15 CPT & Coding Issues for Orthopedics and Spine

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Speaker

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15 CPT & Coding Issues for Orthopedic & Spine ASC Facilities

1. **CPT Changes to Shoulder Scope Coding**

- In 2012, CPT changed the scope Subacromial Decompression code 29826 into an Add-on Code. This means it can only be billed with another shoulder scope procedure as the primary procedure and it cannot be billed alone or with only an Open Shoulder procedure.
- For Medicare cases, in 2014, since Medicare made the 29826 code into a "Packaged Procedure," that code will not be reimbursed by Medicare. You may still bill it to payors other than Medicare.

Shoulder Subacromial Decompression

- Subacromial Decompression/ Acromionectomy procedures billed with scope code 29826 or 23130 (open procedure) are not separately-billable to Medicare using a –59 Modifier, when it is Unbundled in the CCI edits from another Shoulder procedure performed in the same case on the same Shoulder.

Medicare Shoulder Unbundling Guidelines

Also for 2014, Medicare CCI Edit guidelines have now been made to be very literal, with it not being allowed to append the -59 Modifier to a code which is Unbundled in the CCI Edits on the unbundled procedure performed on the same shoulder. Medicare considers the shoulder joint to be one anatomical area, which drives this coding change. Medicare also considers that the only time a scope Debridement of the shoulder is billable is when it is the *only* procedure performed on that shoulder. Use these rule for Medicare claims and this does not have to be followed with all payors. It depends on other payors' use and interpretation of the CCI Edits and if that payor follows Medicare rules.

Medicare Changes with Pain Management Add-on Codes

2. In 2014, Medicare added many Add-on Codes to the "Packaged Procedures" List, which makes them now not separately reimbursable by Medicare.

–Pain Management Add-on Code 64480 for each additional level Transforaminal Epidural Injection with imaging guidance, Cervical or Thoracic, is not separately payable by Medicare to ASCs.

–Pain Management Add-on Code 64484 for each additional level Transforaminal Epidural Injection with imaging guidance, Lumbar or Sacral, is not separately payable by Medicare to ASCs.

–Pain Management Add-on Code 64491 for 2nd Level Facet Joint Injection with imaging guidance, Cervical or Thoracic, is not separately payable by Medicare to ASCs.

Medicare Changes with Pain Management Add-on Codes

- Pain Management Add-on Code 64492 for 3rd and additional Level Facet Joint Injection with imaging guidance, Cervical or Thoracic, is not separately payable by Medicare to ASCs.
- Pain Management Add-on Code 64494 for 2nd Level Facet Joint Injection with imaging guidance, Lumbar or Sacral, is not separately payable by Medicare to ASCs.
- Pain Management Add-on Code 64495 for 3rd and additional Level Facet Joint Injection with imaging guidance, Lumbar or Sacral, is not separately payable by Medicare to ASCs.

Medicare Changes with Pain Management Add-on Codes

- Pain Management procedure Add-on Code 64634 for Radiofrequency Destruction by neurolytic agent, paravertebral Facet Joint Nerve(s), with imaging guidance, Cervical or Thoracic, each additional facet joint is not separately payable by Medicare to ASCs.
- Pain Management procedure Add-on Code 64636 for Radiofrequency Destruction by neurolytic agent, paravertebral Facet Joint Nerve(s), with imaging guidance, Lumbar or Sacral, each additional facet joint is not separately payable by Medicare to ASCs.

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- Add-on Code 22522 for Percutaneous Vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; each additional Thoracic or Lumbar vertebral body is not separately payable by Medicare to ASCs.
- Add-on Code 22525 for Percutaneous Vertebral Augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, **Kyphoplasty**); each additional Thoracic or Lumbar vertebral body is not separately payable by Medicare to ASCs.

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3. Knee Scope Synovectomy Procedures

For 2014, Medicare CCI Edit guidelines have now been made to be very literal for Arthroscopic procedures. Medicare considers that the only time the 29875 single compartment Arthroscopic Knee Synovectomy procedure is billable is when it is the *only* procedure performed on the same Knee.

The 29876 for a 2 or 3 compartment Synovectomy procedure is only billable when there are no other procedures performed in those 2 or 3 compartments on the same Knee.

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4. CMC Joint Arthroplasty

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. If the surgeon uses an Arthrex Mini-Tightrope device to perform a Suspensionplasty for this type of repair, a tendon transfer is not usually done, so only the 25447 code with L8699 for the implant are billed.

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5. Subtalar Arthroereisis Procedure

Use code S2117 or Unlisted Foot CPT code 28899 for the open Subtalar Arthroereisis procedure, which is not covered by Medicare or BC/BS, due to Medical Necessity/ Outcomes issues. The procedure is usually performed by podiatrists.

Your Schedulers should watch for this procedure and make informed decisions related to reimbursement and whether or not to accept the case at the time of scheduling.

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6. Injections for Post-Operative Pain Control

When a patient is to receive an Injection or has a Catheter/Pump placed during an Arthroscopic Ortho. 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.

- **Do not bill to Medicare.**
- **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).**
- **The Block must not be the *only* anesthesia for the case.**

Injections for Post-OP Pain Control cont.

- Bill on a different claim form from the Ortho. surgery procedure and bill the Injection/Catheterization procedure claim in the name of the anesthesiologist (or other physician) who performed the Injection/Catheterization procedure. You can bill on the same claim form when a UB-04 form is used, listing the Ortho. surgeon's name in fl. 76, followed by the anesthesiologist's name in fl. 77. Use the -59 Modifier on the Post-Op Injection code.
- Codes for billing Injection/Catheterization Shoulder post-operative pain procedures:
  - 64415 – Brachial Plexus Block (also for Interscalene Block) for a Single Injection for Shoulder cases OR
  - 64416 – Brachial Plexus Infusion by Catheter with Pump

Injections for Post-OP Pain Control cont.

- If Injections are given for Post-Op Pain Control after Knee Surgery, use codes:
  - Code 64447 for a Femoral Nerve Block Injection OR
  - Code 64448 for a Femoral Block by Catheter using a Pain Pump

  For Foot Surgery, use code 64450 for Blocks for Ankle and Foot procedures

  AGAIN: **DO NOT BILL TO MEDICARE!!!!!!**

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7. Meniscus Procedures

- Use code 29881 for an Arthroscopic Meniscectomy in either the Medial OR Lateral Compartment.
- 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.

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CPT Changes to Meniscectomy Scope Code in 2012

In 2012, the AMA revised the Arthroscopic Knee Meniscectomy codes 29880 and 29881 to INCLUDE a 29877 Debridement/Chondroplasty procedure when performed in the same case in the same or other compartments. What this means is that if a Chondroplasty is performed on the same Knee in the same case with a Meniscectomy (even if it was the ONLY procedure performed in that 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.

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8. ACL Reconstruction Procedures

- **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 Reconstruction procedures are coded 29888.**
- **Use code 27407 for an Open ACL Reconstruction 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 scope Re-do ACL Reconstruction procedure is 29888.**
- **The 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.**

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9. Epidural Steroid Injections

- 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

Epidural Steroid Injections cont.

- 62311 – 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; Lumbar or Sacral (caudal)
- 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)
- Use codes 62318-62319 ONLY if the patient still has the catheter in place after the procedure and goes home with it in place. These codes include the injection contrast material. If Fluoroscopic Guidance was used, the Fluoroscopy would be separately-billable with CPT code 77003-TC, if the payor covers this type of imaging.

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10. Transforaminal Epidural Injections

The Transforaminal ESI Injection (also referred to as Selective Nerve Root Blocks SNRB) codes include the use of imaging (Fluoro. or CT) and billing separately for those types of imaging is not allowed with code 77003-TC. Codes are:

- 64479 - Injection, anesthetic agent and/or steroid, transforaminal epidural; Cervical or Thoracic, single level
- +64480 - Cervical or Thoracic, Add-on code for each additional level
- 64483 - Injection, anesthetic agent and/or steroid, transforaminal epidural; Lumbar or Sacral, single level
- +64484 – Lumbar or Sacral, Add-on code for each additional level

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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.

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11. Facet Joint Nerve Injections

- Facet Injections (also referred to as Medial Branch Nerve Blocks) 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/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 (per payors guidelines).
- These codes have a different code for each level billed and they include the Imaging, which is not separately billable. 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.

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11. Facet Joint Injection Codes cont.:

- 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.

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12. Radiofrequency Procedures

In the Pulsed Radiofrequency procedure, the physician applies 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 standard Radiofrequency procedure "destroys" the nerve. Use codes 64633-64636 for the spinal Radiofrequency procedures. The Pulsed Radiofrequency procedure must be coded using the 64999 Unlisted CPT code. The Destruction by Neurolytic Agent codes 64600-64681 would not be appropriate for the Pulsed Radiofrequency procedure.

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RF Procedures (cont.)

The Radiofrequency codes (revised by CPT in 2012) are:

- **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.**
- **Use 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.**
- **Use Add-on Code for additional levels is code 64636.**

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13. Discogram Procedures

- 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

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14. Posterior Laminotomy/Laminectomy Procedures for Herniated Discs

- **The commonly performed procedures primarily as a Discectomy had the CPT codes revised by the AMA in 2012, and now the 63020/63030 regular codes which could previously be used for either an Open or Scope/Percutaneous procedure are now for use for OPEN procedures only, as follows:**
- **Code 63020 for a Cervical Discectomy [Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, 1 interspace, Cervical] which EXCLUDES the Endoscopically-assisted/Percutaneous approach.**

Posterior Laminotomy/Laminectomy Procedures for Herniated Discs cont.

- Code 63030 for a Lumbar Discectomy [Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, 1 interspace, Lumbar] which EXCLUDES the Endoscopically-assisted/ Percutaneous approach.
- Add-on code 63035 for a Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure) is used to report the procedure being done on additional levels.

Posterior Laminotomy/Laminectomy Procedures for Herniated Discs cont.

CPT directs using the following Category III codes for use of the Endoscopic or Percutaneous approach to a Discectomy procedure:

- Use code 0274T for a Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an Endoscope, single or multiple levels, unilateral or bilateral; Cervical or Thoracic.
- Use code 0275T for a Percutaneous laminotomy/laminectomy (intralaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an Endoscope, single or multiple levels, unilateral or bilateral; Lumbar.

Since these codes include imaging, the 70000-section codes are not separately billable, there is no additional code to use for multiple levels and you do not use the –RT or –LT Anatomic Modifiers with these codes.

Posterior Laminotomy/Laminectomy Procedures for Herniated Discs cont.

- In Laminotomy procedures, part of the lamina is removed on one side to allow access to the spinal cord. Use the –RT and –LT or -50 Modifiers with the 63020/63030 codes. Anatomic modifiers are not used with the 0274T/0275T codes and the code is only billed once, regardless of the number of levels at which the procedure is performed. If a disk has ruptured, fragments or the part of the disk compressing the nerves are removed. A partial removal of a facet or removal of bone around the foramen may also be performed to relieve pressure on the nerve.
- With the Endoscopic approach, a small guide probe is inserted under fluoroscopic guidance. Using magnified video, as well as fluoroscopic guidance, the endoscope is manipulated through the foramen and into the spinal canal. When the guide probe is in the surgical site, a larger tube is manipulated over the guide probe. Instruments are advanced through the hollow center of the tube. Herniated disk fragments are removed and the disk is reconfigured to eliminate pressure on the nerve roots.

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15. Laminectomy Procedures for Spinal Stenosis

- **Use code 63045 for Cervical, 63046 for Thoracic, or 63047 for Lumbar areas, with Add-on Code +63048 for each additional level (Cervical, Thoracic or Lumbar); Unilateral or Bilateral. These procedures are usually performed for Spinal Stenosis or Spondylosis conditions.**
- **In this procedure, the physician removes the spinous process. If the stenosis is central, the lamina may be removed out to the articular facets using a burr. If the compression is in the lateral recess, only half of the lamina is removed. The ligamentum flavum is peeled away from the dura. Nerve root canals are freed by additional resection of the facet, and compression is relieved by removal of any bony or tissue overgrowth around the foramen. Removal of the lamina, facets, and bony tissue or overgrowths may be performed bilaterally, when indicated. Do not use the –RT, -LT or -50 Modifiers with these codes.**

Comparison of the Difference in Laminectomy Procedures

The difference between the Laminectomy/ Laminotomy procedures performed for Stenosis and those procedures performed for Herniated Discs should be discernable by the OP Report documentation. If the procedure was primarily done for a disc herniation and a minimal amount of nerve decompression was performed in the procedure, use the 63020-63035 or 0274T-0275T codes. If the procedure was primarily done for nerve decompression with little or no bony work done on a disc herniation condition, the 63045-63048 codes should instead be used.

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QUESTIONS?

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