**Straight Talk About Orthopedic & Spine Coding & Reimbursement**

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**LEARNING OBJECTIVES**

Orthopedic & Spine Coding and Reimbursement

**Learning Objectives**

- The Coding Systems & Who Creates Them
- Understand The Language of Coding
- Identify Orthopedic Coding & Coverage Hurdles
- Learn Surgical Modifiers that May Be Overlooked
- Understand the Impact of Revision Coding in Orthopedics
- Incorporate New Technologies in Your Reimbursement Strategy

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**DISCLAIMER**

"The opinions and codes denoted within are suggestions only, which reflect SHA’s understandings of the identified sources and the presenters' personal experiences. This information should not be construed as authoritative. Codes and values are subject to frequent change without notice. The entity billing Medicare and/or third party payors is solely responsible for the accuracy of the codes assigned to the services and items in the medical record. Therefore health care providers must use great care and validate billing and coding requirements ascribed by payors with whom they work. SHA assumes no responsibility for coding and cannot recommend codes for specific cases. When making coding decisions, we encourage you to seek input from the AMA, relevant medical societies, CMS, your local Medicare Administrative Contractor and other health plans to which you submit claims."

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There is No Coding 101

Understanding the Two Pathways to Reimbursement

Communication Among all Parties is Key to Reimbursement.

Extremely Complex System w/ High Chance of Error in Each & Every Code
**THE LANGUAGE OF CODING**

Correct Coding Requires Detailed OP Notes and Knowledge of Device and Anatomy

- Clinical procedures and services are documented “as performed” by the provider.
- Coding translates the clinical narrative into alpha-numeric characters
- These characters capture:
  - Patient diagnoses
  - Services provided
  - Procedures performed
  - Supplies used
  - Drugs, products & devices
- Codes are then reported for reimbursement to payers.
- Sounds Simple
- Simple Errors are the most common reason for prior authorization and claim denials.

Example: Total Knee Replacement Procedure

- CPT 27447 = Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
- CPT 27446 = Arthroplasty, knee, condyle and plateau; medial OR lateral compartment

**Preventive Claim Audits can help pinpoint Simple Errors and reduce denials and post-claim appeals. Review of denials and correction is always necessary.**

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**THE LANGUAGE – MIS (Minimally Invasive Surgery) Define**

- **Non-Invasive** = No Break in Skin
  - Ex: Diagnostic Images, BP, PT
- **Invasive** = Surgery, Breaks the Skin
  - Ex: Large Incision, Open Approach
- **Minimally Invasive** = ?????????
  - + 5 LESS THAN TRADITIONAL PROCEDURES?
    - Smaller Incisions, Different Approach, Shorter Surgery Time, Faster
    - Less Blood Loss, Indirect Visualization, Endoscopy, Less Muscle Disruption
  - BUT No Definitive Definition

- AANS Lists the following MIS Spine Procedures as Examples: XLIF, PLIF, TLIF, DLIF, Microdiscectomy, Microendoscopic Laminectomy, Vertebroplasty, Kyphoplasty
- NASS: Surgery Done Through Multiple Small Incisions Rather Than a Large, Open

**MIS Does Not Translate to Coding Language Well**

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**WHAT CODES DO I USE FOR MIS PROCEDURES**

**CODING FOR LUMBAR DISCECTOMY – DOES MIS MATTER?**

MIS is Not Definitively Defined – All Could Be Considered MIS

**What Matters is What You Do**

- **63030** = Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
  - Per AMA/CPT 2012 – Requires Open & Direct Visualization by the “Surgeon’s” eyes or Operating Microscope. Endoscope can be used in conjunction but naked eye must visualize procedure. Size of Incision is Not Clarified.

- **0275T** = Percutaneous laminotomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous excision, discectomy, facetectomy and/or foraminotomy), unilateral, uses microdrill or other small diameter instruments, (eg, Laminacut, LT), with or without sublaminar or foraminotomy; lumbar
  - Per AMA/CPT – Used for Indirectly Visualized Procedures Including Endoscopic, Tubular and Non-visualized Approaches. NOTES: Very Bundled Code. Includes imaging, bilateral and multi level. Size of Incision or MIS is not Clarified.

- **62287** = Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove the material under fluoroscopic imaging or other form of indirect visualization, with the use of an excisional, with endoscopy, and/or endoscope, spinal drilling or the treated level(s), when performed single or multiple levels
  - Per AMA/CPT – Used for Needle Based, Indirectly Visualized Procedures Including Endoscopic, and Non-visualized Approaches. NOTE: Very Bundled Code. Includes imaging, and multi level. MIS is not Clarified.
Allograft Products Are Increasingly Being Used in Orthopedic Procedures

- Spine Procedures
  - CPT Coding Exists for the Application of the Allograft
    - CPT 20930 - Allograft, morselized, or placement of osteoporotic material, for spine surgery only
  - CPT 20931 - Allograft, structural, for spine surgery only

- Orthopedic Procedures – Repair & Augmentation (Shoulder, Knee, Ankle, Achilles Repairs, Fingers & Toes)
  - No Separate CPT Coding Exists for the Application of the Allograft
  - Application of the Allograft is Inclusive in the Primary Procedure
  - If Allograft Application Increases Service Significantly
    - Possible Use of Modifier 22 – Documentation Must Detail Increase
    - Facility Responsible for Cost of Allograft (Inpatient & Outpatient)

Allograft Products Are Increasingly Being Used in Orthopedic Procedures

- Orthopedic Procedures – Tendon Allograft Products (Shoulder, Knee, Ankle, Achilles Repairs, Fingers & Toes)
  - No Separate CPT Coding Exists for the Application of Tendon Allograft Tissue
  - Application of the Allograft is Inclusive in the Primary Procedure
  - Procedures May Include:
    - ACL Reconstruction
    - PCL Augmentation
    - MFC
    - Lateral Ankle Procedures
  - If Allograft Application Increases Service Significantly
    - Possible Use of Modifier 22 – Documentation Must Detail Increase
    - Facility Responsible for Cost of Tendon Allograft (Inpatient & Outpatient)
  - Examples:
    - L8699 Prosthetic implant, not otherwise specified
    - C1762 Connective tissue, human (includes fascia lata)

Allograft Products & Reimbursement Pathways

- Facility Reporting of Orthopedic Allograft Use
  - Some Allograft Products Have HCPCS “Q” Codes
  - The HCPCS 41-“Q” Codes Report Skin Substitute Products & Other Uses of the Name Brand Product
  - Tendon Allografts Do Not Have Specific HCPCS Codes
  - HCPCS Unclassified Drug or Biologicals Code “C9399” Provides Coding Pathway
  - Products Should Be Reported to All Payers with HCPCS Codes for Tracking
  - Reimbursement Depends on Payer Coverage Guidelines
  - Consider Payer Contract Negotiations on Allograft Reimbursement for Specific Orthopedic Procedures Commonly Performed

What About CPT Code 15777?

- CPT 15777 - Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk)
- AMA/CPT Guidelines Do Not Include Nerve Wraps, Tendon & Ligament Repairs in soft tissue reinforcement. Reporting of this code should be limited to soft tissue augmentation.
**Allograft Products & Coverage Concerns**

- **Medicare**: Per a recent MLN Matters® Publication, Coverage for Brand Specific Biologics with assigned HCPCS Codes, in the Outpatient Facility, is Determined by the Medicare Administrative Contractor (MAC).
  
  The fact that a drug, device, procedure, or service is assigned a HCPCS code and a payment rate under the OPPS does not imply coverage by the Medicare program. Instead, MACs determine whether a drug, device, procedure, or other service meets all program requirements for coverage. For example, MACs determine that it is reasonable and necessary to treat the beneficiary’s condition and whether it is excluded from payment.
  
- **Commercial Payors**: Coverage Policies Are Commonly:
  - Brand Specific (by “Q” Code or Name)
  - Diagnosis Specific
  - Procedure/Anatomy Specific

Always Pre-Authorize with Commercial Payors or Verify with your MAC

Provide All Relevant Information (Brand Name, Diagnosis, Procedure)

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**Subtalar Arthroereisis** (Not Arthrodesis)

- **What is it?**
  - A surgical procedure that places a device or product below the talus, with the intended function to block or limit excessive talar motion.

- **Derived From**
  - Sub-Talar (below the talus)
  - Arthro – Ereisis (joint / blocking)

- **How is it Coded?**
  - CPT 28899 – “unlisted” foot/toe code Use “special report” to describe S2117 (arthroereisis, subtalar) Recognized by some Commercial Payors

- **How is it NOT Coded?** (NOT A FUSION PROCEDURE)
  - CPT 28725 – Subtalar Arthrodesis
  - CPT 28725 – 52 – Subtalar Arthrodesis; reduced services

Coverage is Often Limited – Medical Necessity Must be Established

Many "New Technologies" are Addressing this Procedure – Specific Technology Details Should be Included in Any "Special Report" Provided to Payor for Review

Always Pre-Authorize with Commercial Payors or Verify Your MAC

Provide All Relevant Information (Device Name, Diagnosis, Procedure)

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**OVERLOOKED SURGICAL MODIFIERS**

**Code Modifiers Can Have a Major Impact on Reimbursement**

- CPT Coding Drives Physician Reimbursements
- Coding for Documented Bilateral Procedures Requires Detailed Review of Codes
- Some CPT Codes are both Unilateral and Bilateral
- Other CPT Codes are Unilateral and Require a Bilateral Modifier
- Watch Code descriptions closely whenever a procedure is described as being bilateral in the OP notes.
- EXAMPLE: Bilateral Lumbar Spine Decompressions
  
  CPT 63030 - 50 – Laminotomy, hemilaminectomy
  Code is a unilateral code and requires a -50 Modifier if done bilaterally
  
  CPT 63047 – Laminectomy
  Code is a unilateral or bilateral code and reports either without modifier

**Why does this Matter?**

<table>
<thead>
<tr>
<th>CPT CODE</th>
<th>2014 Medicare National Average Payment for Physician Services, Physician Fee Schedule</th>
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<tr>
<td>63030</td>
<td>$1,046</td>
</tr>
<tr>
<td>63030-50</td>
<td>$1,596</td>
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<tr>
<td>63047</td>
<td>$1,102</td>
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Important Point: What Part Are you Taking Out and What Part Are You Putting In?

**INSERTION CODES**
(Use to PLACE NEW Humeral and/or Glenoid Components)
- 23470 → Arthroplasty, Glenohumeral joint; Hemiarthroplasty
- 23472 → Total Shoulder (Glenoid and Proximal Humeral Replacement)

**REVISION CODES**
(Use Only when TAKING OUT & PUTTING BACK IN)
- 23473 → Revision of Total Shoulder, Humeral or Glenoid Component
- 23474 → Revision of Total Shoulder, Humeral and Glenoid Components

**REMOVAL CODES** (NEW in 2014)
(Use when REMOVING is the ONLY Procedure Performed)
- 23333 → Removal of Prosthesis, Humeral or Glenoid Component
- 23335 → Removal of Prosthesis, Humeral and Glenoid Components

NOTE: Do Not Report 23334,23335 with 23473,23474 if removed and replaced in same session

**EXAMPLE 1**: Patient has right initial Total Shoulder replacement procedure (Glenoid and Proximal Humeral Replacement)
Per AMA/CPT 2014 - The ONLY code reported is 23472.

**EXAMPLE 2**: Patient has previously placed left Total Shoulder prosthesis (Glenoid and Proximal Humeral) removed without replacement
Per AMA/CPT 2014 - The ONLY code reported is 23335. New prosthesis removal ONLY code in 2014.

**EXAMPLE 3**: Patient has previous placed right Total Shoulder prosthesis (Glenoid and Proximal Humeral) removed and replaced in the same session
Per AMA/CPT 2014 – Report ONLY 23474. Do not report 23335 (removal code) with this code. Revision code includes removal and replacement in same session in same anatomy.

**INSTRUMENTATION CODE CLARIFICATION EXAMPLES**

**EXAMPLE 1**: Patient has right initial Total Shoulder replacement procedure (Glenoid and Proximal Humeral Replacement)
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Per AMA/CPT 2014 – Report ONLY 23474. Do not report 23335 (removal code) with this code. Revision code includes removal and replacement in same session in same anatomy.

**REINSERTION CODE**
(Use Only when EXACT Same Levels Replaced)
- 22849 → Reinsertion of spinal Fixation Device

**REMOVAL CODES**
(Use when Removing is the ONLY Thing Done at Indexed level)
- 22850 → Removal Posterior Non-Segmental Instrumentation
- 22852 → Removal Posterior Segmental Instrumentation
- 22853 → Removal Anterior Instrumentation
INSTRUMENTATION CODE CLARIFICATION EXAMPLES

EXAMPLE 1: Patient had previous surgery at L1-L3. The surgeon removes the old instrumentation at L1-L3 and needs to redo the fusion and places new instrumentation at L1-L3.
Per AMA/CPT 2012 - The ONLY instrumentation code reported is 22849 and the removal of the old is considered inclusive.

EXAMPLE 2: Patient has previous instrumentation at L2-L4. The surgeon removes the old instrumentation at L2-L4 and places new instrumentation at L1-L5.
Per AMA/CPT 2012 - The ONLY instrumentation code reported is 22842. The removal is bundled into this code.

EXAMPLE 3: Patient has previous instrumentation at L1-L4. The surgeon removes the old instrumentation at L1-L4. There is solid fusion at L1-L2. He places new instrumentation at L2-L4.
Per AMA/CPT 2012 - The new instrumentation is reported with 22842 at L2-L4. Since removal was the ONLY thing done at L1-L2 you may report the removal code 22850. It is important to designate the levels independently and report the code with a modifier -59.

NEW TECHNOLOGIES & PROCEDURES

FDA v CMS / Payors
Differing Standards for Approval and Coverage

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NEW TECHNOLOGIES & PROCEDURES

What To Do With a T-Code or “unlisted” Code

• Many New Technologies & Procedures are Correctly Reported with a “T” Code or Generic “unlisted” Code
• Called “T” Codes Because they End with the Letter T (xxxxT)
• T-Codes are Temporary CPT Category III Codes for Emerging Technologies that Have Not Been Fully Proved by AMA/CPT Standards
• FDA Approval, if Applicable, Should be Confirmed
• Medicare Does Not Assign RVUs or Payment Rates to T-Codes
• At Times, Medicare Will Assign an APC Code to the T-Code
  • EXAMPLE - 0275T - Percutaneous laminotomy/laminectomy, lumbar
  • Assigned APC – 0208 – Laminotomies/Laminectomies
  • This APC Has an Assigned Medicare Reimbursement Value
  • This Can Help the OP/ASC Report for Reimbursement
• “unlisted” Codes Require Similar Treatment as T-Codes for Reimbursement
• Private Payors May Have Fee Schedules for Some “T” Codes
• Always Know Private Payor Guidelines When Using “T” Codes or “unlisted” Codes
• Yes, There is A Process that Can Help Get these Reimbursed
• Prior Authorization Time and Physician Commitment is Essential
NEW TECHNOLOGIES & PROCEDURES
“T” Code Strategies & “unlisted” Codes Too!
1. Include Any Common Procedures Reported with “T” Codes in Your Payor Contracts
   1. Surgeon Commitment to New Procedure A Must
   2. Both the Surgeon and the Facility Should be Involved
   3. If both Do Not Get Reimbursed, Neither Will Continue
2. Know the Code Description Inside Out
   1. Many “T” Codes are Highly Bundled and Include Imaging, Bilateral and Multi – Levels (in spine)
   2. Make Sure to Report Correctly
3. Create a “Special Report” to describe the Procedure
   1. Include All Technical Information
   2. FDA Approval, Instructions for Use (device), Articles Supporting Efficacy
   3. Reason for Medical Necessity (Surgeon Narrative, Detailed Case Info)
4. Provide a “Crosswalk” Code for Reimbursement Valuation
   1. This should represent the Work, Skill and Time of the Procedure
   2. Do Not Report the “Crosswalk” Code
   3. Use it to Represent the Value of a Similar Procedure, Can be Different Anatomy
5. Always Take the Prior Authorization Process Through Appeal
   1. Most Payors Will Deny a Simple Prior Auth, Provide Detail & Clinical Support

PRE AUTHORIZATION PROCESS
Pre-Authorizations
Pre-Authorizations are critical for reimbursement of new, unique technologies. Complete and accurate documentation is needed to support the new procedure.

THE IMPACT OF CODING ACCURACY ON
Health Care Economics
Coding Accuracy Directly Impacts Health Care Economics
What Can Be Done to Improve Results?

Be Proactive

COMMUNICATE Procedure Clinical Documentation

COOPERATE Surgeon Facility

TRANSLATE Clinical Codes

CONTRACT Provider Payor

INNOVATE New Technology Strategize

HEALTH CARE ECONOMICS
Questions?

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Thank You