

## Common Orthopedic Procedures which are Frequently Coded Incorrectly

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- **Hardware Removals**

Use code 20680 for **Deep** Pin Removal procedures, where the physician makes an incision overlying the site of the implant dissects deeply to visualize the implant (which is usually below the muscle level and within bone), and 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 (such as K-wire removals) are billed with code 20670.

*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 pieces of hardware removed or 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 codes 24160-24164. 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**

In the CPT book, 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 not allowed 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* - 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 only 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 payer.

- **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 Lipoma 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.
- Associated Tendon work 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 Hammertoe procedure 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 designated as a “separate procedure” in the CPT book. 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 and use the –RT or –LT Modifiers on these codes, and the -59 Modifier would need to be 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).

- **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 only once.

#### Chondroplasty Documentation Tips:

- If the Chondroplasty is performed in the *same* compartment with other Arthroscopic surgery procedures, and is unbundled in the CCI material, it 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).
- The Chondroplasty procedure would be bundled into a meniscectomy procedure, unless it is done in a different compartment from the Meniscectomy.
- Use modifier –59 on the 29877 Chondroplasty code to indicate it was performed in a separate compartment, when it is billable to payors other than Medicare to indicate it was performed in a separate compartment.
- You may want to include the OP Report with the claim for clarification.
- Special Instructions/Different Coding for Chondroplasty procedures:
  1. Use code G0289 in place of the 29877-59 code when billing Chondroplasties performed in a separate compartment from other procedures (such as a Meniscectomy - when they are billable) to Medicare. However, you will not be reimbursed by Medicare for the G0289 code, as the G0289 code is not presently on the Medicare list of covered procedures for ASCs. Thus, the G0289 code should be billed to Medicare using the –GZ Non-covered Modifier.
  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, unless you have clarified with the payor that they prefer the use of the G0289 code, instead.

- **Synovectomy Procedures**

For coding Synovectomy procedures, the following applies:

1. The 29875 code for an Arthroscopic Limited Synovectomy includes the partial resection of synovium or plica from one knee compartment. Code 29875 is considered a “Separate Procedure”, thus if a Limited Synovectomy is performed in the same compartment with another procedure, it is not billable. If the procedure is performed in a separate

- 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 with other procedures performed in the same compartment(s) 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.

- **Bunionette Procedures**

Tailor’s Bunion Correction Procedure – Coded as 28110, which is a bunion correction done with a partial ostectomy of the 5<sup>th</sup> metatarsal head and soft tissue release of the 5<sup>th</sup> metatarsal joint. This procedure is performed only on the 5<sup>th</sup> 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 5<sup>th</sup> metatarsal with screw fixation-sometimes referred to as the Weil procedure), only the 28308 procedure would be billable.

## **Spine/Pain Management Procedures**

### **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).

For 2010, there were major changes to the Facet Injection codes, and the 2010 Medicare ASC List fee schedule is reimbursing significantly less for these procedures. The new 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 3<sup>rd</sup> 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 4<sup>th</sup> 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; single level. This code reimburses \$288.44 nationally by Medicare.

Code 64491 —...second level Injection, cervical or thoracic; single level. This code reimburses \$102.38 nationally by Medicare.

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. This code reimburses \$102.38 nationally by Medicare.

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; single level. This code reimburses \$288.44 nationally by Medicare.

64494 —... second level Injection, lumbar or sacral; single level. This code reimburses \$102.38 nationally by Medicare.

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. This code reimburses \$102.38 nationally by Medicare.

## **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

- 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.
- There is no CPT code for a Radiofrequency Treatment of the SI Joint – use an Unlisted code.

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.

## **Fusions**

### **Anterior Cervical Discectomy and Fusion (ACDF)**

Code 22554 - Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); Cervical below C2, in addition to code 63075, Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophylectomy; Cervical, single interspace – to report both codes together, the surgeon must perform additional work that leads to the decompression of neural elements. In most cases, the dura and/or neural elements are exposed to ensure decompression, which is considered over and above the work described by code 22554 for the Cervical Fusion. Therefore, the Decompression procedure (code 63075) would be reported in addition to code 22554. Documentation should include drilling off the posterior osteophytes, opening the posterior longitudinal ligament to look for free disk fragments (decompressing the spinal cord), or removing far lateral disk fragments to decompress the nerve roots. The Add-on Code for additional Cervical levels of Discectomy and Decompression is 63076. If Anterior Cervical Fusions are performed at additional levels, use Add-on Code 22585. This procedure is not currently reimbursable by Medicare in the ASC setting. The usual ACDF procedure will include use of Anterior Instrumentation – code 22845 for 2-3 Segments or 22846 for 4-7 Segments. When the Discs upon which the surgery is performed is listed in the OP Report as C4-5, C5-6 and C6-7, the 22846 code for 4 segments would be billed. Other typical charges would include 20931 and L8699 for the use of Allografts in the procedure and 20937 for Morselized Autografts.

### **PLIF and TLIF Procedures**

Posterior Lumbar Interbody Fusion (PLIF) and Transforaminal Lumbar Interbody Fusion (TLIF) procedures are coded 22630 for a Lumbar initial interspace Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression). Use Add-on Code 22632 for each additional Lumbar Interspace Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression).

In these procedures, the surgeon removes the entire facet joint so that more disc material can be excised during the procedure and producing less nerve retraction. These procedures are only performed on one side of the spine – not bilaterally, which would result in spinal instability.

### **Posterior/Posterolateral Fusions**

For Posterior/Posterolateral Fusions performed below C2, the Cervical initial level code is 22600 for Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment. Use code 22610 for an Arthrodesis, posterior or posterolateral technique, single level; thoracic (with or without lateral transverse technique). Use code 22612 for a Lumbar Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique). The Add-on Code for any additional Vertebral Segment for these fusions is 22614.

The code to use for the Re-Exploration of a Spinal Fusion is 22830. This code is used for the fusion procedure when it is performed at any spinal level (cervical, thoracic, lumbar, sacral, etc.).

### **Fusions for Spinal Deformities (Scoliosis & Kyphosis)**

Use codes in section 22800-22812 for Fusion procedures for Spinal Deformities, such as Scoliosis and Kyphosis. These codes are not differentiated based on the technique used to perform them or the spinal level – just whether they were performed as Anterior or Posterior procedures and the number of vertebral segments upon which the procedure was performed.

### **Spinal Instrumentation**

CPT defines Segmental Instrumentation as involving “fixation at each end of the construct and at least one additional interposed bony attachment.” Non-segmental Instrumentation is defined as “fixation at each end of the construct and may span several vertebral segments without attachment of the intervening segments.” Almost all spinal surgery currently performed involves Segmental Instrumentation, and Non-segmental Instrumentation is rarely used.

Anterior Instrumentation: 2-3 vertebral segments (code 22845), 4-7 segments (code 22846), 8 or more segments (code 22847).

For the Removal of Posterior Nonsegmental Instrumentation (such as a Harrington Rod), use code 22850. For Removal of Posterior Segmental Instrumentation, use code 22852. For Removal of Anterior Instrumentation, use code 22855.

### **Cages used in Spine Surgery**

Use code 22851 for Synthetic (sometimes referred to as PEEK) Cages implanted during Fusion procedures. Per *CPT Assistant* guidance, the 22851 code for cages is only to be billed once per spinal interspace area. Thus, if the physician inserts 2 cages at level L3-4 and 1 cage at level L4-5, bill the code twice (codes 22851 and 22851-59) for the case (do not bill the 22851 code 3 times

because 3 cages were used). Usually codes 20936 or 20937 are used for Morcellized Autograft being used to fill in around the cages. Bill the implant supply with code L8699.

### **Other Spinal Procedures:**

Use Category III code 0171T for an Interspinous Distraction Device placed at the initial level of the Lumbar spine. Use Add-on Code 0172T for additional Lumbar spinal levels. This is the code to use for the X-Stop procedure.

### **Bone and Other Types of Grafts**

Codes 20930-20938 are not covered in an ASC by Medicare.

Structural bone grafts (20931 Allograft & 20938 Autograft) consist of a single piece of bone that provides direct support for skeletal structures. Morselized bone grafts (20930 Allograft & 20937 Autograft) consist of spinal bone fragments joined together to fill bony cavities primarily to promote new bone growth (which is referred to as “Morcelized” and are also called Cancellous Chips). Some physicians may also use Bone Marrow Aspirate (code 38220-59) may be taken from the iliac crest for fusions.

## **GI Procedures**

### **EGD Procedures**

- Use code 43235 for a Diagnostic EGD procedure. Since this is classified as a “Separate Procedure” in the CPT book, it is not billable when a more extensive EGD procedure is performed.
- Two Upper Gastrointestinal Endoscopy procedures such as code 43239 for Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple and code 43245 for Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum, as appropriate; with dilation of gastric outlet for obstruction (e.g., balloon, guidewire, bougie) performed at the same setting would both be billable.
- If an EGD is done to collect a specimen for a CLO/H. Pylori test, since the test involves obtaining a tissue biopsy through the endoscope, the 43239 Biopsy code should be used. If the test is positive, the diagnosis code 041.86 for Helicobacter pylori (H. pylori) infection would be billed.
- If an EGD is performed with a biopsy, and then the physician removes the scope and performs an Esophageal Dilation by unguided sound, it should be billed using two CPT codes – CPT code 43239 for the scope with biopsy and code 43450 for the Esophageal Dilation would both be billed.
- Use CPT code 43248 if the patient has an EGD procedure with a flexible-tipped guidewire passed through the endoscope, the endoscope is withdrawn and the guidewire is left in place for dilators to be passed over the guidewire to dilate the Esophagus. If the guidewire is passed under fluoroscopic guidance for esophageal dilation, without the use of an endoscope, use CPT code 43453.

- The control of bleeding is included in biopsy (and most other) endoscopic procedures, and is not separately-billable. Control of bleeding can be obtained through means of injections, as well as cauterizations. Injections of Epinephrine through an endoscope are coded as 43255. This injection would be included in the ASC facility fee, and would not be reimbursed separately from the EGD procedure, unless the EGD case is completed and the patient is in the PACU and has a bleed, necessitating a return to the OR to treat the hemorrhage.
- For an EGD with a Polypectomy done by Cold Biopsy Forceps, use the 43258 Ablation code – not the 43239 Biopsy code.

- **Upper GI Dilations**

Dilation procedures must sometimes be performed for those patients whose esophagus becomes closed because they suffer from such problems as esophageal varices, achalasia, reflux esophagitis (GERD), problems after radiation therapy for esophageal cancer, scarring from drinking of poisons, certain medications that can cause ulcerations, and esophageal “webs”. Some dilation procedures are done with endoscopy – coded from the appropriate Endoscopy codes, and some are not (when they are not, they are called Manipulations – codes 43450-43458). Bougies are flexible dilators, which have different sizes increasing in thickness.

Bougie Dilations – If an EGD is performed prior to a bougie dilation (where the physician removes the endoscope), the endoscopy would also be coded as 43235. For the dilation, use code 43450 for a Dilation of the Esophagus by unguided sound or bougie, single or multiple passes, or code 43453 for a Dilation of the Esophagus over a Guidewire. For Dilation procedures performed with a Balloon, use codes 43456, 43458 or 43460, as appropriate.

According to the *AMA CPT Assistant* (June 1998), “it is appropriate to report codes 43200 and 43450 separately”. Code 43450 does not include the endoscopy; therefore, the 43200 code can be reported along with the dilation procedure. The –59 modifier should be appended to the code 43200, as it is denoted as a “separate procedure” in the CPT book.

Code 43220 is for an Esophagoscopy, rigid or flexible; with balloon dilation (less than 30-mm diameter). The measurement refers to the maximum diameter of the balloon itself, not the diameter of the esophagus.

- Pustow Dilator – this dilator is used with a guidewire and is coded as 43453.
- Bougie Dilations - dilations with bougies are coded as 43450. If an Endoscopy is performed prior to the bougie dilation, the Endoscopy would also be coded as 43235.
- Dilations using a Guidewire are usually coded as 43248.
- Balloon Dilators – usually inserted by Endoscopy, which would be coded as 43249.
- Dilation of the Esophagus for Achalasia with a Balloon is coded 43458.
- For an Upper Gastrointestinal Endoscopy of the esophagus, stomach, and either the duodenum and/or jejunum, as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), which includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum, use code 43242.

## PEG Tubes

- Codes for Percutaneous Endoscopic Gastrostomy (PEG) Tubes or J-Tubes (which can also be referred to as “buttons”) are as follows:
  - Placement procedures:
    - Code 43246 - Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with directed placement of percutaneous gastrostomy tube.
    - Code 49440 - Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s).
    - Code 49441 - Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s).
  - Change/Adjustment of Tube procedures:
    - Code 43760 - Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance.
    - Code 43761 - Repositioning of the gastric feeding tube, through the duodenum for enteric nutrition.
  - Replacement procedures:
    - Code 49450 - Replacement of gastrostomy or cecostomy (or other colonic) tube, percutaneous, under fluoroscopic guidance including contrast injection(s).
    - Code 43760 - Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance.
    - Code 43269 - Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent.
    - Code 49451 - Replacement of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s).
    - Code 49452 - Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s).
  - Mechanical Removal of Tube Obstructions:
    - Code 49460 - Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s), if performed.
  - Tube Removal:
    - Code 43870 - Closure of gastrostomy, surgical – there MUST be stitches placed, with a surgical closure to use this code.  
If NO stitches are placed and the tube is just pulled and steri-strips are put over the gastrostomy opening, use the 49999 Unlisted GI code.

## Colonoscopy Procedures

Coding guidelines for Colonoscopy procedures:

- Use CPT code 45378 for a Diagnostic Colonoscopy. There will be a symptom prompting the test and this is not a screening procedure for Medicare. However, you may use this code for screening procedures billed to payors other than Medicare.
- CPT code G0105 is to be used for a Colonoscopy done for Cancer Screening on an Individual at High Risk. These procedures are covered every 24 months for Medicare patients.
  - *High risk* is defined as a personal history of any of the following:
    1. Colorectal cancer;
    2. Personal history of adenomatous polyps;
    3. Some Inflammatory Bowel disorders, such as Crohns Disease or Ulcerative Colitis;
    4. The patient has a close relative (sibling, parent or child) who has had colorectal cancer or an adenomatous polyposis;
    5. The patient has a family history of familiar adenomatous polyposis; or
    6. The patient has a family history of nonpolyposis colorectal cancer.
- The G0121 procedure code is to be used for a Screening Colonoscopy done on an Individual not meeting the criteria for High Risk. Colonoscopies for Medicare patients of average risk (not at high risk) are covered by Medicare once every 10 years.
- It is not necessary to use the G-codes for Screening Colonoscopy procedures on claims going to payors other than Medicare. Use the 45378 code, unless a biopsy is taken (45380) or a polyp is removed.
- The Diagnosis codes to use for Screening Colonoscopies appear in the V-code section of the ICD-9-CM book. Medicare has issued LCDs in many states on Colonoscopies, which include covered circumstances and covered diagnosis codes – check Medicare policies or with your Carrier for this information and review it carefully. The basic screening code is V76.51.
- If, during the course of a Screening Colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, it should be billed with a Biopsy or Polypectomy code pertaining to what was performed, instead of as a Screening procedure.
- For either a Colonoscopy or EGD procedure, if a lesion is biopsied, and then subsequently the SAME lesion is removed during the same operative session, code the removal of the lesion only.
- For either a Colonoscopy or EGD procedure, if the one lesion is biopsied, and a separate lesion is removed during the same operative session, code both the biopsy of the lesion and the removal of the separate lesion. Append a –59 Modifier to the biopsy procedure.
- For Colonoscopy procedures performed involving Biopsies and/or the Removal of a Polyp using Cold Biopsy Forceps, use CPT code 45380 for Biopsy(s), for the removal of *portions* of a polyp by cold biopsy forceps, and for the removal of an *entire* polyp by cold biopsy forceps. This is referred to as “cold”, since the electric current is running to the instrument and no cauterization of bleeding takes place during the removal of the tissue.
- If the physician intends to perform a Diagnostic Colonoscopy (CPT code 45378), but he/she cannot complete the procedure (due to medical complications), the 45378 code should be billed, appending the –74 Modifier for Terminated Procedure. Some payors prefer the use of the -52 Reduced Services Modifier, instead of the -74 for a Terminated procedure.

- To qualify for billing a Colonoscopy code, the scope must move beyond the Splenic Flexure of the Colon. If the scope is not able to move that far, and is only used to examine as far as the Sigmoid Colon and a portion of the Descending Colon, it should be coded as 45378 with a -52 Modifier.
- If the patient has a particularly long GI tract, and the physician runs out of scope before viewing the entire colon, (for example, the scope goes past the Splenic Flexure, but does not extend all the way to the Cecum) – these procedures should have a -52 Modifier appended for billing purposes.
- Failed Colonoscopies are also referred to as “incomplete”. This occurs when the scope is not able to be advanced past the splenic flexure. Causes of this problem include incomplete preps, unusual patient anatomy, the patient has an obstructing lesion, or the provider performing the procedure is inexperienced. These procedures are coded as 45378-74, with the -74 Modifier indicating a Discontinued Procedure. Some payors might prefer the use of the -52 Modifier, instead of the -74 Modifier.
- Biopsies – Code 45380. Use this code for the removal of a portion of a polyp or an entire polyp by cold biopsy forceps, in which disposable forceps is used. This is referred to as “cold”, since no electric current is running to the instrument and no cauterization of bleeding takes place during the removal of the tissue. Tissue samples (biopsies) are taken.
- Submucosal Injection – Code 45381. For Submucosal Injections of Saline, India Ink, Botox, or Steroids, or for the Tattooing of Lesions.
- Control of Bleeding – Code 45382. The only time the control of bleeding is separately-billable (it is included in the procedure most of the time), is when the bleeding occurs at a different site and was not caused by the actions of the physician performing the procedure.
- Ablation Technique – Code 45383. A polyp is removed using the APC, laser, heat probe, or other device to cauterize it or the remnants of a polyp previously removed during a colonoscopy procedure.
- Hot Biopsy Technique – Code 45384. A polyp is removed during a colonoscopy where the polyp is snipped off and cauterized at the same time. Bipolar cautery may be billed using this same code.
- Fulguration – Code 45383. This is the code for use if the surgeon states in the procedure report that polyps were Fulgurated.
- Snare Technique – Code 45385. A polyp is removed during a colonoscopy where a wire loop (which heats up) is used to shave off the polyp. It is the most common method of removal, especially with larger lesions. This procedure may also be referred to as “hot snare” or “cold snare” technique. Monopolar and bipolar snares can be used.
- If a “bleeder” must be controlled during a Colonoscopy procedure, use CPT code 45382. This, however, would not be separately-billable if a polyp was removed during the procedure by snare technique (it is unbundled from CPT code 45385). Bleeding sites related to biopsies and/or lesion removal (Polypectomy) procedures are not billable.
- If the physician attempts – but fails – to remove a polyp by Snare technique, however, he/she is successful at removing the polyp via another technique (such as Hot Biopsy Forceps) only bill the CPT code for the procedure that was successful.
- \*\*\* Medicare guidance for the situation where a Colonoscopy is scheduled as a Screening Colonoscopy, but a Polyp is Removed and/or a Biopsy is taken is to not bill the G-code for a Screening study, but bill the appropriate CPT codes for the procedure(s) performed (45385, etc.) and on the claim listing of the diagnoses in field 21, list the Screening V-code (V76.51) first, followed by the 211.3 Polyp or other diagnosis code. When linking the diagnosis to the procedure in field 24E, only link the 211.3 Polyp code

with the 45385 or other Colonoscopy code and do NOT link the Screening V-code in field 24E to any procedure code.

## Ophthalmology Procedures

### Be Sure You are Billing for your PC IOL Cataract Cases Correctly

When your ASC facility has a Medicare patient who requests a Presbyopia-Correcting (PC) IOL lens (instead of a regular/standard IOL), there are special guidelines that must be followed to stay in compliance with Medicare guidelines. It is critical that these guidelines are followed. This can be an important compliance problem you can have without even knowing it, so make sure these cases are being handled correctly at your facility.

#### Billing Correctly

Even though Medicare won't reimburse any more than they usually do for regular IOLs for these cases – the usual reimbursement of \$150.00 is included in the payment of the usual 66984, 66982, etc. cataract extraction procedure code, you still need to indicate on the claim form that the PC IOL was used in the case. Bill these special IOLs using the V2788 code for the PC IOL (ReStor® and ReZoom®). It is advisable to append the –GY Non-Covered Modifier and/or the –GA Modifier to the V-code to indicate you have had the patient sign an Advanced Beneficiary Notice (ABN form or waiver). While it is not mandatory to have the patient sign an ABN, since the PC IOLs are *never* covered by Medicare, but it is a good idea, so that there will be no misunderstandings with patients on his/her owing portion. While the Crystalens® is a PC-IOL, it was added to Medicare's list of NTIOLs, to be billed with code Q1003, in April of 2010.

#### Medicare Reimbursement

When you bill the 66984, 66982 or other Cataract Extraction procedure code to Medicare, understand that those codes include the insertion of an IOL in the procedure, and that the payment of the cataract CPT code includes a \$150.00 allowance for payment of a regular posterior chamber or anterior chamber IOL. That does not change when you use the PC IOL in the case, instead of a regular IOL. Your facility is still being reimbursed for the placement of an IOL. Even though it is a different type of IOL, it does not change that you have been paid for the IOL by Medicare.

#### Compliance Issues

The compliance issues which can come up with these types of cases are outlined as follows:

1. When the surgeon wants to purchase the PC IOL for the case and bring it into the ASC for the case, it is a compliance issue. Why? Because Medicare does not allow the ASC to bill for cataract extraction procedures with placement of an IOL with the -52 Reduced Services Modifier or using any other billing method to convey to Medicare that the ASC did not supply the IOL and should not be reimbursed for the IOL supply. Since there is no provision to allow the ASC to break out the implant portion of the procedure from the cataract extraction, **Medicare requires the ASC facility to supply (purchase) the IOL for these and ALL cataract cases - always.** Medicare considers it to be a False Claim

for the ASC to submit a cataract extraction claim for which they are receiving payment for the IOL when the ASC is not supplying the IOL.

2. Medicare does not allow the ASC facility to reimburse the physician for the IOL if the IOL was supplied by the physician in these cases. The IOL must be purchased and supplied by the ASC facility for these cases.
3. Also, what you charge patients for the use of the PC IOLs can be another compliance issue, as Medicare directs what you can charge patients for these cases. Overcharging patients for these lenses can be a compliance issue. Therefore, you need to be sure you aren't overcharging Medicare patients for PC lenses. For example, if the ReStor® PC IOL is used and your facility's cost for the lens is \$1,100.00, what can you charge the Medicare patient for the IOL? Keep in mind that you are receiving the \$150.00 as usual for the IOL from Medicare as part of the cataract extraction code, so that amount must be subtracted from the amount you charge the patient. Medicare allows you only a modest mark-up (\$25-\$50) on the IOL for handling on PC IOLs. That is all you can charge the patient. Medicare does not allow you to charge the patient a massive mark-up (2-3 times cost or more) on these lenses.

Following is an example of how to correctly charge a Medicare patient on a PC IOL for these types of cases:

\$1,100.00	Lens Cost
- \$150.00	Medicare reimbursement for regular IOL
\$950.00	
+ \$50.00	ASC's cost for handling of lens
\$1,000.00	Final suggested Maximum amount ASC can charge patient

Since physicians can purchase and bring in implants for many other types of cases (i.e., breast implants, etc.), it can seem like it would not be a problem to do the same for these cataract extraction procedures involving PC IOLs, however, it is a process which must be handled differently, due to the bundled payment for the IOL in the cataract extraction CPT code.

### New Technology Lenses

- Medicare will not generally reimburse for IOLs (as a supply) billed as a separate line item on the claim form. It is included in the ASC facility fee reimbursed for the CPT code for the Cataract procedure itself. Medicare may reimburse for some new technology IOLs. In 2006 (effective dates are 2/27/2006-2/26/2011), the code changed to **Q1003** (category 3 New Technology IOLs), Q1004 (category 4 New Technology IOLs), and Q1005 (category 5 New Technology IOLs).

The **Q1003** code is approved for payment for the following NTIOL models:

- Tecnis® models Z9000, Z9001, Z9002 and ZA9003, also AR40xEM and ZCB00 manufactured by Advanced Medical Optics (AMO)
- AcrySof® IQ SN60WF and Acrysert SN60WS by Alcon
- Sofport® models LI61AO and LI61AOV by Bausch & Lomb
- Affinity Collamer CQ2015A, CC4204A and Elastimide AQ2015A by STAAR
- Bausch & Lomb Akreos AO
- Bausch & Lomb Akreos MI60

- Hoya FY-60AD
- Hoya FC-60AD
- Alcon Acrysof IQ Toric Model SN6ATT
- Bausch & Lomb Crystalens Models AT-50AO and AT-52AO Presbyopia-Correcting Lens

The last 5 lenses listed were added to the Q1003 list by Medicare in August of 2009 and the Crystalens was added in April of 2010. With the addition of the Astigmatism-Correcting Toric Lens and Crystalens IOLs, new billing guidelines apply to the Toric and Crystalens IOL lenses ONLY. The addition of the Bausch & Lomb Crystalens and Alcon Toric lens presents some significant reimbursement challenges for facilities. Usually, ASC facilities cannot charge patients extra for use of a special IOL beyond what Medicare reimburses, which is included for the lens in Medicare's payment for the 66984 (also 66982 and 66983) Cataract Extraction codes of \$150.00 and an extra \$50.00 for use of the Q1003 code for an NTIOL. While facilities have the ability to charge Medicare patients the difference between their cost for a Presbyopia-Correcting (PC) IOL lens minus the \$150.00 amount Medicare usually reimburses as part of the 66984 Cataract procedure payment, (and previously, the same procedure could be used for Crystalens and Astigmatism-Correcting [AC] IOL lenses), the Toric and Presbyopia-Correcting lenses have been the only type of lenses where the provider could charge Medicare patients directly for the lens in a Cataract procedure. Use of regular Anterior or Posterior Chamber IOLs and all NTIOLs prior to now could not have any associated extra charge for the lens to Medicare patients, other than the patient's usual owing co-pay and deductible amounts for the cataract procedure itself. Medicare does not allow the facility to charge the patient any extra fee for the use of the Q1003 models of IOLs (other than the Crystalens and Toric lenses), other than the patient's usual owing co-pay and deductible amounts for the cataract procedure itself.

With the addition of the Astigmatism-Correcting (AC) IOL Toric lens and Crystalens to the NTIOL list falling under code Q1003, a change now occurs in the previous policies. Since the Crystalens and Toric lenses cost more for the facility than Medicare reimburses, the previous policy Medicare has had that the difference in the cost and the \$200.00 total Medicare will reimburse for a lens on the NTIOL list can be charged to patients still applies to the Crystalens and Toric Lens IOLs.

Following is an example of how to correctly charge a Medicare patient for Crystalens/Toric lens:

\$500.00	Approximate CrystalLens/Toric Lens Cost to facility
- \$150.00	Medicare reimbursement for regular IOL as part of Cataract CPT code
- <u>\$ 50.00</u>	Extra \$50.00 Medicare reimburses for use of NTIOL w/code Q1003
\$300.00	
+ <u>\$50.00</u>	ASC's cost for S&H of lens (\$25-\$50 maximum) – modest markup
\$ 350.00	Final suggested Maximum amount ASC can charge Medicare patient

Since the facility will be charging the patient for the difference, Medicare strongly recommends that the facility have the patient sign an Advanced Beneficiary Notice (ABN form or waiver).

It would be a rare circumstance that these special lenses are used. New Technology IOLs should reimburse approximately \$50.00 more by Medicare when properly billed. Review your state's Medicare coverage for these supplies for guidance. Regular IOL Lenses for patients with coverage other than Medicare may be billable – check with the payors. If

billable, use code V2632 for Posterior Chamber IOL or code V2630 for Anterior Chamber IOL.

- “Difficult” Cataracts

In 2001, CPT came out with a new procedure code to differentiate the usual Cataract procedures from those patients with special problems – those problems which make the procedure more difficult, require the surgeon to utilize unusual techniques, and involving a higher risk. Use CPT code 66982 to bill these “Difficult” Cataract procedures.

This Complex Cataract Extraction procedure requires the use of devices or techniques not used in routine Cataract surgery, such as:

- Iris Expansion Devices
- Pupil Stretcher
- Use of a Capsular Ring in the procedure
- Use of Dye in the procedure
- Suture Support for the IOL or
- Primary Posterior Capsulorrhexis

The patient population who will more likely have “Difficult” Cataracts usually includes the following:

Pediatric patients (under age 8)

Performed on patients in the Amblyogenic Developmental Stage

Patients with weakened or absent lens support structures, usually resulting from:

- Glaucoma (code section 365)
- Small pupils (code 379.40)
- Subluxated lens
- Pseudoexfoliation
- Trauma
- Marfan Syndrome
- Uveitis
- Male patients taking Flomax

Patients suffering from Glaucoma will present the ophthalmologist with an increased level of complexity to deal with when performing cataract surgeries. The cataract surgery procedure often will require the use of iris retractors, causing the surgeon to have to make additional incisions, because the Glaucoma causes these patients to have small or undilated pupils.

Patients needing cataract surgery who have sustained an injury to an eye may require insertion of a capsular support ring for the cataract implant, which also increases the level of complexity from the normal cataract procedure.

Special coding provisions **when using the 66982 code require that you can only use the code for surgical problems the physician identified *prior to the surgery***. The code cannot be used for difficulty with a normal cataract procedure or obstacles that come up (unexpectedly) *during* the normal cataract surgical procedure. It is imperative that when you are appending the diagnosis codes for this type of procedure to (of course) code the Cataract diagnosis code first, and use the appropriate diagnosis code (i.e., Glaucoma, etc.) for the diagnosis that made the surgery fall into the “difficult” category as the second diagnosis code on the claim. You must support the medical necessity for billing of that code.

## **Presbyopia-Correcting IOLs**

The Presbyopia-Correcting Lenses, which are also called Astigmatism-Correcting Lenses are sold under the brand names Restore Lens® or Rezoom Lens®, used in Cataract Extraction procedures are to be billed to Medicare using HCPCS code of V2788 (effective 1/1/06). This is a non-covered code and the \$150.00 usual facility fee paid by Medicare for IOLs as part of the 66984 (or other) Cataract procedure does not change. The difference in this type of lens implant from the usual IOLs used in Cataract procedures is that the patient pays the ASC facility for part of the lens cost. Medicare placed the Crystalens®) PC-Correcting IOL on the NTIOL list in April of 2010, so now that lens would be billed with code Q1003. The specific guidelines for the billing and coverage of this procedure are on the CMS website for viewing at: <http://www.cms.gov/MedlearnMattersArticles/downloads/MM3927.pdf>.

## **Complicated Vitrectomy Procedures Performed with Other Procedures for Diabetic Retinopathy, Macular Holes, Retinal Detachment, Vitreous Hemorrhage, etc.**

- Use code 67039 for a Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation, which is a less extensive procedure for smaller defects.
- Use code 67040 for a Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation, which is a more extensive procedure for larger defects.
- Use code 67041 for a Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker). In this procedure, the surgeon removes a cellular membrane from the anterior surface of the macula, which is the center of the retina.
- Use code 67042 for a Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina, which includes (if performed) intraocular tamponade (ie, air, gas or silicone oil). This procedure would usually be performed for patients with macular holes or diabetic macular edema.
- Use code 67043 for a Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation. This is a commonly performed procedure and is relatively complex compared to the other procedures. This procedure would usually be performed for patients with proliferative vitreoretinopathy, diabetic traction, retinal detachments, retinal tears.

## **Retina Procedures**

- Use code 67101 for a Repair of retinal detachment, one or more sessions; cryotherapy or diathermy, with or without drainage of subretinal fluid.
- Use code 67105 for a Repair of retinal detachment, one or more sessions; photocoagulation, with or without drainage of subretinal fluid.
- Use code 67107 for a Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), with or without implant, with or without cryotherapy, photocoagulation, and drainage of subretinal fluid. This is the most common procedure.
- Use code 67108 for a Repair of retinal detachment; with vitrectomy, any method, with or without air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique.

- Use code 67110 for a Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy).
- Use code 67112 for a Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques.
- Use code 67113 for a Repair of complex retinal detachment with vitrectomy and membrane peeling, may include air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens. This procedure is usually done for patients with proliferative vitreoretinopathy, stage C-1 or greater, diabetic traction retinal detachment, retinopathy of premature babies, and retinal tears of greater than 90 degrees.
- Use code 67115 for a Release of encircling material in the posterior segment. This procedure is performed to release tension in a previously placed scleral buckle by adjusting the buckle.