCs (A), and some are for use by both provider types.

-50 Bilateral Procedure P & A

Use this modifier when an identical procedure is performed on both the Right and Left sides of the body. The policies each payor has for the use of modifiers for reporting bilateral procedures can vary widely, so the ASC facility should check with each payor to which they submit claims for their preferred method of billing Bilateral procedures. Modifier –50 identifies a procedure performed identically on the opposite side of the body (mirror image). Some payors prefer the use of the -50 Modifier and others require the use of the -RT Anatomic Modifier on one code and the -LT Modifier on the other code. Don't mix the use of -50 and –RT or –LT Modifiers on the same code. Many payors will reduce the second procedure by one-half when using the –50 modifier. Don't use Bilateral Modifiers on those CPT codes with descriptions designated as “Bilateral” or “Unilateral or Bilateral”.

-51 Multiple Procedures P

This Modifier is for use on physician claims ONLY. **ASCs should not use the –51 Modifier on their codes, unless the payor requires its use.** When more than one procedure (excluding E & M codes) is performed on the same day during the same encounter by the same physician, modifier –51 should be appended to the subsequent procedures on the physician's claim. The exception to this guideline is if the CPT code is an Add-on code, or if it is –51 Modifier-exempt.

-52 Reduced Services P & A

This modifier is used to indicate that a procedure was partially reduced or eliminated at the physician's discretion. Usually, the procedure fee is reduced to reflect the reduced services provided.

For ASC facilities, the “Global Period” or “Post-operative Period” for ASC facilities is 24 hours from the time the surgery begins – it is NOT 10 or 90 days like the physician's Global Period. However, some payors may consider the Global Period to be 48 – 72 hours for ASC facilities.

-58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period P & A

Use this modifier to indicate the performance of a procedure or service during the post-operative period that was:

1. Staged;
2. More extensive than the original procedure; or

3. For therapy following a diagnostic surgical procedure.

Example: For Moh's Surgery Excision of Malignant Lesions (where the surgeon is acting as both the surgeon and the pathologist) and the patient has a Reconstructive procedure performed the same day or shortly thereafter to repair the area by the same physician.

-59 Distinct Procedural Service

P & A

Use this modifier to indicate the procedure or service was distinct or independent from other services performed on the same day, to identify procedures not normally reported together (due to CCI edits or "Separate Procedure" status in the CPT book), but which are appropriate under the circumstances, or to represent a different session, different procedure or surgery, different compartment, different site or organ system, separate incision/excision, separate lesion or separate injury not normally encountered or performed on the same day by the same surgeon. This modifier may override edits in the payor's system, which would normally deny the code (i.e., Unbundling, etc.), but under special circumstances, the modifier can be used to make the service payable – thus, the -59 Modifier has a higher audit potential with Medicare and other payors. **Do not use a –59 modifier on the 1st code listed on the claim form.** **Claims filed with this Modifier may be under close review by Medicare. Do NOT use this Modifier unless it is absolutely necessary (the situation where CPT codes are Unbundled and will be denied without use of the -59 Modifier) – do not use the -59 Modifier like the -51 Modifier, merely to indicate an additional procedure was performed.

-73 Terminated/Discontinued Out-Patient Hospital/Ambulatory Surgery Center Procedure Prior to the Administration of Anesthesia

A

This modifier is appended to the CPT code for the intended procedure(s) to indicate that a procedure was terminated due to medical complications after the patient had been prepared for surgery and taken to the OR, but *before* anesthesia was induced. The ASC must have "expended significant resources" to charge for the scheduled procedures using this modifier.

-74 Terminated/Discontinued Out-Patient Hospital/Ambulatory Surgery Center Procedure After the Administration of Anesthesia

A

This modifier is appended to the CPT code for the intended procedure(s) to indicate that a procedure was terminated due to medical complications *after* anesthesia for the procedure was induced.

-76 Repeat Procedure or Service by Same Physician

P & A

Use this modifier only if an identical procedure is being performed following the initial procedure by the same surgeon. The time frame for this usually falls during the usual physician's global period for the surgery. Use this modifier for a repeat surgery at the same site by the same surgeon.

-77 Repeat Procedure or Service by Another Physician P & A
This modifier is used in the situation where a physician repeats a procedure that had previously been performed by a different physician. It is usually assumed to occur on the same day that the initial procedure was performed.

-78 Unplanned Return to the OR for a Related Procedure During the Postoperative Period P & A
This modifier will result in reduced reimbursement for the physician, as the payment will reflect the surgery component only. However, failure to use this modifier when necessary will probably result in a claim denial.

-79 Unrelated Procedure or Service by the Same Physician During the Post-operative Period P & A
This modifier is to be used to indicate that an unrelated procedure was performed by the same physician during the post-op period. It is best to use modifier –78 most of the time for this situation, as it reimburses at a higher rate. This modifier is meant for situations where a patient presents (during the post-op period) for a problem requiring a service or procedure that is not related to the surgery that was previously performed.

Anatomic Modifiers are not used on Skin codes (10000-section), except on Breast and Nail procedures, Unlisted CPT codes, or when the definition of the code is inherently Bilateral (like a Tonsillectomy or Sterilization procedure).

-RT Right Side **-LT Left Side** P & A
It is extremely important to use the –RT and –LT Anatomic Modifiers on eye procedures and for podiatric procedures. Many orthopedic procedures require the use of these modifiers, as well. Not using them when they are necessary can have a profound effect on reimbursement. If you bill a procedure that will be done bilaterally without the modifier for that side, later when you bill the other side, it may (needlessly) be denied as a Duplicate claim, which will have to be appealed.

-TC and -26 P & A
The –TC Modifier reflects that the Technical Component only of an x-ray is being billed for by the ASC. This is billing for the taking of the x-ray by the facility. Physician practices should append the -26 Modifier when the imaging is performed during a procedure at an ASC or hospital facility. If x-rays are done in the physician’s office and the practice owns the equipment, the practice can bill the radiology code with no modifier, indicating they are billing for the Global service of both the Professional and Technical components of the imaging procedure.

Digit Modifiers:

P & A

(Do not use –RT or –LT Modifiers with these modifiers)

-FA	Left hand, thumb	-F5	Right hand, thumb
-F1	Left hand, second digit	-F6	Right hand, second digit
-F2	Left hand, third digit	-F7	Right hand, third digit
-F3	Left hand, fourth digit	-F8	Right hand, fourth digit
-F4	Left hand, fifth digit	-F9	Right hand, fifth digit
-TA	Left foot, great toe	-T5	Right foot, great toe
-T1	Left foot, second digit	-T6	Right foot, second toe
-T2	Left foot, third digit	-T7	Right foot, third digit
-T3	Left foot, fourth digit	-T8	Right foot, fourth digit
-T4	Left foot, fifth digit	-T9	Right foot, fifth digit

It is not necessary to use -59 Modifiers with the Ophthalmology or Digit Modifiers, unless you need to report more than one procedure on the *same* Eyelid, Toe, or Finger *when* it is separately-billable.

The Digit Modifiers are used on the Phalanx area of the Toes and Fingers – when procedures are performed on the Metatarsal or Metacarpal areas or below, use the –RT or –LT Modifiers instead of the Digit Modifiers.

-GA Modifier

A

Use this modifier when providing a service or item to a Medicare patient when that service or item is not covered by the Medicare program at any place of service. The –GA Modifier indicates the patient signed an Advanced Beneficiary Notice (ABN) or Waiver form and will be paying cash for the service or item. ASC facilities should NOT be using this Modifier often, since CMS changed the rules in 2001 to not allow ASCs to have Medicare patients sign ABNs for non-covered procedures performed in the ASC setting when the procedure is covered at another place of service.

-GX Modifier

P&A

Use this modifier when an ABN is not required by Medicare but the provider had the patient sign an ABN for the service anyway.

Wrong Site Surgery Modifiers

P&A

-PA Modifier – surgery or other invasive procedure performed on the wrong body part.

-PB Modifier – surgery or other invasive procedure performed on the wrong patient.

-PC Modifier – the wrong surgery or other invasive procedure was performed on the patient.

“Billing Everyone the Same” – Use the –GY Modifier

If your facility is trying to “bill all payors with the same” codes in the same manner, it can be challenging, since some payors (especially Medicare) do not cover all billed codes for procedures performed. When billing a CPT code to a payor you know is not covered by that payor (for example, an ASC billing 77003 Fluoroscopy to Medicare), append the

-GY Modifier, which lets the payor know you that you are aware they don't cover the service and you expect a denial for that charge. This code would be billed to Medicare as 77003-GY-TC for the ASC for non-covered Fluoroscopy.

Modifier Usage

It is extremely important to append the appropriate -RT and -LT Anatomic Modifiers to CPT codes on claims, when needed (e.g., Orthopedic or Pain Management services). When a patient has a bilateral problem (such as Bunions on both feet), the surgeries to correct the problem may be done one side at a time, with the patient returning months later for the repeat procedure on the other side. If the claim for the first surgery is submitted without the appropriate -LT or -RT Modifier, many times when the payor (or Medicare) receives the claim for the second surgery, they will deny it as a Duplicate claim. It saves a great deal of time, energy and money to append the appropriate Modifier on the claim the first time through, to avoid these types of unnecessary denials.

Multiple Modifiers

When using more than one Modifier on a CPT code, append those modifiers which effect payment (i.e., Modifiers -GY, -59, -73, -74, -50, -52, etc.) before those modifiers which are informative in nature only (i.e., -LT, -T3, -78, -TC etc.). When the ASC uses the -SG Modifier (such as on Medicaid claims being billed on a CMS-1500 claim form), it is **always** placed first on the CPT codes, followed by other modifiers. If you run out of space for all necessary modifiers in the usual field on the claim form, append the first or second essential modifier, followed by the -99 modifier, then continue the other modifiers in the other modifier field (field 19 on a CMS-1500) on the claim form.

Surgery Section Terms

The Surgery section of the CPT manual is divided into subsections by individual body systems and subsequently by specific anatomical areas. There are five subheadings common to many major subsections. These subheadings generally appear in the following order:

Incision: These codes involve cutting into the body. All "-otomy" (e.g., cutting, making an incision into), which are also Release procedures are located under this subheading. Incision codes routinely include various drainage, exploration, piercing, releases, puncture, and centesis procedures.

Excision/Destruction: This subheading includes procedures that remove or cut out a particular body area, part, or extract a foreign body. All "-ectomy" (e.g., excision or surgically cutting out) procedures are found under this subheading.

Introduction or Removal: The Introduction subheading includes procedures that scope, irrigate, inject, insert, remove, or replace into the various body areas.

Repair/Reconstruction: This code subheading describes those procedures that surgically improve and repair improperly functioning, deformed, or painful parts

of the body. All “-orrhaphy” (suturing) or “-plasty” (surgical repair) procedures are found under this subheading.

Other/Miscellaneous procedures: The Other/Miscellaneous subheading is inclusive of those procedures that are unique and not associated with other standard groupings. Some other procedures include endoscopy, arthrodesis, manipulation, amputation, suture, fracture/dislocation, splints, strapping, casts, and unlisted procedures.

Medicare ASC Billing Rules

Terminated Surgical Procedure Rules

- Procedures which are Cancelled or Postponed

If a procedure is cancelled due to medical or non-medical reasons before the ASC has expended substantial resources, no payment is allowed by Medicare. **Do not bill.**

- Procedures which are Terminated Before Anesthesia has been Induced

If a procedure is terminated due to medical complications after the patient has been prepared for surgery and taken to the OR, but before anesthesia has been induced, Medicare should reimburse at 50% of the allowed amount. Append the –73 Modifier to the billed CPT code for the 1st procedure that was planned, but not performed.

***The patient MUST be physically located in the OR or procedure room when the procedure is called off in order to bill Medicare.

- Procedures which are Terminated After Anesthesia has been Induced

If a procedure is terminated due to medical complications after anesthesia has been induced, Medicare should reimburse at 100% of the allowed amount. Append the –74 Modifier to the billed CPT code if the 1st procedure has been started and the patient has received anesthesia for the case.

- Termination of an IOL Procedure

If a procedure involving an IOL insertion, in which the IOL was not inserted, the allowance for the unused IOL will be deducted from the ASC’s payment prior to calculating their payment. Be sure to write a letter to Medicare notifying them the IOL was opened, so you will be reimbursed – since the IOL must be wasted.

- Documentation

The documentation requirements for Medicare claims for discontinued procedures are quite laborious. The information can be captured on the OP Report or by completing a form with the information, or it can be recorded by a nurse. The surgeon must sign the documentation, regardless of who completes the required documentation.

OP Reports (or the facility's designated form) for Terminated Procedures need to specify the following:

- Reason the surgery was terminated
 - The services which were actually performed
 - The supplies that were actually provided/used
 - The services which were not performed (intended)
 - The supplies that were not provided/used (intended)
 - The time actually spent in each stage of the surgery that was completed (i.e., Pre-op, Operative, and Post-procedure termination)
 - The time that would have been spent (intended), and
 - The CPT procedure code(s) for the covered procedure, had the intended procedure been performed with the appropriate modifiers appended
- When anesthesia was administered only, but **none** of the procedures which were planned were started at all, bill the code for the 1st procedure with the -74 Modifier and the rest of the planned procedures are not billable.
 - If several procedures were to be performed and some (but not all) planned procedures were completed, bill as follows:
 1. Bill procedure(s) which **were** completed at full fee **without** the -74 Modifier.
 2. Bill those procedure(s) which were started but **were not** completed at full fee with the -74 Modifier.
 3. Those procedures which were planned but were not started at all are not billable.

Physician practices would usually bill using the -53 Modifier for a Discontinued Procedure.

Claim Forms

Medicare requires that the CPT procedure codes submitted on the ASC facility and the surgeon's claims are identical, and that there should be no discrepancies in this information. The ASC and surgeon are responsible for the coordination of this information. Any discrepancies identified with the coding being different between the two subjects both the ASC and the physician to a higher audit risk. However, the facility should always bill the correct codes describing the documented procedure(s), as documented in the OP Report.

Medical Record Documentation Issues

- Information in the medical record must support the Medical Necessity of all CPT and Diagnosis codes billed.
- The patient's name and/or Medical Record Number should be on *every page* in the medical record.
- The medical record should be complete and legible. Handwritten entries should be made in black ink.

Incomplete OP Reports and OP Report Addendums

- Read the entire OP Report - It is very important for the ASC's coder to read the *entire* OP Report for each case, to be sure all procedures performed during an operative session are captured and properly documented before billing for them.
- Code only from the OP Report - **DO NOT code from the surgery schedule** without having the OP Report in hand! Never code a bill for a procedure you are unsure took place (i.e., case was scheduled but cancelled). It is best practice to avoid coding from superbill/ chargeticket documents without an OP Report in hand.
- Code in a compliant manner - Medicare directs that only those procedures documented in the *body* of the OP Report can be billed. If a procedure is documented in the summary section at the beginning of the OP Report, but not in the *body* of the OP Report, the physician should do an Addendum to the OP Report with the missing information.
- OP Report Addendums - Addendums should be dated with the date the Addendum is done (which might be different from the surgery date), it needs to be stated that it is an "Addendum", and addendums can be done on the original OP Report or on a separate piece of paper, as an addition to the original OP Report. If it is done on a separate piece of paper, it should document the date of the original procedure and the procedure performed. OP Reports are not to be re-done or re-typed as a new original document. Addendums can be handwritten by the surgeon or typed, and they must be signed by the surgeon.

"Canned" OP Reports

Sometimes with surgical procedures, the physician utilizes a "Canned" Operative Report in the record, instead of doing an individualized OP Report tailored to that patient and the procedure performed. Many times, "canned" OP Reports do not contain all of the information necessary for proper documentation of the service performed. Sometimes the reports have no Pre- or Post-operative diagnosis tailored to the patient, the detail of the report for the procedure may contain no language tailored to the patient's surgery (to include noting any actual occurrences of problems during the procedure, etc.), and at times, they may not even list the procedure performed and/or indicate upon which side (Left or Right) the surgical procedure was performed. Using a canned OP Report can

save time for the surgeon, but it is neither an advisable nor an acceptable way to document procedures. Medicare and other payors frown on the use of “canned” OP Reports (which they refer to as “Cloned Records”). If some sort of template is used for an OP Report (where similarities in procedures occur), it must still be tailored enough *to each patient’s individual surgery* and circumstances for use, and not appear to be “canned”. Also, any deviations from the normal during surgery (in the form of a complication with the patient, something going wrong with the surgery, or a change in something for just that patient’s procedure, etc.), must appear and be correct in the OP Report. If the report is not accurate, detailed and individualized (as required by Medicare and other payors), it can be a compliance issue, which can cause the ASC to have to refund money to the payor, it can cause an issue with the facility’s state survey (for the ASC’s licensure), and/or it could be a potential malpractice issue for both the surgeon and the facility. A Cataract Extraction OP Report which does not even designate that the procedure was performed on the Right or Left Eye is not acceptable.

Radiology Documentation

When x-rays are taken or fluoroscopy is used in procedures, the physician’s report/interpretation of the findings of the radiology test or fluoro./C-arm guidance must be documented. The interpretation can be documented in the OP Report itself or on a separate piece of paper.

Place of Service Issues with OP Reports

An issue that can cause problems in the event of a payor audit with OP Report documentation is when physicians dictate OP Reports off-site from the ASC facility (not using the ASC’s transcription system). If an OP Report lists at the top “White Medical Center” (or WMC) or “Dr. Taylor’s Pain Clinic”, it makes it appear that the procedure was performed at the hospital or at the physician’s office, with the ASC not listed as the “place of service” anywhere on the report. It is also insufficient for the ASC facility to only be listed as “cc: XYZ Surgery Center” at the bottom of the OP Report, which also does not identify the place of service to be the ASC facility. If these surgical procedures were billed by the ASC and Medicare or another payor were to audit these claims, the ASC could be charged with filing a false and Fraudulent claim. It **MUST** be very clear on the OP Report that the procedure was performed at your surgery center.

Timeliness of OP Reports

Be sure each service billed is properly documented **PRIOR** to billing it. Medicare expects OP Reports to be complete and in the patient record within 30 days of the procedure, but some ASC facilities might endorse a narrower guideline of 20 days following the procedure date. Physicians should realize that there are financial, as well as compliance consequences, to slow/late dictation. It slows down cash flow when procedures are performed but not documented – i.e., if there is no OP Report documenting the procedure, the ASC facility and the physician’s office should not bill for the procedure – if they do, they are filing a false and Fraudulent claim with Medicare and other payors.

Medical Record Errors

Be sure Errors are corrected properly in the medical record. Never use white-out for corrections. Be sure Errors in OP Reports are corrected by the physician before he/she signs the report and makes it a permanent part of the medical record. Never scratch out Errors in medical records. The proper way to correct an error in the medical record is to make a *single line* through the error (in ink), write the word “Error” above it, make the correction, and initial the change. Never alter a medical record in an improper manner.

Patient Demographic Information/Dates

OP Reports, History & Physicals, Surgical Consents and other medical record documents must be dated with the date the record was completed. Using the facility sticker or stamper with the patient’s name, surgery date, etc. on these documents is not a sufficient way to document the date that document was completed, as required. There are date issues with most of these documents which are checked at survey time, and the date the H & P was performed must be on the H & P, rather than using the facility sticker with the surgery date, which does not indicate the date the physician performed and documented the H & P. The surgery consent dates must be completed according to the guidelines for the state, which is another issue checked at survey time. Medicare might have an issue with an OP Report that only has the facility stamp with the surgery date on it, but the OP Report is not physically dated at the time it is dictated by the physician. All entries in the medical record must be dated with a full date (including Month/Day/Year) and should be signed by all physicians and nurses recording in the record.

Doctor’s Codes on OP Reports

If physicians list diagnosis and/or CPT procedure codes on OP Reports, this does not relieve the ASC’s coder from the obligation of checking through the entire OP Report to be sure that the codes given are correct and thorough, and that everything that will be coded on the billing is pertinent and properly documented.

Use of Signature Stamps to Authenticate Medical Record Documentation

Medicare issued guidance in the Fall of 2008 that physicians are not to use signature stamps to sign their OP Reports, H & Ps, office visit notes, Consultation Reports, etc. In the 4th Quarter of 2008, Medicare issued guidance that the use of signature stamps to authenticate official medical record documents by physicians is no longer allowed, so if your facility has physicians using signature stamps, this practice should not continue. Electronic signatures are allowed.

Integumentary/Skin Procedures

Remember, by ICD-9-CM book definition, the V-Codes for a Personal History of a disease/condition (i.e. Cancer, Skin Cancer, Malignant Melanoma, etc.) are only to be used to indicate that a patient has had the disease **in the past** but the medical **condition no longer exists** (i.e., it is no longer active) and **the patient is not receiving any treatment**, however, the disease has the potential for recurrence and may require continued monitoring.

For coding purposes for lesion removals/excisions, intermediate or complex repairs, or advancement flaps or skin grafts, if the physician is performing a subsequent procedure to biopsy or remove additional tissue/skin because they are worried they didn't get all of the disease during the initial procedure to remove the disease (i.e., margins were too close or not clear), you will still use the Skin Cancer or other appropriate disease code for billing the diagnosis – even if the path. report states the tissue examined on the 2nd surgery was cancer-free. The 2nd procedure was performed as part of *current treatment* for the disease which is considered to be a current problem and the patient is not yet considered to be disease-free.

Incision & Drainage (I&D) Procedures / Post-OP Hemorrhages

Code 10060 - Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single

Code 10061 - Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple

Code 10140 - Incision and drainage of hematoma, seroma or fluid collection

Code 10160 - Puncture aspiration of abscess, hematoma, bulla, or cyst

Code 10180 - Incision and drainage, complex, postoperative wound infection

Code 35800 - Exploration for postoperative hemorrhage, thrombosis or infection; neck

Code 35820 - Exploration for postoperative hemorrhage, thrombosis or infection; chest

Code 35840 - Exploration for postoperative hemorrhage, thrombosis or infection; abdomen

Code 35860 - Exploration for postoperative hemorrhage, thrombosis or infection; extremity

Diagnosis Codes – 998.11 – Post-OP Hemorrhage, 998.12 – Post-OP Hematoma, 998.51 -Infected Post-OP Seroma and 998.13 – Post-OP Seroma.

Wound Dehiscence

Code 12020 - Treatment of superficial wound dehiscence; simple closure

Code 12021 - Treatment of superficial wound dehiscence; with packing

Code 13160 - Secondary closure of surgical wound or dehiscence, extensive or complicated

Diagnosis Codes

- 998.30 – Disruption of wound, unspecified
- 998.31 – Disruption of internal operation (surgical) wound
- 998.32 – Disruption of external operation (surgical) wound
- 998.33 – Disruption of traumatic injury wound repair
- 998.59 – Other postoperative infection

Debridements

There were many changes made in CPT 2011 to the 10000-section Debridement codes, which coders need to review closely. Codes 11040 for Debridement; skin, partial thickness and 11041 for Debridement; skin, full thickness have both been deleted for 2011 and CPT now refers to Wound Care codes in the 90000-section.

The codes for use in 2011 for Debridements in the 10000-section are for more extensive/deeper debridement procedures and the coder now must know the size of the area being debrided. If the coder does not have size information when coding these procedures, you must use the code for the smallest area.

- Code 11042 for Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
- Code 11045 for Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
- Code 11043 for Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less
- Code 11046 for Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
- Code 11044 for Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less
- Code 11047 for Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Lesion Excisions and Closure Procedures

All CPT codes for surgical procedures in the CPT book sections 20000 codes and above include the closure/repair and the 10000-section codes should not be separately billed unless the closure involves a Complex Repair, Skin Graft, Adjacent Tissue

Transfer/Rearrangement, or other special circumstance not usually encountered in the closure of that type of surgery.

Measuring

For Lesion Excisions, the sizes in the OP Report or Path. Report should be added together before choosing the coding size. An example is when the surgeon removes a skin lesion on the right wrist stated to be 2.5 x 3 x 1.5 – this size for coding an Actinic Keratosis would be 7 cm. Even though it is a sizeable lesion, since this is for a condition which originates on the Skin, the 20000-section CPT codes cannot be used. Since it is a Benign process, code 11406 would be billed for the Excision. If the same lesion was Basal Cell Skin Cancer, code 11606 would instead be used. If a Layered Closure/Repair was performed to close the area (whether it was a Benign or Malignant process), code 12032 would also be billed. However, if an Advancement Flap or Tissue Transfer was used instead of a Layered Closure to close the defect, only code 14021 would be billable for the case, because neither code 11406 nor code 11606 would be billable because they are Unbundled from code 14021 in the CCI edits. While the same 7 cm. size of the dimensions added together is used for the Excision and Repair coding, those same 3 numbers are multiplied together to code for Advancement Flap or Tissue Transfer procedures because the code descriptor states the size to be in square cms. Thus, for the above stated information, 2.5 x 3 x 1.5 multiplied together would be a sq. cm. size of 11.25 for code 14021 for Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm. Even though the lesion was removed from an extremity, the –RT modifier would not be used on the CPT codes billed.

In a similar scenario, if the wrist diagnosis was a Lipoma that was deep down at the level beneath the fascia – using the same size discussed above, the CPT can be coded from the 20000-section codes using code 25073 for the Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater because the condition (lipoma) was a tumor which did not originate in the skin. No 120XX Repair code would be billable because the procedure was closed in layers and the codes in the 20000-section include a layered closure.

Definitions:

1. Lesion Excisions
An Excision is defined as a full-thickness (i.e., through the dermis) removal of a lesion, and includes a Simple (non-layered) Closure. If the procedure involves an Intermediate Closure, it should be coded and billed separately from the lesion excision code(s), unless the code description or the CCI Unbundling material direct otherwise.
2. Simple Closures are non-layered
The wound is superficial and involves primarily the epidermis, dermis, or subcutaneous tissues. Medicare defines this closure as a repair of the wound involving the skin and subcutaneous tissue, and it is not usually covered separately from the Lesion Removal/Excision procedure.

3. Intermediate Closures are layered closures
The wound requires a layered closure of one or more of the deeper layers of subcutaneous tissue and superficial fascia, in addition to the skin closure. Medicare defines this closure as a wound involving the closure of one or more fascial layers, in addition to the skin and subcutaneous tissue. Layered Closures involve a dermal closure with separate suture closure of at least one of the deeper layers of subcutaneous and nonmuscle fascial tissues.
3. Complex Closures are more than layered closures
This type of Repair would include wounds requiring more than layered closure, some scar revisions, some debridements, traumatic lacerations, some avulsions, and some procedures involving extensive undermining, stents, or retention sutures. The physician should state in the note that it was a Complex Repair or Closure.

- The surgeon needs to document the Size and Location of Lesions removed in the OP Report. The measurement should be made at the time of the excision, in order to properly code these procedures. Lesion sizes are measured by their clinical diameter for a circular or elliptical lesion. The diameter is the length of a straight line segment that passes through the center of the lesion and terminates at the periphery. For irregular or asymmetrical lesions, the maximum width would provide the measurement of the lesion.
- Lesion sizes on Path. Reports can be significantly smaller (due to shrinkage or fragmentation of the specimen), and can result in having to revert to a lower code for billing purposes. Code from path. reports only when you have no other choice, due to no lesion sizes being provided in the OP Report.
- Encourage surgeons to properly document the size of the lesion(s) and include the margin size necessary for the excision in the OP Report. Keep disposable rulers/measuring tapes in the OR and have the nurses strongly encourage the physicians to measure and dictate the size at each surgical session. The nurse is your strongest ally with this problem.
- Excisions of Malignant Lesions are coded with codes from section 11600-11646. For Removal of Malignant Lesions by all methods other than excision, use codes 17000-17999.
- Mohs Micrographic Surgery, codes are used for the removal of complex skin cancer with histologic examination of 100% of the surgical margins are in the section of codes from 17311-17315.

These procedures include the removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), and are coded based on the body area

where the procedure was performed and the number of tissue blocks taken/examined. The pathologic exam of the tissue must be performed by the same physician who performs the excision procedure in Mohs procedures.

- For the Destruction of Multiple Benign or Premalignant Lesions by laser, electrosurgery, cryosurgery, chemosurgery, or surgical curettement:
 1. Use code 17000 for the Destruction of the 1st Lesion
 2. Use code +17003 (which is an Add-on code) for the destruction of EACH lesion from the 2nd to the 14th Lesion
 3. Use code 17004 ONLY for the destruction of 15 or more Lesions (do not use with codes 17000 or 17003 – use 17004 only).
- For the Destruction of Benign Lesions other than skin tags or cutaneous vascular proliferative lesions of up to 14 lesions by laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement:
 1. Use code 17110 for the Destruction of up to 14 Lesions
 2. Use code 17111 (only) for the Destruction of 15 or more Lesions
- The Excision(s) of Benign or Malignant Lesion(s) codes - which fall in the 11400-11646 code section - include a Simple Closure. Intermediate and Complex Closures would be reported separately. Intermediate (or Layered) closures involve dermal closure with separate suture closure of at least one of the deeper layers of subcutaneous and nonmuscle fascial tissues. These closure codes run in the 12031-13160 section. When tissue transfer or rearrangement codes are used to code the revision of a scar, use codes 14000-14350.
- Use 11400-11646 CPT codes for Lesion Excisions when the lesion arises from the skin, even if it invades into the deeper tissues. For Skin Cancers, Malignant Melanomas, Actinic Keratosis, Moles, Nevus Lesions, etc. use the 10000-section skin codes and separately bill the closure using the Repair/Closure codes if a Layered or Complex Closure is performed, as long as the codes are not Unbundled. When the Lesion removed is in a deeper structure that does NOT originate from the skin, such as a Tumor, Lipoma, Cyst, etc. and a Layered Closure is performed, the 20000-section codes for tumor excisions can instead be used. Those codes include a Layered Closure, which is not separately coded.
- With many of the Lesion Excision Codes, if more than one lesion is excised, code each lesion separately (except if more than one by the same incision), unless the code description or the CCI Unbundling material direct otherwise.
- If two Benign Skin Lesions were removed together using a *single excision*, then only *one* Excision of Lesion code would be coded and billed.
- CPT codes for Benign and Malignant Lesion Excisions are coded based on the anatomic area involved, whether the lesion is Benign or Malignant (if the code differentiates), and the size of the lesion. Use care in coding the procedures and

diagnoses on these procedures, as you do not want to label a patient as having a malignant process, when he/she does not have a malignancy, and you need to support the Medical Necessity of the procedure by coding correctly, if the patient does have a malignancy. Try to wait until the Path. Report comes back before coding, for the highest accuracy when billing these claims.

- When an excised lesion is a Neoplasm of Uncertain Morphology (such as a Malignant Melanoma, as opposed to a Dysplastic Nevi), the choice of a CPT code for billing relates more to the manner in which the lesion was excised, than the final pathologic diagnosis.
- Scar Excisions (includes Hypertrophic Scars) are usually coded from the 11400-11446 codes for Excision of Benign Lesions. Scar Excisions usually include a Simple closure of the wound. Cicatricial Lesions (which pertain to or resembles a scar) are coded from the 11400-11446 codes for Excision of Benign Lesions.
- Repairs of Scars involving Complex Repairs coding is from the 13100-13160-section, which includes the Excision of the Scar (which is not coded separately). The physician should specify in the OP Report details of removing the scar and indicating it was a Complex Repair.
- For use of the Repair codes for Intermediate and Complex Wounds after the removal of lesions, measure the total length of the repaired defects (not the size of the lesions) for coding purposes. Each area of the body is coded only once, so if more than one repair is performed per area, the sum of the total repair for the area is coded. For example, excisional repairs of the trunk, arms, or legs would be added together, as would excisional repairs from the scalp, neck, hands, feet, genitalia areas, etc.
- Closures of defects caused by incisions, excisions, or trauma usually are coded with Intermediate Closure codes.
- The Adjacent Tissue Transfer codes (14000-14302) include Scar Revisions, Lesion Excisions, and/or Repair by Adjacent Tissue Transfers, Advancement Flaps and Tissue Rearrangement procedures. This coding would usually include the excision of the defect – so it is wise to check the CCI material.
- If a Flap is used to repair a defect after a scar removal, but a free skin graft must be used to close the flap donor site defect, two CPT codes would be reported: One code should include the scar excision and the flap, with an additional code to indicate that a free full-thickness graft was performed.

Grafts

Skin Grafts

Code Skin Graft procedures based on the type of Graft used and the recipient site.

1. Free Skin Grafts involve an unattached portion of skin that is transferred to another site.
2. Split Grafts contain both Epidermis and Dermis layers.
3. Full-thickness Grafts include an equal and continuous section of both Epidermal and Dermal layers of skin.
4. Composite Grafts include more than one type of tissue, such as the skin mixture of the ears and nostrils. This “mixture” is assembled to fill in a defect to provide skin and structural support (cartilage) in the recipient site, minimizing scarring and distortion.
5. Derma-fascia-fat Grafts are used (similarly to Composite Grafts) to blend in blemishes or defects from surgical excisions, atrophy, and other skin problems.
6. Punch Grafts are used for hair transplants or for revision of scarring, such as acne scars.

Types of Skin Grafts

Autograft – Uses the same patient’s own skin.

Allograft – Uses skin obtained from another person.

Xenograft – Uses free skin grafts obtained from a non-human source (usually a pig).

Surgical Preparation

CPT codes 15002-15005 describe burn and wound preparation or incisional or excisional release of scar contracture resulting in an open wound requiring a skin graft.

Autografts/Tissue Cultured Autograft Procedures

The codes for Autografts/Tissue Cultured Autograft procedures run from the 15040-15157 codes.

Acellular Dermal Replacement

Acellular Dermal Autografts use human skin with the epidermis and other cells removed, which reduces the chance of rejection. The codes for Acellular Dermal Replacement procedures run from the 15170-15261 codes.

Allograft/Tissue Cultured Allogeneic Skin Substitute

Tissue Cultured Allogeneic Skin Substitutes use a mixture of collagen, fibroblasts, and deratinocytes. The codes for Allograft/Tissue Cultured Allogeneic Skin Substitute procedures run from the 15300-15366 codes. These codes are used for Graft Jacket procedures. The Q4107 Implant code would also be billed. Use codes 15330 or 15335 when Alloderm is used in procedures.

Xenografts

Codes for Xenograft procedures run from the 15400-15431 codes.

Lipoma Removals

Lipomas are benign fatty tumors in the subcutaneous or deeper tissues. They are tumors arising in soft tissue areas. They can occur on the chest, back, flank, neck, shoulder, arm, hand, wrist, fingers, hip, pelvis, leg, ankle, or foot. Lipomas can be of varying depth into the tissues, which is what dictates how you code their removal.

While there are diagnosis codes for Lipomas (214.X section), there are no specific CPT procedure codes for Lipoma Excisions. Lipomas can be as superficial as the subcutaneous tissue or extend deep into the intramuscular tissues. Therefore, it is very important to code these accurately – using the appropriate code from the 10000-section (11400-11446), if the Lipoma is located in the subcutaneous tissues, or coding from the 20000-section codes, if the implant is removed from a deep intramuscular tissue area.

Nail Procedures

- Use code 11730 for the Avulsion of nail plate, partial or complete, simple; single
- Use Add-on Code 11732 for the Avulsion of nail plate, partial or complete, simple; each additional nail plate (List separately in addition to code for primary procedure)
- Use code 11750 for the Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal
- Use code 11752 for the Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal; with amputation of tuft of distal phalanx
- Use code 11760 for the Repair of nail bed
- Use code 11762 for the Reconstruction of nail bed with graft

Orthopaedic/Musculoskeletal System Procedures

Common Orthopedic Procedures which are Frequently Coded Incorrectly

➤ **Hardware Removals**

Use code 20680 for **Deep** Pin Removal procedures, which are usually done in an ASC. To define, the physician makes an incision overlying the site of the implant. Deep dissection is carried down to visualize the implant, which is usually below the muscle level and within bone. The physician uses instruments to remove the implant from the bone. The incision is repaired in multiple layers using sutures, staples, etc.

Superficial pin or K-wire removals not requiring a layered closure are billed with the 20670 code.

While there are several methods for how many 20680 implant removal codes to bill when multiple pieces of hardware are removed, *CPT Assistant* and the AAOS (American Academy of Orthopedic Surgeons) direct that the 20680 code is to be billed once per fracture site, rather than based on the number of incisions made to remove the hardware from one fracture site or original area of injury. Billing the 20680 code more than once is only appropriate when hardware removal is performed in a different anatomical site unrelated to the first fracture site or area of injury.

- Removal of Hardware from Ankles has its own procedure code, code 27704 for the Removal of an Ankle Implant, which should be used instead of the 20670 or 20680 codes. However, if only one or two screws are removed and it is not an extensive procedure, use the applicable 20670 or 20680 code, instead, as the 27704 code is for a more involved/extensive procedure.
- Removal of a Finger or Hand Implant should be billed with the 26320 CPT code. However, if only one or two screws are removed and it is not an extensive procedure, use the applicable 20670 or 20680 code.
- Removal of an Implant from the Elbow or Radial Head should be billed with the 24160-24164 codes. However, if only one or two screws are removed and it is not an extensive procedure, use the applicable 20670 or 20680 code.

➤ **Tendon Grafts with ACL Repairs**

The 20924 code for the Harvest of a Patellar or Hamstring Tendon Graft states “from a distance”, and billing this code with the 29888 ACL Repair code is usually not allowed and will likely be denied, because the tendon graft is usually obtained from a separate incision on the *same knee*, which does not constitute a

far enough distance to bill for it separately, according to the *CPT Assistant* publication, (even though it is not Unbundled in the CCI material and is done through a separate incision). The tendon graft is billable with the 20924 code when the graft is obtained from the opposite knee or either ankle. If the tendon graft is an Allograft, which is purchased, bill for an Implant (code L8699), if allowed by the payor.

➤ **Lipoma Removals**

Lipomas are benign fatty tumors in the subcutaneous or deeper tissues. They are tumors arising in soft tissue areas. They can occur on the chest, back, flank, neck, shoulder, arm, hand, wrist, fingers, hip, pelvis, leg, ankle, or foot. Lipomas can be of varying depth into the tissues, which is what dictates how you code their removal.

While there are diagnosis codes for Lipomas (214.X section), there are no specific CPT procedure codes for Lipoma Excisions. Lipomas can be as superficial as the subcutaneous tissue or extend deep into the intramuscular tissues. Therefore, it is very important to code these accurately – using the appropriate code from the 10000-section (11400-11446), if the Lipoma is located in the subcutaneous tissues, or coding from the 20000-section codes, if the implant is removed from a deep intramuscular tissue area.

➤ **Hammertoe Repairs**

Hammertoe Corrections are done to relieve an abnormal flexion posture of the proximal interphalangeal joint of one of the toes (excluding the big toes). These correction procedures include fixation of the toe with a Kirschner wire, excision of any corns and calluses on the skin and division and repair of the extensor tendon. Procedures that are done for Hammertoe Corrections, which are included in the 28285 code, include any combination or all of the following:

- Interphalangeal Fusion (Arthrodesis) – involves an incision into the proximal interphalangeal joint, excision of intraarticular cartilage, manual correction of the flexion deformity and the misalignment of the toe, and an internal fixation of the joint.
- Extensor Tendon Tenotomy or Lengthening and Reattachment procedures performed on the Phalanx.
- Proximal Phalangectomy – involves an excision of the proximal phalanx and a manual correction of the metatarsophalangeal extension deformity and proximal interphalangeal joint flexion deformity.

*Even though the 28285 Hammertoe code is Unbundled from most of the Bunionectomy procedures, it is billable using the **Toe Modifiers** when the 28285 code is performed on a **different toe** from the Bunionectomy procedure.*

A Metatarsophalangeal Joint Capsulotomy procedure (each joint) done with or without Tenorrhaphy is coded as 28270. It is a Separate procedure. This code is used if the joint capsule released lies between the tarsal and the toe. If this procedure is done in conjunction with a Hammertoe (28285) procedure, it would be separately billable, as long as it is performed through a separate incision and would need the -59 Modifier appended. If it is performed through the same incision as the Hammertoe Repair, it would be considered bundled and not separately billable (even with a -59 modifier), unless it is done on a separate toe (in which case, use the appropriate Toe Modifier).

➤ **Platelet Rich Plasma**

Orthopedic surgeons (as well as those for some other specialties) use Platelet Rich Plasma in some procedures to aid in post-operative healing. In 2011, CPT issued a new code for billing of this procedure. Use code 0232T for the Injection(s), platelet rich plasma, any tissue, including image guidance, harvesting and preparation when performed, which is covered by Medicare at a low reimbursement.

➤ **Synovectomy vs. Debridement Procedures**

Sometimes, it can be difficult to distinguish whether a Synovectomy or Debridement was performed (based on the documentation).

The AAOS directs that Debridement codes are used when articular cartilage is debrided and Chondroplasty procedures are performed.

Synovectomy codes should be used when only soft tissue is removed, synovium is excised, or plica is excised.

The AAOS further clarifies that if Loose or Foreign Bodies are removed from the same compartment/area where a synovectomy or debridement is performed, the Loose or Foreign Body removal would not be separately billable. If the loose or foreign body removed is very large (over 5 mm.), and/or it is removed through a separate incision, it can be billed with the -59 Modifier, if it is Unbundled in the CCI material.

Hip Procedures

- Use code 20610 for an Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa).
- Use code 27275 for a Manipulation, hip joint, requiring general anesthesia.
- While these 2 codes are billable together, Manipulations should only be billed when it is the only procedure performed. If a surgical arthroscopy is performed

on the same joint, the Manipulation should not be billed. It is billable when the Manipulation procedure is performed in the same case with a Joint Injection procedure.

- Total Hip Replacements are coded 27130 for an Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft.
- Hip Arthroscopy Procedures
CPT added 3 new codes for Hip Arthroscopies for 2011, which are covered by Medicare:
 - Code 29914 – Arthroscopic Hip Femoroplasty
 - Code 29915 – Arthroscopic Hip Acetabuloplasty
 - Code 29916 – Arthroscopic Hip Labral Repair

Treatment of Hip and Pelvis Fractures and Dislocations

- Code 27267 is used for the Closed treatment of a fracture of the proximal end of the femoral head. In this procedure, no incisions are made and no manipulation is used.
- The 27268 code is for the Closed treatment of a fracture of the proximal end of the femoral head using manipulation. In this procedure, no incisions are made and the surgeon uses manipulation to correct the bone to its proper anatomic position. Traction may be used post-operatively in this procedure.
- Code 27269 is for the Open treatment of a fracture of the proximal end of the femoral head, which is an ORIF (Open Reduction/Internal Fixation) procedure, if Internal Fixation is used.

These procedures would most likely be used for traumatic fractures of the femoral head, and would be seen primarily in younger patients, rather than the elderly population, who may have a hip fracture caused by Osteoporosis.

Coding of Other Orthopedic Procedures

Injection Procedures in Orthopedics

Trigger Point Injections

- Use code 20552–Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
- Use code 20553–Injection(s); single or multiple trigger point(s), 3 or more muscle(s)
- Do not bill trigger point injection as a local anesthetic for surgery
- Not allowed on the same day as any surgery

- High utilization in a short period could be a Medicare “red flag” for audits.
- Injections of tendon sheaths, ligaments and ganglion sheaths should be limited to 1-2 per site, except in very unusual circumstances.
- Medical necessity will always need to be supported. If initial symptoms are not resolved within 3 weeks, a paper claim with documentation supporting the medical necessity of the injections may be requested.
- Medical record documentation for all tendon sheath, ligament, or trigger point injections is expected to indicate the clear and concise medical necessity with the patient’s medical record, should review become necessary.
- Since Medicare does cover these procedures, but reimburses at a low amount, we recommend performing TPIs as an Add-on Procedure only and not as the only procedure.

Joint Injections

- Use code 20600 for an Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes).
- Use code 20605 for an Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa).
- Use code 20610 for an Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa). Use this code if an SI Joint Injection is done without any imaging (instead of 27096 or G0260).

Brachytherapy

- Code 20555 is for the Placement of needles or catheters into muscle and/or soft tissues for the subsequent placement of interstitial radioelements. The brachytherapy seeds can either be placed at the time of this procedure or they can be placed later at a different time. Interstitial radioelement application is a form of brachytherapy, which is a treatment for cancers (such as a soft tissue sarcoma) where radioactive isotopes are placed to deliver radiation to the body internally over a period of weeks or months. Needles or catheters are placed into the soft tissues or muscle close to the tumor bed for treatment with tiny seeds, which are the radiation sources.
- Code 20555 would not be used for Brachytherapy procedures performed on the breast, prostate or head and neck areas.
- For Image Guidance, use codes 76942, 77002, 77012 or 77021, as appropriate.

Computer-Assisted Navigation Guidance for Ortho. procedures

- Add-on code 20985, which is for Computer-assisted navigation guidance for use in musculoskeletal procedures, performed *without* the generation of an *image* when the guidance is used.
- Add-on code 0054T for Computer-assisted navigational guidance during musculoskeletal procedures, which provides image *guidance* based on *fluoroscopic* images.

- Add-on code 0055T is for Computer-assisted navigational guidance during musculoskeletal procedures, which provides image *guidance* based on *CT/MRI* images.
- Remember that these are Add-on codes, which should only be listed in addition to the code for the primary procedure performed and are never listed as the only code on the claim.
- These 3 codes are NOT on the Medicare ASC Payment List as covered procedures.

Treatment of TMJ

The 21073 code is for the Manipulation of the Temporo-mandibular joint for therapeutic purposes, and the patient would be under General or Monitored anesthesia for the use of this code. This code is used for therapeutic, not diagnostic, purposes. In this procedure, no incisions are made - the surgeon applies manual manipulation to return the mandible to its correct position.

Bone and Other Types of Grafts

Some bone graft procedures are not covered by Medicare in an ASC setting. These procedures are billed with CPT Codes 20900-20926. Types of Bone Grafts procedures are:

- Autografts – Grafts transferred from one part of the body to another
- Allografts/Homograft – Donor tissue taken from the same species
- Alloplastic – Use of synthetic materials having little or no ability to react with other composition
- Composite grafts – Combinations of autogenous material and allograft or alloplastic materials.

Report only one bone graft procedure per operative session. These are add-on procedures. The CPT states that codes for obtaining autogenous bone grafts through separate incisions are to be used only when the graft is not already listed as part of the basic procedure. The codes usually used to bill these services are 20900-20926. For codes 20900-20902, code selection should be based on the size of the bone harvest, rather than the difficulty of the access needed to harvest the bone.

Most bone, cartilage and fascia graft procedure codes include obtaining of the graft by the operating surgeon.

Codes for obtaining autogenous bone grafts, cartilage, tendon fascia lata grafts, or other tissues, through separate incisions are to be used only when the graft is not already listed as part of the basic procedure.

The 20924 code for a Tendon Graft states “from a distance”, and billing this code with the 29888 ACL Repair code is usually not allowed and will likely be denied, because the tendon graft is usually obtained from a separate incision on the *same knee*, which does not constitute a far enough distance to bill for it separately, according to the *CPT*

Assistant publication. It is billable with the 20924 code when the graft is obtained from the opposite knee or either ankle.

Introduction and Removal Procedures

Removal of a foreign body in a muscle or tendon sheath-simple (code 20520) is normally considered incidental, when performed with a larger and more invasive procedure.

Use code 20525 for the removal of a foreign body in a muscle or tendon sheath that is deep or complicated, involving a more extensive procedure to remove the object.

Fracture Care

Fracture Treatment Diagnosis Coding

- Code pathologic or non-traumatic fractures as 733.1X. Use additional code(s) to identify underlying conditions causing the fracture.
- Compression fractures of the spine:
 - Caused by a fall (traumatic – ICD-9-CM codes 805-806)
 - Caused by degenerative disease (ICD-9-CM code 733.13)

Internal fixation devices may break or malfunction, causing multiple symptoms and may require an inpatient hospital admission. Coding these cases is made easier by locating the main term – “complications” and the sub-terms “mechanical” and “orthopedics device” in the alphabetical listings. These are coded from the 996 diagnosis coding section.

Fracture Care – What’s Included

There was a major revision to the fracture care language on many of the fracture codes in 2008, where CPT revised the descriptor to say “Includes Internal Fixation when performed” and the revised language excludes External Fixation. The previous language on many of the fracture codes was “with or without internal or external fixation.”

When external fixation is used, CPT is stating it can be coded and billed in addition to the Fracture care procedure. However, since this change is in the CPT code wording, and Medicare may not necessarily agree with the separate billing of external fixation from the fracture code, it would be wise to check the CCI Unbundling material each time to be sure the codes are not bundled, when billing for external fixation.

GENERAL INFORMATION

- Fracture treatment designated to be performed “Intra-articular” is performed IN the joint. Procedures designated to be “Extra-articular” are not performed in the joint.
- Dislocations are located in the coding book in the same section as fractures.
- With **Closed** fractures, there is no open wound into the skin. Examples – comminuted, greenstick, simple, impacted.

- Fractures are considered “Closed” unless specified to be an Open Fracture in the medical records.
- “Closed treatment” of a fracture specifically means that the fracture site is not surgically opened (exposed to the external environment and directly visualized). Closed Fractures are treated using three methods:
Without manipulation
With manipulation
With or without traction
- With **Open** fractures, there is an open wound into the skin. Examples – compound, infected, puncture, with foreign body.
- “Open treatment” of a fracture (called ORIF) is used when the fracture is surgically opened (exposed to the external environment). In this instance, the bone is visualized and internal fixation may be used.
- Stress fractures are not to be billed using fracture codes.
- Fracture care is coded based on the way the fracture is treated by the physician. The type of fracture (e.g., open/compound, closed) does not always correlate with the type of treatment (e.g., closed, open, or percutaneous) provided. The codes for treatment of fractures and joint injuries (dislocations) are categorized by the type of manipulation (reduction) and stabilization (fixation or immobilization). These codes can apply to either open (compound) or closed fractures or joint injuries.
- When coding for fracture care, consider the following:
 - Where is the site of fracture or dislocation?
 - Is the treatment open or closed?
 - Was manipulation involved?
 - Was skin or skeletal traction applied?
 - Was skeletal fixation (percutaneous, external, or internal) applied?
 - Was soft tissue closure performed?
 - Were any grafts used?
- The term manipulation refers to the “attempted” reduction or restoration of a fracture or joint dislocation to its normal, anatomical alignment by manual application of applied forces (traction) – so even if the reduction procedure is not successful, the code for treatment with manipulation may be used.
- In keeping with the policy on most extensive procedures, when a fracture requires closed reduction followed by open reduction in the same case (e.g., inability to accomplish the closed reduction), only the open reduction service is billed.

External Fixation Systems

For the application of an external fixation system (which includes the application of a Uniplane [pins or wires in one plane]) use code 20690. For the application of a Multiplane unilateral external fixation system (using pins or wires in more than one plane), use code 20692. Code either of these codes in addition to the code for treatment of the fracture or joint injury, unless listed as part of the basic procedure. Use code 20693 for the Adjustment or revision of an external fixation system requiring anesthesia [eg, new pin(s) or wire(s) and/or new ring(s) or bar(s)]. For the Removal of an External Fixation System under anesthesia, use code 20694.

Use code 20696 for the Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s).

Use code 20697 for the Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each.

Arthroscopic Procedures

In Arthroscopic procedures, the physician visualizes the interior of the knee (or another) joint by inserting an arthroscope through small incisions and uses a camera to transmit images onto a monitor. These minimally-invasive procedures offer a quicker rehabilitation time for patients.

When both a Diagnostic and Surgical Arthroscopy procedure are performed in the same Joint area, the Diagnostic Arthroscopy is included in the Surgical Arthroscopy, and would not be billed separately. For procedures involving both an Arthroscopy and an Arthrotomy, both may be billed, as long as the procedures are in different compartments for different diagnoses, and the OP Note clearly documents this fact. Those CPT codes which list the procedure as being performed “by any method” may be used for either open or arthroscopic procedures. Those procedures performed arthroscopically for which there is no specific CPT code should be billed with the Unlisted CPT code from the Arthroscopy section, and it is advisable to send the OP Report with the claim. Coding an Open Procedure for an Arthroscopic one is considered Fraudulent by Medicare.

Shoulder Procedures

Shoulder Anatomy

The shoulder is the most moveable joint in the human body, due to its unique structure of three bones, muscles, ligaments and tendons, which is why chronic shoulder problems can become a nightmare for some patients.

The three bones which make up the shoulder are the clavicle (collarbone), humeral head (upper arm bone), and the scapula (shoulder blade), which meet at the top of the shoulder joint. The scapula is an unusually-shaped bone, which extends up and around the shoulder joint in the back and over the shoulder joint, creating a “roof” at the shoulder joint (called the acromion), and around the front to the coracoid process. The clavicle forms the front of the shoulder girdle and extends from the sternum to the scapula. The humeral head is joined to the scapula in the glenohumeral joint, which is a ball-and-socket type of joint. The *ball* (the head of the humerus) fits into the part of the scapula known as the *socket* (or glenoid), which is lined with the labrum. The labrum is a ring of fibrous cartilage that makes the glenoid more “cuplike”. The capsule, which is lined with

synovium, encircles the glenohumeral joint. It is these muscles, tendons, and ligaments that hold the shoulder bones in place. It is a complicated structure, which can experience problems that can cause patients to have impingement, weakness and/or tingling extending down the arm, limited motion, and severe pain.

The AAOS recognizes 3 areas/regions of the Shoulder: The Glenohumeral joint, the Acromioclavicular joint, and the Subacromial Bursal Space – which are clearly separate areas.

Remember (when coding Medicare claims) to follow the Correct Coding Initiative (CCI) Unbundling directives closely. Watch for the “Separate Procedure” designations in the CPT book (such as with codes 29805 for a Diagnostic Shoulder Arthroscopy done with or without a Synovial Biopsy), which directs that those procedures are not billable when any other (usually more extensive) procedure is performed on the same shoulder. Many other payors follow the same guidelines as Medicare and expect the provider to observe the same CCI Unbundling and CPT directives.

Shoulder Manipulations

Manipulations (code 23700) should only be billed when it is the only procedure performed. If a surgical arthroscopy is performed on the same joint, the Manipulation should not be billed. It is billable when the Manipulation procedure is performed in the same case with a Joint Injection (code 20610). This procedure is usually performed for Adhesive Capsulitis, for post-shoulder replacement stiffness and for “frozen shoulder” conditions.

Rotator Cuff Tears

The largest muscle of the shoulder is the deltoid muscle, which lies above the rotator cuff. The rotator cuff consists of a group of flat tendons which cover the front, back and top of the shoulder joint, like the cuff of a shirt sleeve, which, along with other muscles, holds the top of the humerus in the glenoid socket and provides mobility and strength to the shoulder joint. The rotator cuff tendons are attached to four muscles: The supraspinatus, the subscapularis, the infraspinatus, and the teres minor.

An arthroscopic repair of the rotator cuff would be coded 29827. An open repair would be coded using either 23412 for a chronic condition or 23410 for an acute condition, unless the tear is considered to be “Complete”.

Reconstructive procedures for Complete Rotator Cuff Tears or Ruptures are coded 23420, which includes an acromioplasty procedure. According to the AAOS, conditions which justify the use of this code would include:

1. When the physician performs multiple or extensive releases during the procedure
2. If the physician performs mobilization during the rotator cuff release

3. When a fascial graft or synthetics are used in the repair
4. A large tear or avulsion with extensive retraction

Some arthroscopic repairs require a conversion to an open procedure. When this occurs, report only the code for an Open (or a “Mini-Open”) procedure. Also use the V-code V64.43 for an Arthroscopic surgical procedure converted to an Open procedure (as the last diagnosis code on the claim form).

Remember that when an Arthroscopic procedure is converted to an Open procedure in the same area/for the same problem, only the Open procedure would be billed. If an Arthroscopic procedure starts out as a Diagnostic procedure only (where the surgeon is looking into the joint only, but he/she is not performing any surgical or therapeutic procedure) and the surgeon converts the Diagnostic procedure to a Surgical procedure, only the more extensive surgical procedure is billed.

The diagnosis code for an Acute Rotator Cuff Tear would be 840.4 for a Rotator Cuff Sprain and Strain involving a Current Injury. For a Chronic Partial Rotator Cuff Tear use code 726.13. For Chronic Rotator Cuff Syndrome, use code 726.10 for Disorder of Bursae and Tendons in Shoulder Region, Unspecified. For the most extensive Complete Rupture of the Rotator Cuff, use code 727.61.

Acromioclavicular Conditions / Subacromial Decompression Procedures

The Acromioclavicular (AC) joint is located between the acromion and the clavicle and is held together with the support of the acromioclavicular and coracoclavicular ligaments. Spurs projecting from the bones may develop around the joint, which usually causes pain and swelling, which can limit the motion of the arm.

The arthroscopic procedure (code 29826) used to repair this condition is a Subacromial Decompression with Partial Acromioplasty, with or without Coracoacromial Release. Open procedures would be coded 23130 for an Acromioplasty or Acromionectomy, Partial, with or without Coracoacromial Ligament Release or 23415 for a Coracoacromial Ligament Release, with or without Acromioplasty.

CPT Changes to Shoulder Scope Coding

If an Arthroscopic Subacromial Decompression of the Shoulder is performed for dates of service in 2012 going forward and it is the ONLY scope procedure performed in the case, the 29999 Unlisted Scope code must now be used, because the AMA revised the 29826 Arthroscopic Subacromial Decompression code for 2012 making it an Add-On Code only. This means it can only be billed with another scope procedure as the primary procedure.

The AAOS considers Acromionectomy procedures to be separately-billable from Rotator Cuff Repair procedures (whether performed arthroscopically or as open procedures), except in the case of the Complete Repair procedure, since the 23420 code includes the verbiage “includes Acromionectomy” in the code descriptor. If there is a CCI Unbundling edit encountered, consider the payor’s guidelines and whether or not it is

allowable to bill the Acromionectomy procedure using a –59 Modifier. Do not bill the scope or open acromioplasty/subacromial decompression code to Medicare if it is unbundled in the CCI edits from another shoulder procedure performed in the same case (i.e., 23410 and 23412 Open Rotator Cuff Repair procedures).

Synovectomy Procedures

Joint Capsules, which are lined with a synovial membrane, which produces synovial fluid, encases the joint and protects the cartilage, muscle, and connective tissue. Because of the unique range of motion of the shoulder joint, there is a greater chance of capsular injury. The arthroscopic removal of synovium from the shoulder would be coded as either 29820 or 29821, depending on whether it is a partial or complete removal. The AAOS directs that the 29821 Complete Synovectomy procedure is not to be billed unless the surgeon documents removal of the entire intra-articular synovium. The open code for a shoulder synovectomy procedure would be 23105 or 23106, and is coded based on which joint is involved in the procedure - the glenohumeral or the sternoclavicular joint.

Instability of the Shoulder Joint

When a patient suffers from Instability of the shoulder joint, it can be the result of a Bankart Lesion (which is a defect at the insertion of the capsule, where it enters the rim of the glenoid) or a problem with an unstable or loose capsule. Bankart Lesions can occur in the glenoid at the posterior, inferior, or anterior/inferior (most common) areas. Bankart repairs are coded as 29806 for an arthroscopic procedure or 23455 for an open procedure.

For an arthroscopic repair to the capsule, code 29806 would be used. There are 6 codes for OPEN capsular repairs: Codes 23450, 23455, 23460, 23462, 23465, or 23466. The open shoulder codes are specific for anterior, posterior, or multi-directional instability, so read the code descriptors carefully.

There is no code for an Arthroscopic Thermal Capsulorrhaphy, so two possibilities are codes S2300 or the Unlisted code 29999.

SLAP Tears

The biceps tendon, which comes from the muscle on the forearm, goes through the shoulder joint and attaches to the top of the labrum. A SLAP (Superior Labrum Anterior to Posterior) tear can occur when there is damage to the labrum, where the biceps tendon attaches. There are several different types of SLAP lesions, which can affect the type treatment performed. The AAOS directs that if Debridement is the only procedure performed to treat a SLAP I Lesion and no repair is performed, use the 29822 or 29823 Debridement codes, as appropriate. The arthroscopic code for a SLAP repair of a type II or type IV SLAP lesion is 29807. There is **no** corresponding open code. Type III SLAP lesions (called Bucket-handle tears) are coded using either the 29822 or 29823 Arthroscopic Debridement codes or the 29807 Arthroscopic Repair code, as appropriate.

The AAOS states that one of the most common errors made with the coding of SLAP repairs is to use the 29806 Arthroscopic Capsulorrhaphy code with either a Debridement code or the 29807 SLAP Repair code. The 29806 code should not be billed unless the OP Report specifically states that the patient had a capsular defect in a *different area* from where the SLAP lesion was being addressed. A Capsulorrhaphy procedure should not be billed when the surgeon puts a staple or similar device through the capsule to perform a SLAP repair.

The only diagnosis code for a SLAP Lesion is 840.7, which is for a Current Injury/Acute condition. For a chronic condition, use code 726.2 (for Other Affections of Shoulder Region, NEC), if the physician states the patient also has impingement.

For a repair of the distal biceps tendon (close to the elbow, rather than the shoulder area), use the codes in the Humerus and Elbow Section.

Clavicle Procedures

The Clavicle (the collar bone) runs from the scapula or shoulder blade to the sternum. The arthroscopic procedure for a partial distal claviclectomy (involving removal of approximately 1 cm. of bone) is coded 29824, while the open procedure for a partial procedure would be coded as 23120. The open code for a total claviclectomy procedure would be 23125. Claviclectomy procedures may be referred to as the Mumford procedure. The AAOS guidelines direct that the surgeon should document that at least 1 cm. of the distal clavicle was removed. If only bone spurs are removed from the clavicle area, it is not separately billable.

Shoulder Debridements

There are two codes for the arthroscopic Debridement of the Shoulder. Code 29822 would be used for Limited Debridement and code 29823 would be used for Extensive Debridement. Read the OP report carefully to ascertain how extensive the procedure was, to know which code to select. The AAOS directs that the 29822 code is used for Limited Labral Debridements, Limited Rotator Cuff Debridements, or the Removal of Degenerative Cartilage and Osteophytes. The 29823 Extensive Arthroscopic Debridement code is only justified when the physician performs Debridements in both the front *and* back areas of the shoulder. The 29823 code includes a Chondroplasty of the Humeral Head or Glenoid and Osteophytes or the Debridement of multiple structures including the Labrum, Subscapularis and Supraspinatus areas.

Post-Operative Shoulder Surgery Pain Control Injection Procedures

When a patient is to receive an Injection or has a Catheter placed during an Arthroscopic Shoulder surgical procedure for control of post-operative pain, there are certain requirements which must be met in order to bill the Injection/Catheterization procedure separately.

- The Injection/Catheterization procedure must be performed by a *different physician* (usually the anesthesiologist) from the surgeon who performs the ortho. scope surgery.
- There must be a *separate* Procedure Report for the Post-Op Injection/Catheterization procedure (it cannot be part of the surgeon's OP Report or part of the Anesthesia Record).
- The Block must not be the only anesthesia for the case.
- If there is a separate report for the Injection/Catheterization procedure and the Injection/Catheterization procedure was performed by a different physician, you may bill for the Injection/Catheterization procedure. Use a different claim form from the Shoulder surgery procedure and bill the Injection/Catheterization procedure claim in the name of the anesthesiologist (or other physician) who performed the Injection/Catheterization procedure.
- Codes for billing Injection/Catheterization post-operative pain procedures:
 1. 64415 – Brachial Plexus Block (also use this code for an Interscalene Block) for a Single Injection
OR
 2. 64416 – Brachial Plexus Infusion by Catheter using a Pain Pump

Medicare has issued specific guidance that in most cases they consider Injections performed routinely for Post-Operative Pain Control to be bundled into the orthopedic surgeon's global services (even when the Injection is performed by a different physician), so we would recommend not billing them to Medicare.

If Injections are given for Post-Op Pain Control after Knee Surgery, the 64447 code for a Femoral Nerve Block Injection or code 64448 for a Femoral Block by Catheter using a Pain Pump would be used. Use code 64450 for Blocks for Ankle and Foot procedures.

Tenodesis Procedures

Tenodesis procedures are performed on the long tendon of the biceps, which can become frayed or rupture from Impingement and other degenerative conditions of the shoulder. Tenodesis involves suturing the end of a tendon to a bone and/or shaving the frayed portion of the tendon for repair.

- Use code 23430 for an Open Tenodesis of the long tendon of the Biceps.
- Use code 29828 for an Arthroscopic Shoulder Biceps Tenodesis procedure. Use the 29828 code for Biceps Tendon Repairs of tears, tendinosis, and subluxation conditions.

CPT directs when billing the 29828 code, do not bill separately for:

- Diagnostic Shoulder Arthroscopy – code 29805
- Arthroscopic Shoulder Synovectomy – code 29820
- Arthroscopic Shoulder Debridement – code 29822

Knee Procedures

Knee Anatomy

The knee joint is the largest joint in the body, and it is one of the body's most complex structures. The three main Compartments of the Knee joint are the inner (medial), the outer (lateral), and the kneecap (patella or also called patello-femoral), which includes the Trochlear Groove.

- Knee Joint Manipulations procedures (code 27570) should only be billed when it is the only procedure performed. If a surgical arthroscopy is performed on the same joint, the Manipulation should not be billed. When a Manipulation procedure is performed in the same case with a Joint Injection (code 20610), both procedures are billable, unless Unbundled.
- Lateral Releases performed Arthroscopically should be billed with code 29873. The Open Lateral Release is coded 27425.
- If CPT codes 29875-29881 are billed, and the surgeon also performs Arthroscopic Removal of Loose or Foreign Bodies (CPT code 29874) in the same compartment, the 29874 code would be considered bundled and not separately billable. If the 29874 procedure occurred in a different compartment, it might be separately-billable with a -59 Modifier or the G0289-GY code for Medicare. The G0289 code is not presently on the Medicare list of covered procedures.
- Use code 27385 for the Suture of quadriceps or hamstring muscle rupture; primary. This code can also be used if the work is done on the Tendon.
- Use code 27427 for a Ligamentous reconstruction (augmentation), knee; extra-articular.

- **Dislocating Patella**
When the patient has a chronically Dislocating Patella, the Reconstruction procedures for correction of that condition are in the 27420-27424 codes.
 - Use code 27420 for the Reconstruction of a Dislocating Patella; (also referred to as the Hauser procedure).
 - Use code 27422 for a Reconstruction of a Dislocating Patella when an Extensor Realignment and/or Muscle Advancement/Release are performed (also referred to as the Campbell or Goldwaite procedures).
 - Use code 27424 when the Reconstruction of a Dislocating Patella procedure is performed with a Patellectomy.
- Use code 27437 for an Open Abrasion Arthroplasty, patella; (without prosthesis) – this is the closest code to an open debridement or chondroplasty procedure.

Knee Replacement Procedures

- Use code 27446 for an Arthroplasty, knee, condyle and plateau; medial OR lateral compartment. This code is covered by Medicare in an ASC.

- Use code 27447 for an Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty) - This Total Knee Replacement procedure is not covered by Medicare in an ASC.
- Use code 27486 for a Revision of total knee arthroplasty, with or without allograft; 1 component. This code is not covered by Medicare in an ASC.

Knee OCD Lesion Treatment

- The 27416 code is for an Open Osteochondral Autograft (also called a mosaicplasty) of the knee. This code would include harvesting of the autograft. Bill the code only once, regardless of the number of harvests or grafts used in the repair. CPT directs that the 27416 code is not to be billed with the 27415 code (for an Open Allograft Osteochondral procedure of the knee) on the same case.
- Use code 27415 for an Open Allograft Osteochondral procedure of the knee and the 29866 code for an Osteochondral Autograft procedure when it is performed Arthroscopically, the 27416 code can be used for an Open Osteochondral autograft procedure.
- Use code 29866 for an Arthroscopic osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s]).

Synovectomy Procedures

For coding Synovectomy procedures, the following applies:

1. The 29875 code for a Limited Synovectomy includes the partial resection of synovium or plica from one knee compartment. Code 29875 is considered a “Separate Procedure”, thus if this Limited Synovectomy is performed in the same compartment with another procedure, it is not billable. If the procedure is performed in a separate compartment, is a separate procedure, is carried out independently, or is considered unrelated (different compartment) from the other procedure from which the 29875 code is Unbundled, it could be billed with a -59 Modifier.
2. The 29876 code for a Major Synovectomy involves removal of the synovium and plicae from 2 or more knee compartments.
3. If both a Limited and Major Synovectomy procedure are performed, the 29875 and 29876 codes should not be billed together. The 29876 code would be all-inclusive, and should be the only code billed.
4. If a multiple compartment Synovectomy is performed in the same compartment where another procedure from which the 29875 code is Unbundled, the Synovectomy would be included in the other procedure and would not be separately-billable using the 29876 code. However, if the Synovectomy was performed in another compartment and was the only procedure performed in that compartment, it would be billable with the 29875 code using the -59 Modifier.
5. The Synovectomy codes are used for the Excision of Plica and Resection of Fat Pad in the Knee procedures.
6. For Open Synovectomy procedures use codes:
 - 27334 for an Arthrotomy, with synovectomy, knee; anterior OR posterior

- 27335 for an Arthrotomy, with synovectomy, knee; anterior AND posterior including popliteal area

- **OATS Procedures**

When the surgeon performs Mosaicplasty procedures, these codes are used. OATS procedures performed Arthroscopically are coded as follows:

- Use code 29866 for an Arthroscopic Osteochondral Autograft.
- Use code 29867 for an Arthroscopic Osteochondral Allograft.
- Use code 29868 for an Arthroscopic Meniscal Transplantation procedure.
- Use Unlisted Scope code 29999 or HCPCS code S2112 for an Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells) when the surgeon is harvesting the cartilage for later use in the implant/transplant procedures listed above. Use code J7330 for the Genzyme Kit used in that procedure.

Abrasion Arthroplasty (also called PICK Arthroplasty) Procedures (CPT code 29879) are usually performed to promote the regeneration of cartilage by creating access to blood and nutrients by smoothing the cartilage and/or drilling holes to create microfractures. The AAOS Guidelines state that the OP Report documentation must state that the procedure was performed “down to bleeding bone” or to the “subchondral level”. The 29879 code includes a Chondroplasty (bill separately only if performed in a different compartment), Resection of Osteophytes, and Removal of Loose or Foreign Bodies, when performed in the same compartment.

For an Open Abrasion Arthroplasty procedure, use code 27437 for an Arthroplasty, patella; without prosthesis.

Meniscus Procedures

- Meniscectomy procedures are performed for Meniscal Tears. A motorized cutter or shaver is used through the arthroscope to remove the meniscus in either the Medial OR Lateral Compartments of the Knee and is billed with code 29881.
- If a Meniscectomy procedure is performed in both the Medial AND Lateral Compartments arthroscopically, use code 29880.
- Meniscal Repairs are billed with code 29882 for an arthroscopic repair in the Medial OR Lateral Compartment. If an arthroscopic Meniscal Repair is performed in both the Medial AND Lateral Compartments, it is coded 29883.
- If an arthroscopic Meniscal Transplant procedure is performed in the Medial OR Lateral Compartment, use code 29868.
- If an Open Arthrotomy procedure is used to Excise the Meniscus in either the Medial OR Lateral Compartment, use code 27332.
- If an Open Arthrotomy procedure is used to Excise the Meniscus in both the Medial AND Lateral Compartments, use code 27333.
- An Open Meniscal (Inside Out) Repair is coded 27403.

CPT Changes to Knee Scope Coding for 2012

The AMA revised the Arthroscopic Knee Meniscectomy codes 29880 and 29881 to INCLUDE a 29877 Debridement/Chondroplasty procedure in the same or other compartments. What this means is that if a Chondroplasty is performed on the same Knee in the same case as a Meniscectomy (even if it was the ONLY procedure performed in a knee compartment), it cannot be separately billed with codes 29877 or G0289. This policy applies for ALL payors – not just Medicare, because it is a change to the CPT guidelines, rather than a payor requirement.

An example would be for a Knee Scope procedure performed on the right knee in which a Synovectomy (29875) is performed in the Patella, a Meniscectomy (29881) is performed in the Medial compartment and a Chondroplasty (29877) is performed in the Lateral compartment. If the claim for this surgery were being filed to Aetna, the coding would be as follows:

29881-RT
29875-59-RT

The 29877 Chondroplasty procedure would not be billable because it was performed in the same surgical case on the same knee as the Meniscectomy procedure, so because of the new CPT guideline, it is not billable, even using a -59 Modifier. The -59 Modifier should be used on the 29875 Synovectomy procedure to avoid a payor denial, since the 29875 code is designated as a “Separate Procedure” in the CPT book and code 29875 is Unbundled from code 29881 in the Medicare CCI Unbundling Edits.

Chondroplasty Procedures

The coding of Chondroplasty procedures can be confusing. Chondroplasty procedures (CPT code 29877) are coded once per knee, per case, regardless of the number of Compartments in which it was performed – so, if the procedure is performed in more than one compartment, bill the 29877 code once only, when it is billable.

Chondroplasty Documentation Tips:

- If the Chondroplasty is performed in the *same* compartment with the other Arthroscopic surgery procedures, it would be considered bundled, and would not be separately-billable.
- The surgeon must document that the Chondroplasty was done in a different compartment than the repair or excision (in order to bill it with other procedures – with the EXCEPTION of a Meniscectomy, with which it would NOT be separately billable).
- The Chondroplasty procedure is bundled into Meniscectomy procedures, regardless if it is done in the same or a different compartment from the Meniscectomy. This is a CPT guideline which must be followed with ALL payors – NOT just Medicare.

- Use modifier –59 on the 29877 Chondroplasty code to indicate it was performed in a separate compartment (when it is billable) because it was performed in a separate compartment from another procedure that is NOT Meniscectomy.
- Special Instructions/Different Coding for Chondroplasty procedures:
 1. Use the G0289 code in place of the 29877-59 code when billing Chondroplasties performed in a separate compartment from other procedures (except a Meniscectomy) - when it is separately billable) to Medicare. However, ASC facilities will not be reimbursed by Medicare for the G0289 code, as the G0289 code is not presently on the Medicare ASC List of covered procedures for ASCs. Thus, the G0289 code should be billed to Medicare using the –GY Non-covered Modifier. The physician will be paid for this G-code.
 2. The –59 Modifier is not needed when billing the G0289 code.
 3. In order for the G0289 code to be billable to Medicare, the physician is required to document in the OP Report that he/she spent at least 15 minutes performing the Chondroplasty in the separate compartment.
 4. The G0289 code is also for use for the Removal of Loose Bodies or Foreign Bodies performed in a separate compartment from the other Knee Arthroscopy procedure from which the usual Chondroplasty/Loose Body/Foreign Body codes are Unbundled in the CCI Unbundling material. The same documentation and billing requirements quoted above for the Chondroplasty apply for Loose Body/Foreign Body removals, when using the G0289 code.
 5. Continue using the 29877-59 code for payors other than Medicare for Chondroplasty procedures performed in a separate compartment from other procedures (except Meniscectomies, as previously discussed), unless you have clarified with the payor that they prefer the use of the G0289 code, instead.
 6. When a Chondroplasty is the ONLY procedure is performed on that knee, it is billable to all payors with code 29877.

ACL Repairs/Reconstructions

Acromioclavicular Clavicular Ligament (ACL) Repair/Reconstruction procedures include the removal of synovium for the surgical approach, notchplasty, removal of the ACL stump, a partial synovectomy, resection of the fat pad, reconstruction of the intra-articular ligament, the harvesting and insertion of a tendon, fascial or bone graft with internal fixation, lysis of adhesions, and joint manipulation.

- Arthroscopic ACL Repair/Reconstruction procedures are coded 29888.
- Use code 27407 for an Open ACL Repair procedure.
- If a procedure is performed on the ACL to Drill the Ligament to enhance the healing response, bill code 29888-52 for Reduced Services.
- If the ACL is Debrided, but not Repaired, use code 29999, the Unlisted Arthroscopy code. Unlisted codes are not covered by Medicare.

- The code for a Re-do ACL Reconstruction procedure is 29888.
- Remember that Hamstring Autografts harvested from the back of the same Knee are not separately billable. Bill purchased Allografts with code L8699 or other appropriate implant code.
- The 29884 Knee Arthroscopy with **Lysis of Adhesions** procedure may be performed with or without manipulation of the knee. The manipulation is done to break up any additional adhesions. This code is also designated as a “Separate Procedure”, thus it should not be billed separately, if performed with another major knee procedure.
- **Capsular Shrinkage** – There is not a specific CPT code for Arthroscopic Medial Capsular Shrinkage procedures. The Unlisted CPT code for the Arthroscopy section of 29999 should be used to bill this procedure, and include the OP Report with the claim. Unlisted codes are not covered by Medicare.

Other Leg and Ankle Procedures

- Use code 27612 for Achilles Tendon Lengthening procedure - Arthrotomy, posterior capsular release, ankle, with or without Achilles tendon lengthening.
- Use code 27675 for a Repair of Dislocating Peroneal Tendons without a fibular osteotomy, and use code 27676 for a Repair of Dislocating Peroneal Tendons with a fibular osteotomy.
- Code 27680 for a Tenolysis of a Flexor or Extensor Tendon of the leg or ankle for *each* tendon, which is also called a Baker Repair procedure.
- Code 27698 for a Secondary Repair of a Disrupted Ankle Collateral Ligament. This procedure is also referred to as the Watson-Jones, Brostrum, Evans, Chrisman-Snook, or Elmsie procedures performed for Ankle Instability.
- Use codes 27720-27726 for the procedures to Repair of nonunion or malunions of the Ankle.
- Code 27745 for a Prophylactic Treatment (nailing or pinning) of the Tibia.
- Code 27829 for Treatment of Syndesmosis, which is an open treatment of a distal tibiofibular joint disruption, performed with or without internal or external fixation.

Fracture Treatment codes for the Tibia, Fibula and Ankle

- The 27726 code is for the Repair of a nonunion and/or malunion of the fibula with internal fixation used in the procedure.

To define:

- A Nonunion of a Fracture is where the bones do not heal back together.
- A Malunion of a Fracture is where the bones heal in an incomplete union or where the bones heal in the wrong position.

Use the 27726 code for a fibular ankle fracture malunion, which has healed improperly with malrotation and derangement at the ankle. In this procedure, the surgeon realigns the bones into the correct position using internal fixation.

CPT directs not to use this code in conjunction with a fibular osteotomy (code 27707).

- Code 27767 is for the Closed Treatment of a Posterior Malleolus Fracture performed without manipulation.
- Code 27768 is for the same procedure when it is performed with manipulation.
- Code 27769 is for the Open treatment of a posterior malleolus fracture, which would include internal fixation, if it is used in the procedure.
- CPT directs that codes 27767-27769 are not to be used with the bimalleolar or trimalleolar ankle fracture treatment codes, which are in code section 27808-27823.

Ankle OCD Lesion Treatment Code

Use code 29892 for an Ankle OCD Lesion procedure when it is performed arthroscopically. Code 28446 is for an Open osteochondral autograft of the talus. This code includes harvesting of the autograft. Use this code for the treatment of large osteochondral defects of the talar dome. Bill the code only once, regardless of the number of harvests used in the repair. This code is not to be used with codes for osteotomy procedures of the tibia and/or fibula (codes 27705 and 27707).

Arthroscopic Ankle procedures

There are two sets of Ankle Arthroscopy codes. Those performed on the Tibiotalar and Fibulotalar Joints (which is up higher on the ankle) and those performed on the Subtalar Joint, which is lower on the ankle.

The Subtalar Joint lies between the calcaneus (heel bone) and talus, which is lower down in the ankle joint than the 298XX Ankle Arthroscopy codes performed at the Tibiotalar and Fibulotalar Joints. These procedures are for intra-articular calcaneus fractures, sinus tarsi syndrome, rheumatoid arthritis and synovitis conditions.

- Codes for Arthroscopic Ankle procedures performed in the Tibiotalar and Fibulotalar Joints:
 - Use code 29894 for an Ankle Arthroscopy for the Removal of Loose or Foreign Bodies in the Tibiotalar and Fibulotalar Joints
 - Use code 29895 for an Ankle Arthroscopic Partial Synovectomy in the Tibiotalar and Fibulotalar Joints
 - Use code 29897 for an Ankle Arthroscopic Limited Debridement in the Tibiotalar and Fibulotalar Joints

- Use code 29898 for an Ankle Arthroscopic Extensive Debridement in the Tibiotalar and Fibulotalar Joints
- Codes for Arthroscopic Ankle procedures performed in the Subtalar Joint:
 - Use code 29904 is for the Arthroscopic Removal of a Loose or Foreign Body from the subtalar joint of the ankle
 - Use code 29905 for an Arthroscopic Synovectomy of the Ankle performed in the Subtalar Joint, which removes the synovial lining of the joint
 - Use code 29906 for an Arthroscopic Ankle Debridement performed in the Subtalar Joint
 - Use code 29907 for an Arthroscopic Subtalar Arthrodesis, which is a joint Fusion, usually done with Morcellized bone grafting and internal fixation with screws in the Subtalar Joint.

Subtalar Arthroereisis procedure

Use code S2117 or an Unlisted code for the open Subtalar Arthroereisis procedure, which is not covered by Medicare or BC/BS. The procedure is usually performed by podiatrists. Watch for this procedure and make informed decisions related to reimbursement and whether or not to accept the case at the time of scheduling.

Elbow, Wrist and Hand Procedures

- Cubital Tunnel Release (which is a Neuroplasty of the ulnar nerve at the elbow) procedures are coded 64718.
- Use code 24310 for a Tenotomy, open, elbow to shoulder, each tendon, which includes thermal cautery and when the Topaz device is used.
- A Radial Repair of the lateral collateral ligament at the elbow is coded 24343.
- Use code 24344 for the Reconstruction of the lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft).
- An Ulnar Repair of the medial collateral ligament at the elbow is coded 24345.
- Elbow Codes for the Treatment of Epicondylitis (also called Tennis Elbow) are as follows:
 - The 1st code is 24357 for a Percutaneous Tenotomy of the Proximal Extensor Carpi Radialis Brevis Tendon at its insertion in the Elbow, which can be performed on the lateral (or outer) side or the medial (inner) side of the elbow. During this procedure, the surgeon makes a small incision and uses a needle to break up the abnormal fibrotic tissue on the tendon to stimulate new blood flow and healing.

- The 24358 code is for the Open Debridement of soft tissue and/or bone in the Elbow. Use this code when the surgeon removes damaged soft tissue and sometimes bone, which would be billed for an Epicondylectomy.
- The 24359 code is similar to the 24358 code, except that in addition to the Open Debridement of soft tissue and/or bone, the surgeon also repairs the affected tendon or does a tendon reattachment, which would be billed for an Epicondylectomy performed with a tendon repair/reattachment.

CPT directs not to use codes 24357-24359 in conjunction with Arthroscopic Elbow Debridement codes 29837 or 29838.

- Use code 24300 for the Manipulation of the Elbow performed under anesthesia. A Manipulation should only be billed when it is the *only* procedure performed. If a surgical arthroscopy is performed on the same joint, the Manipulation should not be billed. It is billable when the Manipulation procedure is performed in the same case with a Joint Injection (code 20605).
- Guyon’s Canal procedure (which is a Neuroplasty of the ulnar nerve at the wrist) is coded 64719.
- Carpal Tunnel Procedures - It is important to distinguish Carpal Tunnel Release procedures between those performed Endoscopically (use CPT code 29848) and those done by Open Repair (use CPT code 64721). If an Injection is performed, use code 20526 for a Therapeutic Injection of the Carpal Tunnel area.
- Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis) of the Flexors use code 25115.
- Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, Tbc, or other granulomas, rheumatoid arthritis) of the Extensors, with or without transposition of dorsal retinaculum use code 25116.

A “Radical” procedure means that all of the bursa, synovia, etc. is removed or excised during the procedure. In these procedures, all of the diseased and/or inflamed tissue is removed and surgeon may remove some normal tissue, as well.

- Use code 25118 for an Extensor Synovectomy of the Extensor Tendon Sheath of the Wrist of a Single Compartment.
- Use code 25109 for the Excision of tendon, forearm and/or wrist, flexor or extensor, each.
- Use code 25431 for the Repair of a nonunion of a carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each.

- For the Carpometacarpal (CMC) Joint Arthroplasty procedure, codes 25447 for an Arthroplasty, interposition, intercarpal or carpometacarpal joints and code 25310 for a Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon OR code 26480 for a Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon (as appropriate) are usually billed. This procedure is usually performed for arthritis.
- Use code 25607 for an Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation – which is NOT performed in the joint.
- Use codes 25608 for an Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments OR 25609 for an Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments – these procedures are performed in the joint.
- Use code 25651 for the Percutaneous skeletal fixation of an ulnar styloid fracture.
- Use code 25652 for the Open treatment of an ulnar styloid fracture.
- Wrist Fusion Procedures:
 1. Use code 25800 for an Arthrodesis, wrist; complete, without bone graft (includes radiocarpal and/or intercarpal and/or carpometacarpal joints).
 2. Use code 25805 for an Arthrodesis, wrist; with sliding graft.
 3. Use code 25810 for an Arthrodesis, wrist; with iliac or other autograft (includes obtaining graft).
 4. Use code 25820 for an Arthrodesis, wrist; limited, without bone graft (eg, intercarpal or radiocarpal).
 5. Use code 25825 for an Arthrodesis, wrist; with autograft (includes obtaining graft).
- The usual procedures performed for deQuervains (pronounced Decker Veins) disease is 25000 for the Release with CPT description Incision, extensor tendon sheath, wrist.
- The usual procedure performed for Dupuytren's Contractures are described below:
 1. The least extensive release procedure is 26040 for a Percutaneous Palmar Fasciotomy.
 2. The Open procedure is 26045 for a Palmar Fasciotomy; open, partial.
 3. The more extensive procedures include tissue removal, beginning with code 26121 for a Fasciectomy, palm only, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft).
 4. Code 26123 for a Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft).
 5. Code 26125 for a Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local

tissue rearrangement, or skin grafting (includes obtaining graft); each additional digit (List separately in addition to code for primary procedure).

- Trigger Finger - use code 26055 Tendon Sheath Incision for the Release procedure.
- Use code 26320 for the Removal of implant from finger or hand if an extensive amount of hardware is being removed. If only one or two screws or pins are removed, use codes 20670 or 20680.
- For Repairs/Releases of Contractures of the Hand and Fingers, use codes 26520 for a Capsulectomy or capsulotomy; metacarpophalangeal joint, each joint OR 26525 for a Capsulectomy or capsulotomy; interphalangeal joint, each joint.
- Use code 26546 for the Repair of a non-union, metacarpal or phalanx (includes obtaining bone graft with or without external or internal fixation).

Arthroscopic Elbow and Wrist Procedures

- When the surgeon just looks in the Elbow joint but does not perform any surgical procedure, use code 29830 for Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)
- Use code 29834 for the Arthroscopic Removal of loose body or foreign body from the Elbow
- Use code 29835 for an Arthroscopy, elbow, surgical; synovectomy, partial
- Use code 29836 for an Arthroscopy, elbow, surgical; synovectomy, complete
- Use code 29837 for an Arthroscopy, elbow, surgical; debridement, limited
- Use code 29838 for an Arthroscopy, elbow, surgical; debridement, extensive
- Use code 29840 for an Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)
- Use code 29843 for an Arthroscopy, wrist, surgical; for infection, lavage and drainage
- Use code 29844 for an Arthroscopy, wrist, surgical; synovectomy, partial
- Use code 29845 for an Arthroscopy, wrist, surgical; synovectomy, complete
- Use code 29846 for an Arthroscopy, wrist, surgical; excision and/or repair of triangular fibrocartilage and/or joint debridement

- Use code 29847 for an Arthroscopy, wrist, surgical; internal fixation for fracture or instability
- Use code 29848 for an Endoscopy of the Wrist, surgical, with release of transverse carpal ligament

Foot Procedures

Foot Anatomy

The human foot provides support and balance while standing, as well as raising and moving the body to provide motion. Consisting of ¼ of the bones of the entire body, the foot contains 14 phalanges bones (forefoot), 5 metatarsal bones (midfoot), and 7 bones that form the tarsus or hind portion of the foot. Additionally, there are 33 joints, and over 100 ligaments, muscles and tendons.

The coding of Foot procedures can be difficult, and it is very important to read and analyze the medical record documentation (OP Report) carefully, to make it more likely to code the procedure(s) accurately. Many foot procedures are coded based on the Name of the procedure performed. Foot procedures can be performed by Podiatrists (D.P.M. designation), Medical Doctor Physicians (M.D.), or Doctors of Osteopathy (D.O. designation). It is important for the surgeon to give the full name of the procedure performed in the OP Note.

Be sure on all foot procedures to append the appropriate Anatomic Modifiers, as necessary – use -RT, -LT, or -50 for bilateral, as appropriate. If the procedure was performed on the Toes, you need to use the Toe Digit Modifiers instead. If you do not append the appropriate –RT, –LT or Toe Modifier when needed on billing for the first surgery and the same procedure is performed on the opposite foot/toe at a later date, the second claim will likely be denied as a Duplicate Claim. The Hallux is defined as the Great (Big) Toe. For those procedures performed on the Hallux at the metatarsal level or below, use the –RT or –LT Modifiers, rather than the Toe Modifiers, for Bunion procedures (unless the Bunionectomy is performed on the Phalanx – then use Toe Modifiers).

Foot Procedures

Bunionette

Tailor’s Bunion Correction Procedure – Coded as 28110, which is a bunion correction done with a partial ostectomy of the 5th metatarsal head and soft tissue release of the 5th metatarsal joint. This procedure is performed only on the 5th Toe. This code is designated as a Separate procedure. This procedure would be billable (even though it is a “Separate Procedure”), as long as all of the other procedures are performed on other

Toes. If this procedure is done in conjunction with the 28308 procedure (Osteotomy of the mid-shaft of the 5th metatarsal with screw fixation-sometimes referred to as the Weil procedure), only the 28308 procedure would be billable.

Bunions

A Bunion is an abnormal prominence of the first metatarsal-phalangeal head area (the Big Toe or Hallux), usually accompanied by bursal inflammation, which can result in a lateral or valgus displacement of the big toe. Often, Bunion Deformities develop because of the use of inappropriate shoes, which result from constriction or compression of the forefoot. High heels are usually the biggest culprit - the higher the heel, the worse the problem. However, genetics also play a part in the formation of Bunions. Bunions usually cause lateral (outward) deviation of the great toe. The Lateral Deviation of the Great Toe at the Interphalangeal Joint is called Hallux Valgus Interphalangeus. This can exist independently or be in conjunction with an MTP Joint deformity.

Bunion Surgery

It is very important with Bunion procedures for the surgeon to indicate in the OP note the Type and Name of the procedure he/she is performing to assist the ASC in coding these procedures properly. All Bunion deformities are not the same, and their surgical correction involves different techniques, with varying levels of complexity. Codes 28290-28299 are reported for the correction of Bunion deformities. It is very important to know the type of procedure used, and verify its components before selecting a Bunionectomy code which include the following:

1. Capsulotomy
2. Capsular Release and Reconstruction
3. Arthroscopy
4. Arthrotomy
5. Synovial Biopsy
6. Synovectomy
7. Tendon Release
8. Extensor Tenotomy
9. Tenolysis
10. Removal of Additional Exostoses in the Area of the Joint
11. Excision of the Medial Eminence
12. Excision of Associated Osteophytes
13. Placement of Internal Fixation
14. Scar Revision
15. Articular Shaving
16. Removal of Bursal Tissue (if done at the 1st MTP Joint)
17. Splinting/Casting

If the surgery is done on one foot only, use an –RT or –LT Modifier on the CPT code. If the surgery is done on both feet, use the –50 Modifier, as appropriate, unless it is contractually-prohibited by the payor.

Types of Bunion Procedures:

Silver Procedure – Coded as 28290, which is a **simple resection of the medial eminence** with or without a lateral capsule release and adductor tenotomy. This procedure can be done with or without a Sesamoidectomy procedure and involves a Simple Exostectomy. This is usually done on elderly patients with vascular problems, and is for a mild deformity. There are frequent problems with recurrence when this procedure is performed.

Keller, McBride or Mayo Procedure – Coded as 28292, in this procedure, a portion of the proximal phalanx and usually the **medial eminence** of the metatarsal bone **is removed**. A Sesamoidectomy may be performed. Placement of Kirschner Wires is done to stabilize the joint.

- The **Keller** procedure is a simple resection of the base of the proximal phalanx with removal of the medial eminence.
- The **McBride** procedure is a distal soft tissue release, done by releasing the tight lateral capsule, ligament complex and adductor tendon, and reefing the loose medial capsule, with resection of the medial eminence.
- The **Mayo** procedure (seldom performed), involves a resection of the 1st metatarsal head.

Keller-Mayo Procedure with an Implant – Coded as 28293. The joint of the big toe is removed and replaced with a flexible **silicone implant** in the 1st MTP joint for Arthritis. A Sesamoidectomy may also be performed. HCPCS codes L8641 and L8642 can be used for the Implant itself.

Joplin Procedure – Coded as 28294 is performed when a **tendon transplant** is used to treat a Bunion deformity. Realignment is restored to the tendons of the toe by cutting and reattaching them to the bones. This includes osteotomies, effecting a fusion of the proximal phalanx and metatarsal bone. A Sesamoidectomy is also included in this code.

Austin, Reverse Austin, Mitchell or Chevron, Kalish, Youngswick, Reverdin, Larid, Reverdin-Green and Hohmann Procedures – Coded as 28296. This procedure involves a **metatarsal osteotomy** done with or without a Sesamoidectomy. This code is also used for the Reverdin-Green Osteotomy and LaGreshino Bunionectomy procedures.

- The **Austin** Osteotomy procedure is performed for patients who do not have degenerative joint disease, who enjoy pain-free range of motion, and still have dorsiflexion of the 1st metatarsal, but have mild to moderate hallux abducto valgus. It is also used to shorten or lengthen the 1st metatarsal segment.
- The **Mitchell** procedure is a complex, biplane, double step cut (transpositional) osteotomy, which runs through the neck of the 1st Metatarsal,

with a lateral step-down and removal of the head of the 1st metatarsal, with both distal and proximal osteotomies. It is used to correct moderate bunions, with a subluxed MTP joint.

- The **Distal Chevron** procedure consists of a resection of the medial eminence, a medial longitudinal arthrotomy, combined with a transverse osteotomy of the coronal plane of the metatarsal neck, which is done to lateralize the head.
- The **Concentric Osteotomy** procedure combines a modified McBride procedure with a proximal metatarsal osteotomy procedure.
- A **Tricorrectional Bunionectomy** procedure uses a technique to correct all 3 planes with a distal metatarsal osteotomy, involving a transverse V-osteotomy and long plantar hinge using cannulated bone screws for fixation.

Lapidus Procedure – Coded 28297. This procedure involves a **metatarsocuneiform fusion**, with a distal soft tissue bunion repair. It may be performed with or without a Sesamoidectomy. It is a similar procedure to a Chevron, but the Lapidus does not include a metatarsal osteotomy at the proximal aspect of the 1st metatarsal shaft. It is done for Arthritis or joint instability.

Akin Procedure/Phalanx Osteotomy – Coded 28298, which involves the removal of a medially-based bony wedge from the base of the proximal phalanx (**phalanx osteotomy**), to correct its axis. It may be performed with or without a Sesamoidectomy. This procedure is used when there is little or no angulation of the 1st metatarsal, and it will not offer a satisfactory response for a major bunion deformity.

Austin-Akin/Double Osteotomy – Coded 28299, which is for severe hallux valgus or a congruent joint. Osteotomy procedures of the 1st metatarsal or the metatarsal and proximal phalanx are sometimes performed – a procedure which involves a **combination** of two osteotomy procedures. These procedures are coded differently. **Any combination of Osteotomy procedures performed on the phalanx and metatarsal of the same toe would be considered a Double Osteotomy procedure and should be coded with the 28299 code, instead of being coded out separately.**

Proximal Osteotomy Procedures – Coded 28306. This procedure (also called the Weil Osteotomy procedure) is done at the base of the 1st Metatarsal for severe Metatarsus Primus Varus of more than 15 degrees. The procedure may be done with or without lengthening, shortening or angular correction of the metatarsal. If the procedure involves a separate incision at a more proximal anatomic area, use a –59 Modifier. If the procedure is done at the 1st metatarsal with an autograft to correct the alignment of the 1st metatarsal shaft and it is attached with wire or screws, use code 28307. If the procedure is done on a metatarsal other than the 1st

metatarsal, use the 28308 code for *each* toe. Use code 28309 for multiple toes. These codes are alternative procedures to codes 28111, 28112, 28113 and 28288.

Arthrodesis Procedures – For an Arthrodesis of the Great Toe of the Metatarsophalangeal Joint, use code 28750, which is done for arthritic changes at the 1st MTP joint associated, with severe Hallux Valgus. If the Arthrodesis is performed on the Interphalangeal Joint of the Great Toe, use code 28755. The Jones Suspension procedure is billed with code 28760 for an Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint.

Other Foot Procedures

Subtalar Arthroereisis procedure

Use code S2117 or an Unlisted code for the open Subtalar Arthroereisis procedure, which is not covered by Medicare or BC/BS. The procedure is usually performed by podiatrists. Watch for this procedure and make informed decisions related to reimbursement and whether or not to accept the case at the time of scheduling.

If any of the following described procedures are performed in conjunction with a Bunion procedure and are performed on toes other than the Great Toe or Hallux, they should be separately coded in addition to the Bunion procedure, and they might require the use of a -59 Modifier or a Toe Modifier, to indicate a separate site, if the codes are Unbundled.

- CPT code 28113 – Osteotomy with complete excision of the 5th Metatarsal Head
- CPT code 28116 – Osteotomy, excision of tarsal coalition, which is also referred to as a Haglund’s Deformity
- CPT codes 28230-28234 – Tenotomy Procedures for the flexor or extensor tendons
- CPT codes 28270 – Capsulotomy, metatarsophalangeal joint, with or without a tenorrhaphy. This is designated as a “Separate Procedure” in the CPT book and may require a -59 Modifier
- CPT code 28280 – Syndactylization of the Toes is performed to close an abnormal gap in the toes
- CPT code 28285 – Hammertoe Correction – when this procedure is performed on a toe other than where a Bunionectomy is performed, it is billable. It is very important to append the appropriate Toe Modifier, to indicate the Hammertoe procedure was done on a separate toe from other procedures (especially Bunionectomy procedures, from which it is Unbundled)
- CPT code 28286 – Cock-up 5th Toe Deformity corrects the bones of the 5th toe from pointing upward
- CPT code 28288 – Osteotomy, partial, exostectomy or condylectomy, metatarsal head – bill for each metatarsal head and use the Toe Modifiers
- CPT code 28645 – Open Treatment of MTP Joint dislocation, with or without internal or external fixation.

- Incision & Drainage below the fascia, with or without tendon sheath involvement of the foot, is coded with CPT code 28002 in the single bursal space, and 28003 for multiple areas.
- Incision of the bone cortex of the foot for Osteomyelitis or a bone abscess is coded as 28005.
- Use CPT code 28008 to report a Fasciotomy of the Foot and/or Toe (also called a Percutaneous Plantar Release), which is a Correction of a Flexion Contraction of the Foot or Toe. Use code 29893 for an Endoscopic Plantar Fasciotomy procedure.
- Plantar Fasciectomy procedures are coded using CPT codes 28060 for a partial procedure, and 28062 for a radical procedure. These codes are considered Separate procedures, and they may be Unbundled from other procedures done at the same surgical session. If the procedure is performed in a separate area from a code from which it is listed as Unbundled, append a –59 Modifier and bill it anyway, and enclose the OP Report with the claim.
- Excisions of Tumors in the subcutaneous tissue of the foot are coded as 28043 for sizes less than 1.5 cm. and code 28039 for sizes 1.5 cm. or greater. For tumors excised from deep tissue, subfascial or intramuscular tissue would be coded 28045 for sizes less than 1.5 cm. and code 28041 for sizes 1.5 cm. or greater.
- Excisions of Interdigital Neuromas (also called Morton Neuromas) are coded as 28080 for the single excision of each neuroma. Use –RT or –LT (not Toe) Modifiers on these codes.
- For Cysts or Ganglions, use code 28090 for an Excision of Lesion, Tendon Sheath, or Capsule (which includes a Synovectomy) of the Foot, which may be done for cysts or ganglions. For the same procedure of the toe(s), use code 28092 for each toe.
- Use code 28104 for Excision or Curettage of a Bone Cyst or Benign Tumor of the Tarsal or Metatarsal (which does not include the Talus or Calcaneus).

Ostectomy Procedures

- Use code 28110 for those procedures involving a partial excision of the 5th metatarsal head (also called a Bunionette or Tailor’s Bunionectomy procedure). This is designated as a “Separate Procedure” in the CPT book.
- Code 28111 is for a complete excision of the 1st metatarsal head.
- Code 28112 is used for a complete excision of other (2nd, 3rd, or 4th) metatarsal head.
- Code 28113 is used for a complete excision of the 5th metatarsal head. This code has two alternative codes to check (select the most appropriate code for the procedure performed) – codes 28288 and 28308.
- Code 28114 is for the complete excision of all metatarsal heads, done with a partial proximal phalangectomy, but excluding the 1st metatarsal – this procedure is also called a Clayton type procedure).
- An Ostectomy involving the calcaneus is coded using code 28118. This procedure is performed for Bone Spurs, which is also known as Haglunds or “pump bumps”.

- For Bone Spurs on the bottom of the heel, use code 28119 for an Osteotomy of the calcaneus done with or without a plantar fascial release.
- Use code 28288 for a Partial Osteotomy, Exostectomy or Condylectomy of the metatarsal head. Code it once for each metatarsal head. This code has two alternative codes to check (select the most appropriate code for the procedure performed) – codes 28113 and 28308.
- Code 28122 is used for a partial excision of the tarsal or metatarsal bone. These procedures can be done by craterization, saucerization, sequestrectomy, or diaphysectomy technique. This code does not include the talus or calcaneus areas – for these areas, use code 28120.
- Use code 28124 for a Partial Excision of the Phalanx of the Toe procedure.
- A Reconstruction or advancement procedure of the posterior tibial tendon (which includes an excision of the accessory tarsal navicular bone) is coded as 28238. This procedure is often referred to as a Kidner type of procedure.

Tenotomy Procedures

- Code 28230 is for an Open Tenotomy procedure of the flexor tendon of the foot, involving single or multiple tendon(s). This code is considered a Separate procedure.
 - Use code 28232 for an Open Tenotomy procedure of the flexor tendon of the toe for a single tendon (also a Separate procedure).
 - Use code 28234 for an Open Extensor Tenotomy of the foot or toe for a division of the extensor tendon. Code it once for each tendon. This procedure may be done for a repair of a hammertoe. This is also called a release of the extensor tendon. If this procedure is done in conjunction with a Hammertoe (28285) procedure, it would be considered bundled and should not be billed separately (even with a –59 modifier), unless it is done at a different anatomical site.
 - A Tenotomy done for lengthening or release of the Abductor Hallucis muscle is coded as 28240. This procedure is done to help correct the alignment of the big toe involving a bunion.
- Steindler Stripping - use CPT code 28250 for a Steindler Stripping procedure, which is usually performed for high arches. It is designated as a “Separate Procedure”.
 - Capsulotomy procedures:
 - Use code 28260 for a Capsulotomy procedure of the Midfoot with a Medial Release. This is a Separate procedure. If the procedure is performed with unrelated procedures/ services, it can be billed with a –59 Modifier.
 - For a Capsulotomy of the Midfoot performed with Tendon Lengthening, use code 28261.
 - A Midtarsal Capsulotomy procedure is coded using CPT code 28264, and may be referred to as a Heyman type procedure.
 - A Metatarsophalangeal Joint Capsulotomy procedure (each joint) done with or without Tenorrhaphy is coded as 28270. It is a Separate procedure. This code is

- used is the joint capsule released lies between the tarsal and the toe. If this procedure is done in conjunction with a Hammertoe (28285) procedure, it can be billed separately (with a –59 modifier).
- Capsulotomy procedures of the Interphalangeal Joint are billed using code 28272 for each joint. It is a Separate procedure. This code is used is the joint capsule released is between the small bones of the toe. This procedure is often performed to correct Club Foot deformities. If this procedure is done in conjunction with a Bunionectomy procedure, it would be considered bundled and should not be billed separately (even with a –59 modifier), unless it is done on a separate toe (in which case, use the appropriate Toe Modifier).
 - Hammertoe Corrections are done to relieve an abnormal flexion posture of the proximal interphalangeal joint of one of the toes (excluding the big toes). These correction procedures include fixation of the toe with a Kirschner wire, excision of any corns and calluses on the skin and division and repair of the extensor tendon. Procedures that are done for Hammertoe Corrections, which are included in the 28285 code, include the following:
 - Interphalangeal Fusion or Arthrodesis – involves an incision into the proximal interphalangeal joint, excision of intraarticular cartilage, manual correction of the flexion deformity and the misalignment of the toe, and an internal fixation of the joint.
 - Extensor Tendon Tenotomy or Lengthening and Reattachment procedures.
 - Proximal Phalangectomy – involves an excision of the proximal phalanx and a manual correction of the metatarsophalangeal extension deformity and proximal interphalangeal joint flexion deformity.

If a Joint is *replaced* for a Hammertoe condition, the regular 28285 Hammertoe Repair code cannot be billed. Since the only Toe Joint Replacement CPT code is for the Big Toe only, if this procedure is performed on the 2nd through 5th Toe, the 28899 Unlisted CPT code must instead be billed. Don't forget to bill the Implant with HCPCS code L8641 for a Metatarsal Joint Implant or L8699 if performed on an Interphalangeal Joint.

*Even though the 28285 Hammertoe code is Unbundled from most of the Bunionectomy procedures, it is billable using the **Toe Modifiers** on the 28285 code when the Hammertoe procedure is performed on a **different toe** from the toe upon which the bunion procedure is performed.*

- Cock-up 5th Toe Corrections done with plastic skin closure (also called Ruiz-Mora type procedures) are coded using code 28286.
- A Hallux Rigidus or Cheilectomy Correction procedure with debridement and capsular release of the 1st metatarsophalangeal joint is coded as 28289.
- When an Osteotomy of the Heel is performed, use code 28300 for an Osteotomy of the Calcaneus (this is the code for the Dwyer, Koutsogiannis or Chambers

procedures), which can be performed with or without internal fixation. *****
newly added by SE 12/11

- The Swanson Type Cavus Foot Osteotomy Procedure is done for patients suffering from High Arches, and the surgeon performs osteotomies on the metatarsal bones of the foot. It is coded as 28309. The procedure may be done with or without shortening, lengthening, or angular correction of the metatarsal. It is a multiple digit procedure.
- An Osteotomy performed by the Shortening, Angular or Rotational Correction of the Proximal Phalanx of the 1st Toe is coded as 28310. It is a Separate procedure. If the procedure is performed on any toe other than the 1st toe, use code 28312.
- Use code 28313 for a Reconstruction, angular deformity of toe, soft tissue procedures only (eg, overlapping second toe, fifth toe, curly toes).
- Sesamoidectomy procedures are coded using code 28315 for the 1st Toe. It is a Separate procedure. It is often performed during a Bunion correction surgical procedure (in which case it is NOT separately-billable). This procedure involves removal of the sesamoid bone, which lies under the metatarsal heads of each toe.
 - Subluxations of the Foot are partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles. Medicare does not pay for surgical or non-surgical treatment which has “the sole purpose” of correcting this problem. Medicare will reimburse for:
 - Surgical correction of a subluxated foot structure when this is part of the treatment of a foot injury.
 - Surgical correction of a subluxated foot structure to improve the function of the foot.
 - For the diagnosis and treatment of “symptomatic conditions” such as tendinitis, bursitis, osteoarthritis, and bunions, which result from the partial displacement of foot structure.

Tenotomy Procedures

Percutaneous Tenotomy procedures are performed through a small incision as more of a minimally invasive procedure than Open Tenotomy procedures.

- Code 28010 for Tenotomy, percutaneous, toe; single tendon
- Code 28011 for Tenotomy, percutaneous, toe; for multiple tendons on the same toe

Open Tenotomy procedures are more extensive than Percutaneous Tenotomy procedures.

- Code 28230 for Tenotomy, open, tendon flexor; foot, single or multiple tendon(s) (separate procedure)
- Code 28232 for Tenotomy, open, tendon flexor; toe, single tendon (separate procedure)
- Code 28234 for Tenotomy, open, extensor, foot or toe, each tendon

Shock Wave Therapy

Use the 28890 code for Extracorporeal Shock Wave therapy (with anesthesia other than local) to the Plantar Fascia.

Pain Management Procedures

With Pain Management Procedures, it is very important to know where the needle is going in the Injections performed. Knowing the spinal anatomy for Pain Management Procedures will enable you to understand which procedure the physician is performing – even if it is difficult to tell from the documentation.

Needle Destinations:

- Epidural Space/Extradural Space – This area is located inside the spinal canal and is separated from the spinal cord and the surrounding CSF (Cerebrospinal Fluid).
- “Epidural” – Which is short for “Epidural Anesthesia” and is a form of regional anesthesia involving drugs administered through a catheter placed in the epidural space.
- Dura Mater (Dura) – Separates the epidural space and the arachnoid membrane.
- Arachnoid Mater – This area is adherent to the inside of the dura and is more fragile.
- Subarachnoid Space – This area is inside the arachnoid space and contains CSF and the spinal cord.
- Vertebral Column – Also referred to as “the Spine” is composed of 33 bones, which are divided into 5 regions:
 - Cervical – 7 vertebral segments
 - Thoracic – 12 vertebral segments
 - Lumbar – 5 vertebral segments
 - Sacral – 5 vertebral segments
 - Coccyx – 4 vertebral segments

A vertebrae is a cylindrically-shaped body anteriorly and a neural arch posteriorly (composed primarily of the laminae and pedicles, as well as the other structures in the posterior aspect of the vertebrae), which protect the spinal cord.

An Intervertebral Disk is the tough elastic structure that lies between the bodies of spinal vertebrae. The disk consists of an outer annulus fibrosis enclosing an inner nucleus pulposus.

Pain Management procedures are done for patients having pain requiring treatment.

- Acute Pain is the pain associated with the treatment of post-operative procedural pain. This type of pain management is usually provided on an inpatient basis and is short-term.

- Chronic Pain is associated with the treatment of ongoing pain (usually lasting for 6 months or more), and is not always related to surgery. Pain Management procedures for chronic pain are typically done on an outpatient basis.
- The decision to perform pain management procedures involves the severity of the patient's pain and the *lack of other treatment* options.

Epidural/Subarachnoid Steroid Injections CPT Codes 62310-62319

The regular Epidural Steroid Injection (ESI) procedures are also referred to as “Translaminar” injections. Do not confuse these procedures with Transforaminal ESI procedures.

62310 – ESI Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; Cervical or Thoracic

62311 – ESI Injection - Lumbar or Sacral (caudal)

- The 62310 Cervical or Thoracic Epidural injections would be done for patients with pain in the arms, neck, chest or high back area.
- The 62311 Lumbar or Caudal Epidural injections would be done for patients with pain in the legs and/or lower back/buttock(s) area.

Procedure: The patient is placed in a prone or decubitus position, using fluoroscopy to guide the placement of the needle and confirm the tip of the needle is in the epidural/subarachnoid space. The injection of substance is performed. The subarachnoid route is performed when more specific effects on a nerve root are desired.

62318 – ESI Continuous Infusion or bolus, including catheter placement, by continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; Cervical or Thoracic

62319 – ESI Continuous Infusion or bolus - Lumbar or Sacral (caudal)

Procedure: A catheter is threaded through the needle and placed in the space. A continuous infusion is started for several hours/days. Occasionally, three or more injections might be given over a period of hours/days and may involve different substances.

These codes include the injection contrast material. If Fluoroscopic Guidance was used, the Fluoroscopy would be separately-billable with CPT code 77003-TC for DATES OF SERVICE IN 2011 ONLY.

In 2011, the AMA revised the Transforaminal Epidural Steroid Injection codes to include the use of imaging (Fluoroscopy or CT) and imaging used in the procedure, making the imaging no longer separately billable with code 77003-TC, as it was previously in 2010.

For 2012, the AMA is now doing the same thing with the Epidural Steroid Injection (ESI) CPT codes 62310 (Cervical or Thoracic ESI), 62311 (Lumbar or Sacral ESI), 62318 (Cervical or Thoracic by Continuous Infusion) and 62319 (Lumbar or Sacral) by Continuous Infusion). The four ESI codes listed above now include the contrast for localization, when it is used in the ESI procedures – making the use of contrast no longer separately billable with radiology code 77003.

Transforaminal Epidural Injections

When Transforaminal ESIs are performed for dates of service beginning Jan. 1, 2011, the 64479/64480 (Cervical/Thoracic) and 64483/64484 (Lumbar/Sacral) Injection codes have been revised to now include the use of imaging (Fluoro. or CT) and billing separately for those types of imaging is no longer allowed with code 77003-TC, etc. Codes for these procedures are:

64479 - Injection, anesthetic agent and/or steroid, transforaminal epidural; Cervical or Thoracic, single level
+64480 - Cervical or Thoracic, each additional level

64483 - Injection, anesthetic agent and/or steroid, transforaminal epidural; Lumbar or Sacral, single level
+64484 – Lumbar or Sacral, each additional level

A Transforaminal ESI is more difficult to perform, due to the close proximity of the nerve root to the vertebral artery and spinal cord. Transforaminal ESI Injections are performed under fluoroscopy for precise anatomic localization, to avoid injury to the vertebral artery. The contrast will be in either the foramen into the epidural space or it will be in a fascial plane or epidural vein. These codes are unilateral procedure codes; if the procedure is performed bilaterally, you need to bill in a Bilateral manner, by appending either the -RT/-LT or the -50 Modifier.

Transforaminal ESI Injections with Ultrasound Guidance

CPT added 4 new CPT codes as Category III procedures for 2011 and they are covered by Medicare.

- Use code 0228T for the Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; single level
- Use code 0229T for the Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, cervical or thoracic; each additional level (List separately in addition to code for primary procedure), which is an Add-on Code for an injection at a level subsequent to the first level performed
- Use code 0230T for the Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; single level
- Use code 0231T for the Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with ultrasound guidance, lumbar or sacral; each additional level (List separately in addition to code for primary procedure), which is an Add-on Code for an injection at a level subsequent to the first level performed

Bundling Issues with ESI Procedures

The 64479 code is Unbundled in the CCI Edits from code 62310 (Regular ESI procedure) in the Mutually Exclusive Table of the CCI Unbundling Material. Code 64483 is Unbundled from code 62311 (Regular ESI procedure) in the Mutually Exclusive Table of the CCI Unbundling Material. Therefore, for Medicare and other payors who observe the CCI edits, these codes are not billable together when they are performed at the SAME spinal area. If the physician does an ESI (62311) at level L5 and a Transforaminal ESI (64483) at area L4-5, the procedures are Unbundled and not both billable – only code 62311 would be billable in that case. However, if the physician does an ESI (62311) at level L5 and a Transforaminal ESI (64483) at area L3-4, then it is allowable to put a -59 Modifier on the 64483 code and bill it as the 2nd code following the 62311 ESI code on the claim form.

Paravertebral Facet Joint or Facet Joint Nerve Injections

Facet Injections involve the physician placing the spinal needle at the medial branch nerve of the facet joint (the Cervical or Thoracic areas), which is smaller than the Lumbar area, which makes the Cervical and Thoracic procedure a higher risk than those performed in the Lumbar area. These codes are unilateral procedure codes; if the procedure is performed bilaterally, you need to bill in a Bilateral manner, by appending either the -RT/-LT or the -50 Modifier (NOT for use on Medicare claims).

In 2010, there were major changes to the Facet Injection codes, and the Medicare ASC List fee schedule is reimbursing significantly less for these procedures. These codes include the use of imaging, so the 77003 Fluoroscopy or other imaging technique codes are not billed separately with the new codes. The new codes have a different code for

each level billed. The last code allowable for each spinal area (i.e., Cervical, Lumbar, etc.) is for the 3rd level and the code states that it “cannot be billed more than once per day,” which in CPT rules means that only a maximum of 3 levels are allowed to be billed - so if the physician performs Facet Injections at a 4th level or beyond, there is no code for those levels and they are not billable. While the direction in the CPT book is to use the -50 Modifier if these procedures are performed Bilaterally, Medicare’s previous guidance from 2008 for the billing of Bilateral procedures to Medicare still stands, and they still do not allow ASC facilities to use the -50 Modifier to bill Bilateral procedures in most states, so the use of the RT/LT Modifiers for Bilateral procedures should be observed when billing these codes to Medicare. The new codes for 2010 are as follows:

Code 64490 — Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; 1st/initial level.

Code 64491 —...second level Injection, cervical or thoracic; single level.

Code 64492 —...third and any additional level(s) – This code would only be used once per day and once on a claim, which means if there are injections at 4 or 5 levels, they are not separately coded – you can only code and bill for injections at 3 levels.

64493 — Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; 1st/initial level.

64494 —... second level Injection, lumbar or sacral; single level.

64495 —... third and any additional level(s) – This code would only be used once per claim, which means if there are injections at 4 or 5 levels, they are not separately coded – you can only code and bill for injections at 3 levels.

Sacroiliac Joint Injections CPT Codes 27096 OR G0260

27096 - Injection procedure for Sacroiliac Joint, Arthrography and/or Anesthetic/Steroid
G0260 - Injection procedure for Sacroiliac Joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without Arthrography to be billed by ASC facilities ONLY.

- The ASC should use the G0260 code to bill SI Joint Injections to Medicare.
- The professional side (Physician claim) for SI Joint Injections should be billed to Medicare with the 27096 code.
- The G0260 code is on the Medicare ASC list of covered procedures. The 27096 is NOT on the Medicare list of covered procedures. The physician and facility

claim coding will not match in this instance, but this coding is the correct way to code the procedure.

- The 27096 code is for use when the ASC facility is billing SI Joint Injections to payors other than Medicare, unless they want the G-code instead. The facility would NOT bill the 27096 code to Medicare.
- Radiology codes – for SI Joint Injections performed with Arthrography, the 73542-TC code should be billed. The Fluoroscopy code to use with SI Joint Injections when Arthrography is not performed is code 77003-TC. These codes are billable provided the payor allows the billing of radiology services – which Medicare does NOT reimburse.
- The G-code and 27096 codes are for use billing SI Joint Injections performed with radiologic guidance. If the SI Joint Injection is performed *without* the use of radiologic guidance, neither the G-code nor the 27096 should be billed. SI Joint Injections performed *without* the use of radiologic guidance should be billed using the 20610 code for an Injection into a Major Joint (which is not reimbursed well by Medicare). The 20610 code would be used by both the physician and the ASC facility.
- For a Radiofrequency Treatment of the SI Joint, use code 64640.

The most common diagnosis codes for SI Joint Injection procedures are 724.6 for Disorders of the Sacrum and 720.2 for Sacroiliitis.

If an injection is administered in the Sacroiliac Joint without the use of Fluoroscopic guidance, report only the procedure code for the SI Joint Injection. A formal radiologic report must be dictated when using the 73542 code for the Arthrography. Do not report code 77003-TC with code 73542-TC.

The injection of contrast material is inclusive. This is a unilateral procedure; when a bilateral procedure is performed, bill it in a Bilateral manner by appending the -RT/-LT or -50 Bilateral Modifiers. Report CPT code 73542-TC for the Arthrography performed with the -TC Modifier.

Lysis of Adhesions CPT Codes 62263 and 62264

62263 - Percutaneous Lysis of Epidural Adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), Multiple Adhesiolysis sessions; 2 or more days

62264 - Percutaneous Lysis of Epidural Adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), Multiple Adhesiolysis sessions; 1 day.

This procedure is used for patients with chronic pain - namely low back pain with radiculopathy. It is a Percutaneous Epidural treatment involving targeted injection of various substances via an epidural catheter. The catheter remains in place until the treatment is completed. Adhesions or scarring may also be lysed by mechanical means, including maneuvering of the catheter or by use of an epiduroscope. The appropriate Lysis of Adhesions code is used for Racz Catheter procedures.

The Lysis of Adhesions procedure includes the contrast material for epidurography. For the placement of an epidural catheter inserted and removed at the same session, use code 72275-TC. There must be a formal Interpretation documented. The Fluoroscopic guidance used in the procedure (code 77003-TC) is not separately-billable, as it is bundled into the 72275 code.

Radiofrequency or Pulsed Radiofrequency Neurotomy (PRFN) CPT Codes 64622-64627 for Destruction or 64999 for Pulsed Radiofrequency

Codes for 2011 Dates of Service:

64622 - Destruction by Neurolytic agent, Paravertebral Facet Joint Nerve; Lumbar or Sacral, 1st/initial level

+64623 – Lumbar or Sacral, each additional level

64626 - Destruction by Neurolytic agent, Paravertebral Facet Joint Nerve; Cervical or Thoracic, 1st/initial level

+64627 – Cervical or Thoracic, each additional level

The difference between the two Radiofrequency codes is that in the Pulsed Radiofrequency procedure they apply an electrical field to the target nerve for short intervals at a lower temperature, which does not destroy nerve tissue, but “stuns” the nerve. The Radiofrequency procedure “destroys” the nerve. Use codes 64622-64627 for the spinal Radiofrequency procedures. The Pulsed Radiofrequency procedure must be coded using the 64999 Unlisted code, since there is not a specific CPT code which accurately describes the procedure. Submit supporting documentation with the claim which describes the nature, extent, need, time and effort of the procedure. The Destruction by Neurolytic Agent codes 64600-64681 would not be appropriate for the Pulsed Radiofrequency procedure.

Codes for Radiofrequency procedures on Facet Joints have changed for 2012 in the CPT book. The following codes have been deleted for 2012:

Code 64622 for Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level has been Deleted

Add-on code 64623 for Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure) has been Deleted

Code 64626 for Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level has been Deleted

Add-on code 64627 for Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure) has been Deleted

These four codes have been replaced by the following new CPT codes for 2012:

Use code 64633 for the Destruction of Paravertebral Facet Joint Nerve(s) by neurolytic agent with Fluoro. or CT image guidance; Cervical or Thoracic, single facet joint for the 1st level performed. The Add-on Code for additional levels is code 64634.

Use code 64635 for the Destruction of Paravertebral Facet Joint Nerve(s) by neurolytic agent with Fluoro. or CT image guidance; Lumbar or Sacral, single facet joint for the 1st level performed. The Add-on Code for additional levels is code 64636.

Code Rhizotomy procedures from the Destruction by Neurolytic Agent codes.

Procedure: The patient is placed in a prone position; an electrode is then placed at the border of the vertebrae where the medial branch nerve crosses the vertebrae. Chemical destruction involves injection of a neurolytic substance (e.g., alcohol, phenol, glycerol) into the affected nerve root. Thermal techniques utilize heat. Electrical techniques utilize an electrical current. Radiofrequency, also referred to as Radiofrequency Rhizotomy, utilizes a solar or microwave current.

The Destruction of a Paravertebral Facet Joint Nerve with a neurolytic agent codes are unilateral procedures; when a Bilateral procedure is performed, bill it in a Bilateral manner by appending the -RT/-LT or -50 Bilateral Modifiers.

Miscellaneous Pain Management Procedures

- Use code 20550 for Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")
- Use code 20551 for an Injection(s); single tendon origin/insertion
- IDETs Procedure, which is also referred to as an Annuloplasty
 1. For IDETs procedures performed without use of an Electrothermal Device, use Unlisted CPT code 22899.
 2. When the IDETs procedure is performed using an Electrothermal Device, use codes 22526 and Add-on code +22527 for additional levels.

3. The IDETs procedure is also referred to as Percutaneous Intradiscal Annuloplasty or Intradiscal Electrothermal Coagulation Therapy, and can be performed Unilaterally or Bilaterally. The IDETs procedure includes Fluoroscopic guidance.

**Keep in mind that the IDETS procedures are not covered on Medicare's ASC List.

- Intercostal Nerve Blocks
 - Use code 64420 for a Single Injection
 - Use code 64421 for Multiple Injections
 - Use one code or the other, but not both codes

Some pain management spinal injections are described as the injection being given “from one disc level to another disc level”, for example L4-L5 and L5-S1. When the procedure report for injections given using the codes listed below reads that the injection was performed **into** the interspace, *not at the disc itself*, the injections need to be coded with 1 code (for L4-L5), instead of 2 codes. (However, if the report lists the injections as being given AT the disc level itself, use one code per level injected, or two if performed bilaterally).

- **Nerve Block Procedures**

- Use code 64400 for Somatic Nerve Blocks of the Face
- Use code 64402 for Somatic Nerve Blocks of the Muscles of Facial Expression
- Use code 64405 for Somatic Nerve Blocks of the Scalp
- Use code 64408 for a Somatic Nerve Block of the Vagus Nerve
- Use code 64412 for Somatic Nerve Blocks of the Trapezius and Lower Neck
- Use code 64413 for a Somatic Nerve Block at the C2-C4 level (Lesser Occipital, Greater Auricular, and Supraclavicular Nerves)
- Use code 64415 for Interscalene Somatic/Brachial Plexus Blocks of the Shoulders, Chest, Arms & Hands (Post-OP Shoulder)
- Use code 64416 for Interscalene Somatic/Brachial Plexus for Continuous Catheter Infusion of the Shoulders, Chest, Arms & Hands (Post-OP Shoulder)
- Use code 64417 for a Somatic Nerve Block of the Axillary Nerve
- Use code 64418 for a Somatic Nerve Block at the C5-C6 level
- Use code 64435 for Somatic Nerve Blocks of the Uterine Nerve
- Use code 64447 for a Femoral Nerve Block (Post-OP Knee)
- Use code 64448 for a Femoral Nerve Continuous Catheter Infusion (Post-OP Knee)
- Use code 64449 for a Somatic Nerve Block at the Lumbar Plexus by Posterior Approach by Catheter Infusion (Pelvis, Gluteus Maximus, Legs & Feet)
- Use code 64455 for an Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma).

- Use code 64611 for Chemodenervation of the Parotid and Submandibular Salivary Glands, which is a bilateral procedure.
- Use code 64632 for the Destruction by neurolytic agent of the plantar common digital nerve.
- For Piriformis Injections, use Trigger Point Injection codes, as these are muscle areas.

Fluoroscopy

Fluoroscopic Guidance – when some spinal Injection procedures are performed under fluoroscopic guidance, you may report the fluoroscopic guidance in addition to the injection (unless it is not covered by the payor, such as Medicare) – as long as it is not inherently a part of the CPT code, like it now is for Transforaminal ESIs and Facet Joint Injections. Report code 77003-TC when fluoroscopic guidance is required during spinal injection procedures, unless it is Unbundled from the injection code, per the CCI material. Many payors do not cover the fluoroscopic guidance charges in an ASC setting, however, do not make the decision not to bill Fluoro. to any payors – you may be losing reimbursement.

Fluoroscopy for spine procedures is billed once per spinal area (Cervical, Thoracic, Lumbar, Sacral) – not per level or injection performed.

Do not report Fluoroscopy codes separately with Arthrograms or Epidurograms (which also may not be covered in the ASC setting). Fluoroscopy may be coded in addition to injection codes for procedures (if they are not Unbundled in the CCI material).

Remember, Medicare and some BC/BS carriers will not reimburse the ASC for the billing of Fluoroscopy codes done for pain procedures. However, you may want to bill Fluoro. to the following payor types, unless you are contractually-prohibited from doing so: Workers' Comp. carriers, payors with whom your ASC does not have a contract, Indemnity carriers, and to payors with whom your ASC has a contract, but that contract does not specifically prohibit the billing of radiological services. If you are trying to “bill everyone the same”, then bill the 77003-TC code to all payors (when it is not Unbundled from the Injection codes), and append the –GY Modifier to the Fluoro. code on claims going to those payors who do not reimburse for the Fluoro. charge. The –GZ Modifier indicates to the payor that you know they will not reimburse for those services, as it is considered to be non-covered.

For 2012, CPT code 77003 for Fluoroscopic Guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural or subarachnoid) was revised – the words “(…or sacroiliac joint), including neurolytic agent destruction” were eliminated from the coding descriptor for this code.

Spinal Cord Neurostimulators

Spinal cord stimulation works by blocking pain conduction pathways. For severe chronic pain, sometimes neurostimulators are implanted. When neurostimulator devices are implanted, the electrical stimulations produce paresthesias by sustained electrical depolarization of the spine's neural structures in the posterior part of the spinal cord, which reduces the patient's pain.

Those conditions which present more of a challenge to the success of spinal cord stimulator treatment include: Patients with Bilateral Pain, those with Post-Laminectomy Syndrome, those with Complex Regional Pain Syndrome (CRPS), and those with Sympathetic Pain of both the Upper and Lower Extremities.

Spinal Cord Neurostimulators relieve chronic pain in some patients by generating a continuous sensation of the nerve which reduces pain in the affected area.

Definitions:

Contact – the metal device placed in the Epidural Space to supply the electrical stimulation. In spinal cord stimulator trials, the contact is attached to the catheter, and in permanent placement procedures, the contact is attached to the plate-paddle surface. Most neurostimulator systems contain multiple contacts of 4 or more per unit. A contact is the same as an electrode.

Array – the medley of contacts attached to one catheter in the neurostimulator system. Contacts are attached on a permanent basis to these catheters (for trials) or plate-paddles (for permanent devices).

Electrode – a conductor that allows the transmission of electrical impulses coming from the generator along a lead, which becomes an energy signal which reduces pain.

Plate/Paddle – electrodes which are used in spinal neurostimulators which contains 4-8 electrodes/contacts on one side of the paddle to provide electrical stimulation into the spine to decrease pain.

The 63650-63688 CPT codes apply to both Simple and Complex Neurostimulators. CPT states that a neurostimulator system includes the implanted neurostimulator, external controller, extension and collection of contacts. Multiple contacts/electrodes provide the electrical stimulation delivered to the epidural space. The 63650, 63655 and 63660 codes each are used for the placement, revision or removal of only one electrode catheter or electrode plate/paddle device.

➤ Spinal Cord Neurostimulator Trials

Trials are done to see if a neurostimulator is a viable treatment that will decrease a patient's severe chronic pain. The trial period can be from one to four weeks. These types of devices are left in only temporarily, and if the trial is successful, the device

may be replaced by a permanent neurostimulator device. Devices placed on a trial basis are placed percutaneously (just under the skin) with contacts on a catheter-like lead. The neurostimulator array determines the collection of contacts on the catheter.

➤ **Procedure Codes for Neurostimulator Trials**

CPT code 63650 for the percutaneous (just under the skin) placement of the neurostimulator electrode array in the Epidural Space, which includes 1 contact/electrode. If more than 1 electrode is placed, bill the 63650 again using the -59 Modifier for the placement of each subsequent electrode.

➤ **Permanent Spinal Cord Neurostimulator Procedures**

While neurostimulator procedures will not be successful on all patients, some patients who have a successful neurostimulator trial will move on to the placement of a permanent neurostimulator. The permanent procedure is performed as an open surgical procedure (by Laminectomy). The contacts/electrodes for the permanent device are on a plate on a paddle-shaped surface placed in the Epidural Space, which are connected to an internal pulse generator (also called a battery or receiver).

➤ **Procedure Codes for Permanent Neurostimulators**

CPT code 63655 is for a Laminectomy for placement of the Neurostimulator Electrodes and the Plate/Paddle device.

CPT code 63685 is billed for the Insertion or Replacement of the Neurostimulator Pulse Generator or Receiver, and includes those devices with either direct or inductive coupling.

For both Trials and Permanent placement procedures, if two catheters or two plates/paddles are implanted, bill code 63650 or 63655 more than once.

➤ **Replacement of Neurostimulator Devices**

When a Permanent Pulse Generator becomes depleted and must be replaced, use CPT Code 63688, which includes the removal of the old generator or receiver. CPT directs that code 63688 is not to be billed with code 63685. Also use code 63688 when the generator is removed and not replaced.

➤ **Programming/Electronic Analysis of Neurostimulator Devices**

While Physicians can bill for the Programming and Electronic Analysis of Neurostimulator Devices using CPT codes 95970-95982, this service is not billable by the ASC facility. Those codes are not covered by Medicare for the ASC facility, but physicians can bill for this service.

➤ **InterStim Neurostimulator Procedures for Urinary Incontinence**

These procedures are also performed as Trial and Permanent procedures.

Percutaneous

Use code 64561 for the Percutaneous procedure - Implantation of Neurostimulator Electrodes; Sacral Nerve (transforaminal placement).

For 2012, CPT instructs to use new Category III codes 0282T-0284T when implanting Trial or Permanent electrode arrays or pulse generators to be used for peripheral subcutaneous field stimulation procedures.

Permanent

Use code 64581 for the Permanent procedure – Percutaneous Implantation of Neurostimulator Electrode Array; Sacral Nerve (transforaminal placement) with code 64590 for the Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling. This procedure is not performed via a Laminotomy. InterStim devices are non-rechargeable. The internal lead placed percutaneously during the trial procedure remains in for the permanent procedure and it not replaced.

Use code 64585 for the Revision or Removal of a Peripheral Neurostimulator Electrode Array.

Use code 64595 for the Revision or Removal of a Peripheral or Gastric Neurostimulator Pulse Generator or Receiver.

➤ **Implants/Devices Related to Neurostimulator Procedures**

When the ASC facility bills Medicare for these procedures, the payment for the implants/devices used in these procedures is considered to be a “Device Intensive Procedure” for dates of service in 2008 and forward – thus, payment for the implants/devices is included in the payment for the CPT procedure codes billed for the procedures themselves and should not be separately billed. Check with individual payors other than Medicare for their billing policies, and if they allow separate payment for the implants/devices and do not consider it bundled in to the CPT codes for the procedures, the following HCPCS codes are to be used, as appropriate, for payors other than Medicare.

CPT changed most of the Neurostimulator CPT codes from use of the word “Electrode” to “Electrode Array” in the code descriptors for 2012.

➤ **HCPCS Procedure Codes for Neurostimulator Implants/Devices**

These codes would be billable by ASC facilities.

HCPCS Code L8685 - Implantable neurostimulator pulse generator, single array, rechargeable, includes extension
HCPCS Code L8686 - Implantable neurostimulator pulse generator, single array, non-rechargeable, includes extension
HCPCS Code L8687 - Implantable neurostimulator pulse generator, dual array, rechargeable, includes extension
HCPCS Code L8688 - Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
HCPCS Code L8682 - Implantable neurostimulator radiofrequency receiver
HCPCS Code L8681 - Patient programmer (external) for use with implantable programmable neurostimulator pulse generator
HCPCS Code L8680 - Implantable neurostimulator electrode, each
HCPCS Code L8689 - External recharging system for battery (internal) for use with implantable neurostimulator
HCPCS Code C1767 - Generator, neurostimulator (implantable), nonrechargeable
HCPCS Code C1778 - Lead, neurostimulator (implantable)
HCPCS Code C1820 - Generator, neurostimulator (implantable), with rechargeable battery and charging system

Remember, with Medicare cases, the implants are bundled into the CPT codes for these procedures for the ASC and are not separately billable.

Discograms CPT Codes 62290-62291

62290 - Injection procedure for Discography, each level; Lumbar
62291 - Injection procedure for Discography, each level; Cervical or Thoracic
72285 - Discography, Cervical or Thoracic, radiological supervision and interpretation – bill this code once for EACH LEVEL at which the test is performed
72295 - Discography, Lumbar, radiological supervision and interpretation – bill this code once for EACH LEVEL at which the test is performed

Procedure: A Discogram is an enhanced X-ray examination of the pads of cartilage (intervertebral disks) that separate the vertebral segments (vertebrae). Dye is injected into the center of the disk for more visibility on the X-ray films to detect structural damage in a disk and to determine if the disk is causing the patient's pain. In the test, the physician is trying to mimic the patient's pain. A CT scan is also performed following the Discogram to assess physical changes in the disk.

The Discogram tests are coded per level, if the procedure is performed at four levels (L2-S1), bill the 62290 code for the Discography Injection procedure four (4) times - the 72295-TC Radiological supervision and interpretation will also be billed four times. It is advisable to append the Modifier -59 to the second, third, and fourth procedure codes (depending on your carrier requirements), to help avoid a payor denial.

If a Discogram was performed in the same case as another spine procedure, check CCI edits and if the Discogram is unbundled, it is only billable for the level performed which is at a different level than the procedure from which it is unbundled. For example, if a Discogram is performed at levels L3-L4, L4-L5 and L5-S1 and a 63030-RT Lumbar Discectomy is performed on the right side at level L5-S1 in the same case, then only the Discogram performed at levels L3-L4 and L4-L5 would be billable and the -59 Modifier must be appended (codes would be 62290-59, 62290-59, 72295-59-TC & 72295-59-TC). The Discogram performed at level L5-S1 would not be billable.

QUESTIONS?

RESOURCES

Ingenix's *2012 ICD-9-CM for Hospitals, Vols. 1, 2, & 3 Coding Expert*
AAOS *Complete Global Service Data for Orthopaedic Services*
Ingenix's *Coding Illustrated - Spine and Hip and Knee*
Ingenix's *Coding and Payment Guide for Podiatry Services, 7th edition*
Ingenix's *CPT Coder's Desk Reference*
Ingenix's *Medical Documentation*
AMA *CPT Assistant Newsletters*
AMA's *CPT Companion*
AMA's *CPT Changes 2010-2012: An Insider's View*
American Health Information Mgmt. Assoc.'s *Coding & Reimbursement for Hospital Inpatient Services* by Karen Scott, Med, RHIA, CCS
Ingenix's *Outpatient Billing Expert*
Southern Medical Association's *Coding-Beyond the Basics: Orthopaedics* material by SMA Practice Management-div. of SMA Services, Inc., speaker Margi Clark, RRA, CCS, CPC, CCS-P
Conomikes MEDICARE Hotline
UCG Physician Practice Coder
UCG Coding Answer Book and Part B News
CPT codes and AMA *CPT Professional Edition 2012* are copyrighted by AMA
Healthcare Consultants of America *Physician's Fee & Coding Guide*
UCG's Part B Answer Book
UCG's Pain Management Coding & Billing Answer Book
The American Society of Interventional Pain Physicians' 1st Regional Interventional Pain Symposium Seminar Material
Healthcare Consultants of America, Inc.'s *Part B Billing Guide*
Ingenix's *Coding Companion for Orthopedics*
Ingenix's *Coding & Reimbursement for Orthopedics Newsletter*
Ingenix's *Complete Guide to Part B Billing and Compliance*
PMIC's *Medicare Compliance Manual*
The Medical Management Institute's *Medicare Rules & Regulations*
The Medical Management Institute's *Coding and Medicare for Orthopedics*
Healthcare Consultants of America, Inc.'s *Health Care Fraud and Abuse*
Global Success Corp., *The Coding Institute's Orthopedic Coding Alert Newsletters*
Global Success Corp., *The Coding Institute's General Surgery Coding Alert Newsletters*
Dorland's Medical Dictionary
Orthopedic Coding Workshop material, sponsored by THIMA, Karen Scott Seminars
Coding & Reimbursement Update for Orthopaedic Surgery material, sponsored by The American Academy of Orthopaedic Surgeons, KarenZupko & Assoc., Inc.
ASC Association published coding seminar material (specifically-referenced) and coding guidance
Medicare Bulletins and LCDs
Lessons on Coding for ASCs FASA CPT Coding Seminar
AMA's *CPT 2012 Professional Edition*
AAOS Bulletin Article "Accurately Code Shoulder Procedures" by R. Haralson, III, MD, MBA, R. Friedman, MD, & M.S. Vaught, CPC, CCS-P
AAOS Global Service Data for Orthopaedic Surgery, Volumes 1 & 2

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