

15 CPT & Coding Issues for Orthopedics and Spine ASC Facilities

Speaker

Stephanie Ellis, R.N., CPC



Ellis

Medical Consulting, Inc

256 Seaboard Lane, Suite C-103

Franklin, TN • (615) 371-1506

sellis@ellismedical.com

www.ellismedical.com

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

1. Review the entire OP Report(s) for the surgical case.
2. Code out the CPT procedure code(s) for all surgical procedures performed.
3. Look up each pertinent CPT procedure code(s) with all of the other pertinent CPT procedure code(s) in the CCI material to determine Unbundling for the case.
4. Determine if those procedures designated as “Separate Procedures” in the CPT book and those CPT codes which are Unbundled in the CCI material are billable using the -59 Modifier or they should not be billed. Arrive at the final CPT procedure code(s) that can be billed for the surgery(s) performed.
5. Look up each CPT code to be billed to Medicare on the Medicare ASC List for the associated fee.
6. Sequence the CPT codes for billing from Highest to Lowest Fee listed on the Medicare ASC List.
7. For payors other than Medicare with whom the ASC has a contract and the payor goes by Payment Groupers, sequence the CPT codes on claims from Highest to Lowest Payment Grouper – regardless of the ASC facility’s fee schedule amount.
8. For payors other than Medicare with whom the ASC does not have a contract OR the payor does not go by Payment Groupers, sequence the CPT codes on claims from Highest to Lowest RVU weight – regardless of the ASC facility’s fee schedule amount.
9. For Medicare cases, those CPT codes to be billed which are NOT listed on the Medicare ASC List or have to be billed using an Unlisted CPT code are not covered by the Medicare program and should be billed using the –GY or –GZ Non-Covered Modifier in the last position on the claim form.

SPECIAL CODING GUIDELINES

Bilateral Procedures

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

unilaterally for a surgery, the usual fashion is to bill using an –RT or –LT Modifier on the CPT code.

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

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

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

Add-on Codes

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

Separate Procedures

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

by a separate incision). The separate procedure designation indicates that a certain procedure or service may be:

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

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

- Different session or patient encounter;
- Different site or organ system;
- Separate incision/excision;
- Separate compartment; OR
- Separate lesion

Unbundling of CPT Codes

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

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

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

15 CPT & Coding Issues for Orthopedic and Spine ASC Facilities

1. 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 subcutaneous tissue and a layered closure is performed or the lipoma is removed deep from subfascial or intramuscular tissue area.

2. Joint Injections

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

3. Joint Manipulations

CPT guidelines are that if a surgical arthroscopy is performed on the same joint when a Joint Manipulation and/or Joint Injection are performed in the same case, only the scope procedure is billable.

- Shoulder Joint Manipulation code is 23700. This procedure may be performed in the same case with a Joint Injection (code 20610) on the same joint. This procedure is usually performed for Adhesive Capsulitis, for post-shoulder replacement stiffness and for “frozen shoulder” conditions.
- Knee Joint Manipulations procedures (code 27570) should only be billed when it is the only procedure performed or is performed in the same case with a Joint Injection (code 20610), both procedures are billable, unless Unbundled.

- Use code 24300 for the Manipulation of the Elbow performed under anesthesia and may be performed in the same case with a Joint Injection (code 20605).
- Code 27275 for the Manipulation of the Hip Joint under general anesthesia, which may be performed in the same case with a Hip Joint Injection (code 20610).

4. Subacromial Decompression Procedures

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

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

2012 CPT Changes to Shoulder Scope Coding

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

The AAOS considers Acromionectomy procedures to be separately-billable from Rotator Cuff Repair procedures (whether performed arthroscopically or as open procedures), except in the case of the Complete Repair procedure, since the 23420 code includes the verbiage “includes Acromionectomy” in the code descriptor. If there is a CCI Unbundling edit encountered, consider the payor’s guidelines and whether or not it is allowable to bill the Acromionectomy procedure using a –59 Modifier. Do not bill the scope or open acromioplasty/subacromial decompression code to Medicare if it is unbundled in the CCI edits from another shoulder procedure performed in the same case (i.e., 23410 and 23412 Open Rotator Cuff Repair procedures).

5. Injections for Post-Operative Pain Control

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

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

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

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

6. Meniscus Procedures

- If a Meniscectomy procedure is performed in both the Medial AND Lateral Compartments arthroscopically, use code 29880.
- Meniscal Repairs are billed with code 29882 for an arthroscopic repair in the Medial OR Lateral Compartment. If an arthroscopic Meniscal Repair is performed in both the Medial AND Lateral Compartments, it is coded 29883.
- If an arthroscopic Meniscal Transplant procedure is performed in the Medial OR Lateral Compartment, use code 29868.
- If an Open Arthrotomy procedure is used to Excise the Meniscus in either the Medial OR Lateral Compartment, use code 27332.
- If an Open Arthrotomy procedure is used to Excise the Meniscus in both the Medial AND Lateral Compartments, use code 27333.
- An Open Meniscal (Inside Out) Repair is coded 27403.

CPT Changes to Knee Scope Coding for 2012

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

7. ACL Repairs/Reconstructions

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

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

8. Epicondylectomy Procedures

Elbow Codes for the Treatment of Epicondylitis (also called Tennis Elbow) are as follows:

- The 1st code is 24357 for a Percutaneous Tenotomy of the Proximal Extensor Carpi Radialis Brevis Tendon at its insertion in the Elbow, which can be performed on the lateral (or outer) side or the medial (inner) side of the elbow. During this procedure, the surgeon makes a small incision and uses a needle to break up the abnormal fibrotic tissue on the tendon to stimulate new blood flow and healing.
- The 24358 code is for the Open Debridement of soft tissue and/or bone in the Elbow. Use this code when the surgeon removes damaged soft tissue and sometimes bone, which would be billed for an Epicondylectomy.
- The 24359 code is similar to the 24358 code, except that in addition to the Open Debridement of soft tissue and/or bone, the surgeon also repairs the affected tendon or does a tendon reattachment, which would be billed for an Epicondylectomy performed with a tendon repair/reattachment.

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

62311 – ESI Injection - Lumbar or Sacral (caudal)

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

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

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

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

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

These codes include the injection contrast material. If Fluoroscopic Guidance was used, the Fluoroscopy would be separately-billable with CPT code 77003-TC.

10. Transforaminal Epidural Injections

When Transforaminal ESIs are performed for dates of service beginning Jan. 1, 2011, the 64479/64480 (Cervical/Thoracic) and 64483/64484 (Lumbar/Sacral) Injection codes have been revised to now include the use of imaging (Fluoro. or CT) and billing separately for

those types of imaging is no longer allowed with code 77003-TC, etc. Codes for these procedures are:

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

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

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

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.

11. Paravertebral Facet Joint or Facet Joint Nerve Injections

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

In 2010, there were major changes to the Facet Injection codes, and the Medicare ASC List fee schedule is reimbursing significantly less for these procedures. These codes include the use of imaging, so the 77003 Fluoroscopy or other imaging technique codes are not billed separately with the new codes. These codes have a different code for each level billed. The last code allowable for each spinal area (i.e., Cervical, Lumbar, etc.) is

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

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

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

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

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

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

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

12. Sacroiliac Joint Injections

These are the only procedure where the CPT codes the ASC facility and the physician will bill may differ – codes are 27096 OR G0260.

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

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

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

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

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

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

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

13. Radiofrequency Procedures

The difference between the two Radiofrequency procedures is that in the Pulsed Radiofrequency procedure they apply an electrical field to the target nerve for short intervals at a lower temperature, which does not destroy nerve tissue, but “stuns” the nerve. The Radiofrequency procedure “destroys” the nerve. Use codes 64633-64636 for the spinal Radiofrequency procedures. The Pulsed Radiofrequency procedure must be coded using the 64999 Unlisted code, since there is not a specific CPT code which accurately describes the procedure. Submit supporting documentation with the claim which describes the nature, extent, need, time and effort of the procedure. The Destruction by Neurolytic Agent codes 64600-64681 would not be appropriate for the Pulsed Radiofrequency procedure.

Codes for Radiofrequency procedures on Facet Joints were changed for 2012 in the CPT book.

The new Radiofrequency codes for 2012 are as follows:

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.

Code Rhizotomy procedures from the Destruction by Neurolytic Agent codes.

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

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

14. Discograms

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

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

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

15. Spinal Fusion Procedures

Anterior Cervical Discectomy and Fusion (ACDF)

When Anterior Cervical Fusions are performed, usually a Discectomy is also performed. For dates of service in 2010 and before, two codes (63075 for the Discectomy and 22554 for the Fusion) were required. For 2011, CPT combined these two procedures into one new code. Use code 22551 for the 1st level of Fusion and Discectomy performed and Add-on Code 22552 for subsequent levels. Codes 63075 and 22554 are still valid for use in cases where only those individual procedures are performed and they are not combined.

Code 22554 is for an Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); Cervical below C2 performed without a Discectomy procedure.

Use code 63075 for a Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; Cervical, single interspace performed without a Fusion procedure.

In most cases, ACDFs are performed with both Fusion and Discectomy procedures. The dura and/or neural elements are exposed to ensure decompression, which is considered over and above the work described by the Cervical Fusion alone. 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. 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 are listed in the OP Report as C4-5, C5-6 and C6-7, the 22846 code for 4 vertebral segments would be billed. Other typical charges would include the graft, imaging and L8699 for the use of Allografts and instrumentation in the procedure.

An Example of coding for this procedure performed at a single level C6-7 using a cage and a morcellized autograft harvested from the iliac crest would be:

22551
22845
22851
20937
38220-59
76000-59-TC
L8699

PLIF and TLIF Procedures

For 2012, the AMA made changes to the Lumbar and Thoracic codes for Posterior Fusion procedures by combining commonly performed procedures into one code.

The 22610 code for an Arthrodesis (Fusion) using the Posterior or Posterolateral Technique, single level; Thoracic now states this code is done WITH the Lateral Transverse Technique (the code previously stated with or without).

Code 22612 for an Arthrodesis, posterior or posterolateral technique, single level; Lumbar now states this code is done WITH the Lateral Transverse Technique (the code previously stated with or without). This code has an instructional note to NOT report the 22612 code with code 22630 for an Arthrodesis, Posterior Interbody Technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar. The codes can only be billed together when the procedures are performed at different spinal levels or alone.

The new CPT code for use instead for the PLIF Posterior Lumbar Interbody Fusion procedure for 2012 would now be 22633 for an Arthrodesis, combined Posterior or Posterolateral Technique with Posterior Interbody Technique, including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; Lumbar. Use new Add-on Code 22634 for additional Lumbar levels performed.

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.

An Example of coding for the PLIF procedure performed at 2 levels L3-4 and L4-5 using cages and a morcellized autograft harvested from the iliac crest would be:

22633
63047-59
22842
22851
22851-59
22634
63048
20937
38220-59
L8699

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.

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 22851 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.

Grafts used in Spine Surgery

It is important to know what type of graft is used in spine procedures (Structural or Morselized), as well as any Allografts or Autografts used to choose the correct CPT codes. Use code 20930 for a Morselized Allograft that is purchased or code 20931 for a Structural Allograft that is purchased. Bill the Implant with code L8699 or other valid code for the purchased Implant for Allografts.

Code 20936 is for a Morcellized Autograft used in spine procedures which is obtained “through the same incision,” such as from disc material removed during a discectomy. If a Morcellized Autograft is obtained through a separate incision, such as the Iliac Bone Crest, use codes 20937 and 38220-59.

QUESTIONS?

RESOURCES

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

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