presents…

Orthopedic Coding in ASCs

90-minute audio conference

June 11, 2008

2:00 p.m.–3:30 p.m. (Eastern)
1:00 p.m.–2:30 p.m. (Central)
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Welcome!

We are pleased that you have chosen to set aside a part of your day and join us for our **Orthopedic Coding in ASCs** audio conference featuring **Stephanie Ellis**. We are sure you will find the conference educational and worth your time, and we encourage you to take advantage of the opportunity to ask our experts your questions during the audio conference.

If you would like to submit a question before the audio conference, please send it to *rob@beckersasc.com*. Although we cannot guarantee your question will be answered during the program due to time constrictions, we will include it if time permits.

If you have comments, suggestions or ideas about how we might improve our audio conferences, or if you have any questions about the audio conference itself, please do not hesitate to contact me.

Thanks again for taking part in this program.

Sincerely,
Robert Kurtz
Director of Communications
Phone: (410) 874-7681
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Speaker bio

Stephanie Ellis, RN, CPC, has been the owner and president of Ellis Medical Consulting, Inc. since 1992. Ellis Medical Consulting, Inc., is a healthcare consulting firm providing chart audits for coding and documentation issues, business office operational assessments, research of coverage issues, fee and coding revisions, litigation support, reimbursement research, coding/billing training, and the development and implementation of billing compliance programs for healthcare providers. Ms. Ellis has worked with most specialties, assisting ASCs, physician practices, acute care hospitals, surgical hospitals, IDTFs, and outpatient clinics around the country in her consulting work.

Prior to starting Ellis Medical Consulting, Ms. Ellis worked as the operations manager of a national case management services placement firm, served as a case manager and utilization review nurse, was the director of quality assurance for a statewide homecare agency, was the manager of reimbursement of a national outpatient cancer treatment center, performed utilization review services at a national HMO plan and a large national third party insurance administrator and worked as a Medicaid specialist in the Tennessee Medicaid Program for three years. The experience at Medicaid included working as a coding specialist and as a fraud investigator for the Medicaid program.

Presentation

by **Stephanie Ellis, RN, CPC**

General Billing Issues for ASC Facilities

According to FASA's legal counsel, Ron Wisor of Arent Fox in his February 2002 seminar entitled "Medicare Billing: False Claims Act and Non-Covered Services", some of the common Billing Issues ASCs face are as follows:

- Billing non-covered CPT codes for ASC services with CPT codes for covered services (for example, billing codes which ARE on the Medicare list of covered procedures [to be paid], which do not properly describe the procedure performed).
- Billing for new procedures (which do not have an existing CPT code) with a code for a procedure that does not fit [to be paid]. Carefully check out advice on coding for new technology or equipment you get from salespeople and equipment reps. – if they give you flawed advice and you code incorrectly, YOU are still responsible.
- Upcoding of CPT procedure or diagnosis codes.
- Unbundling of CPT procedure codes.
- Failure to refund Credit Balances in a timely manner.
- Medical Necessity issues.
- Anesthesia Services.
- Scope of Practice violations.
- Assistant-at-Surgery issues.
- Billing improperly for "cancelled cases" vs. "terminated cases".
- Billing Medicare beneficiaries for cosmetic procedures that Medicare deems functional or other procedures not on Medicare's ASC list of approved procedures.
- Changing the Date of Service on claims to correspond with coverage dates.

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

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

General Billing Basics and Tips

- Read the ENTIRE OP Report before coding the claim. Do not just code from or rely on the summary statements/listing of the surgery titles at the beginning of the report, do not code from a Superbill/Chargeticket document, and do not code from the Schedule.

- Sometimes with surgical procedures, the physician utilizes a "Canned" Operative Report in the record, instead of doing an individualized OP Report tailored to that patient and the procedure performed. Many times, "canned" OP Reports do not contain all of the information necessary for proper documentation of the service performed. Sometimes the reports have no Pre- or Post-operative diagnosis tailored to the patient, the detail of the report for the procedure may contain no language tailored to the patient's surgery (to include noting any actual occurrences of problems during the procedure, etc.), and at times, they may not even list the procedure performed and/or indicate upon which side (Left or Right) the surgical procedure was performed. Using a canned OP Report can save time for the surgeon, but it is neither an advisable nor an acceptable way to document procedures. Medicare and other payors frown on the use of "canned" OP Reports (which they refer to as "Cloned Records"). If some sort of template is used for an OP Report (where similarities in procedures occur), it must still be tailored enough *to each patient's individual surgery* and circumstances for use, and not appear to be "canned". Also, any deviations from the normal during surgery (in the form of a complication with the patient, something going wrong with the surgery, or a change in something for just that patient's procedure, etc.), must appear in the report. If the report is not accurate, detailed and individualized as required by the payor, it can cause the ASC to have to refund money to the payor, it can cause an issue with the facility's state survey (for the ASC's licensure), and/or it could be a potential malpractice issue for both the surgeon and the facility.

- Be sure each service billed is properly documented PRIOR to billing it. Medicare expects OP Reports to be complete and in the patient record within 30 days of the surgery.

- If you review EOBs/RAs for denial reasons, they will provide you with a wealth of information of what is being done incorrectly with the insurance verification processes, the coding, and the billing at your facility. The EOBs tell the story.

- Always check CCI Unbundling material when coding multiple procedures. Keep the CCI material current (usually updated quarterly).

- Sequence CPT codes on claims from highest to lowest Payment amount for Medicare. For those other payors with which your facility is contracted who use groupers, sequence codes from highest to lowest grouper.

- Sequence CPT codes on claims from highest to lowest RVUs for those other payors with which your facility is contracted who do NOT go by Payment Groupers or with whom your facility does not have a contract.

- Be sure OP Reports properly identify that the ASC facility is the Place of Service (Use POS 24 on claim forms for ASCs). If surgeons do OP Reports at the hospital or on their own office stationary, it is very important to make it clear that the POS *was* at the ASC facility. Merely mentioning the ASC as a "cc" to the ASC at the end of the OP Report is not sufficient.

- Read and carefully check Medicare Bulletins monthly for changes to existing policies/rules and new policies that affect billing for your ASC and those procedures performed in your ASC (e.g., Colonoscopies, Blepharoplasties, some Pain procedures, etc.).

- Be aware of any Medicare Local Medical Review Policies (LMRP) or Local Coverage Determination (LCD) policies that affect procedures done, services provided, or implants, supplies/equipment used in your ASC. These policies list covered diagnoses for the procedure, which must be followed carefully to assure proper reimbursement for the ASC. Remember – any diagnosis not listed in the LCD used on a claim will usually result in a claim denial for "Medical Necessity" reasons. However, you cannot use a diagnosis from the LCD list which the patient does not have. If you cannot find a supporting diagnosis in the OP Report, review the H & P and/or Pathology Report for a symptom or path. result that is covered on the LCD list.

- Use the *Post-operative Diagnosis* listed on the OP Report for coding the billing, rather than coding from the Pre-operative Diagnosis. If you can't find a suitable diagnosis for billing in the OP Report, it is acceptable to draw diagnosis or symptom information from the Path. Report and/or the H & P.

- If any procedure performed involves the use of Implants, check into whether or not billing them to the payor is allowed (if they are not inherently included in the CPT code billed). Review the HCPCS book for possible codes for use. The L8699 code is frequently used for those implants not having a specific code.

- X-rays and the use of Fluoroscopic Guidance are usually not billable services (not reimbursed by Medicare or BC/BS, in most cases), when done in the ASC setting.

Bill fluoro. charges to Workers' Comp. and to those payors who may reimburse for them (those payors with whom your facility does not have a contract and those payors who do not specifically prohibit billing of radiology in their contract). Use the –GY Non-covered Modifier if you are trying to bill everyone the same.

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

General Coding Basics

ICD-9-CM DIAGNOSIS CODING

- Diagnosis codes are the mechanism for providing payors with the "what" and "why" the service(s) was necessary. They describe diagnoses, signs, symptoms, chronic and acute problems, and conditions. They provide the tools to report the *Medical Necessity* of the services provided to patients.

- Diagnosis codes justify the service/procedure provided. They are VERY IMPORTANT!!! Over 85% of claim denials for "Medical Necessity" reasons are a result of incorrect or non-specific diagnostic coding.

Tips for Appropriate Diagnosis Code Assignment

1. List on claims as the first code the diagnosis that is the reason *chiefly responsible* for the surgery or services provided, with subsequent diagnoses listed in descending order of importance. Be sure to observe the diagnoses listed in LMRP/LCD policies for Medicare patients, where applicable.

2. The use of Unspecified Codes and other general terms is discouraged, as they do not clarify the Medical Necessity of the procedure performed. Terms indicating an Unspecified diagnosis code include NEC and NOS in the ICD-9-CM book.

3. Do not code directly from the Alphabetic Index (Volume 2), without verifying code choices and all applicable coding digits in Volume 1.

4. If a patient has a condition that is both Acute (which is defined as 6 months or less) and Chronic (which is defined as after 6 months from the injury), code both separately and list both codes on the claims, with the acute code listed first.

5. It is very important to LINK the "what" (procedure performed) with "why" (diagnosis/condition) the surgery was performed for each CPT code on the claim.

6. It is very important to purchase new coding books every year and keep all coding and billing materials up-to-date. The new ICD-9-CM books are usually released in late Summer and are effective on October 1st of each year, which is when you must be using the ICD-9 codes for the new year on all of your claims. Review the revisions, additions, and deletions of applicable codes and add them to your system as soon as they are effective.

V-Codes

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

-Aftercare	-Personal & Family History of
-Attention to	-Management
-Admission/encounter for	-Observation for
-Administration (prophylactic)	-Problem with
-Contraception	-Procedure
-Sterilization	-Screening
-Evaluation	-Status-post
-Examination	-Suspected condition
-Follow-up	-Vaccinations
-Supervision	-Testing

- V45.4 for Arthrodesis Status
- V58.61 for Long-Term use of Anti-Coagulants
- V58.69 for Long-Term use of Other Medications
- V54.01 for Encounter for Removal of Internal Fixation Device
- V54.09 for Other Aftercare Involving Internal Fixation Device
- V54.89 for Other Orthopedic Aftercare
- V54.9 for Unspecified Orthopedic Aftercare
- V64.43 for Arthroscopic Surgical Procedure Converted to an Open Procedure

E-Codes

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

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

Coding Neoplasms

1. Codes for Neoplasms are located in the Neoplasm Table in Volume I and are located according to site or anatomic location.
2. Begin location of a neoplasm code by looking up the name/diagnosis first in the Alphabetic Index.
3. If the diagnosis does not indicate whether the tumor is primary or secondary, code it as primary.
4. Unless the coding book indicates otherwise, assume the following are usually secondary (metastatic) sites: Bone, brain, meninges, peritoneum, pleura, spinal cord, and retroperitoneum.
5. Unless you know *where* the secondary sites are to which the Cancer has traveled, you cannot specifically code them. You can use the Neoplasm for the Primary Site as your first code and the 199.0 code (for Metastasis to Multiple Sites NEC) to cover all of the Secondary Sites.
6. **Wait until the path report comes back <u>prior</u> to coding the claim** for those surgery situations that look like a malignant process might be involved (i.e., a Breast tumor, patients with previous cancer who have a new growth, etc.), as the exact diagnosis is needed for correct coding of a neoplasm condition.
7. Terms for Neoplasms:
   <u>Malignant</u> – Cells which spread/multiply with an invasive nature to other parts of the body
   <u>Primary Site</u> – The area of the body or organ that was the original site of the neoplasm
   <u>Secondary Site</u> – The area of the body or organ to which the tumor has metastasized or spread and implanted or grown. This can include local spread or direct extension and distant spread (metastasis)
   <u>Ca. In Situ</u> – A pre-malignant condition where a tumor is undergoing malignant changes, but is still localized at the point of origin
   <u>Benign</u> – Cells that grow, but are non-invasive in nature and do not spread to distant sites
   <u>Uncertain Behavior</u> – Neoplasms which are changing in nature, and which is neither malignant nor benign at the time of diagnosis. It may undergo malignant changes/ behaviors at a future time
   <u>Unspecified Nature</u> – The diagnosis statement does not specify the behavior of the neoplasm as malignant or benign.

Diagnosis Coding in Orthopedics

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

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

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

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

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

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

Hypertrophy of Fat Pad
When a patient has the condition of Hypertrophy of the Fat Pad in the Knee, it is coded 726.91.

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

Degenerative Spine Disorders
In coding degenerative disorders of the spine, first note which part of the spine is involved. Code from the 722 section. Myelopathy indicates spinal cord involvement, and although the physician might not specifically state "myelopathy," certain terms suggest spinal cord involvement, such as sciatic nerve pain, paralysis, paresis, numbness, or foot drop.

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

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

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

Injuries

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

Avoid Upcoding of Injury Diagnosis Coding

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

records. The Exception: It is usually necessary to continue using the Current Injury codes from the 800-section on an ongoing basis for Workers' Comp. claims.

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

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

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

Fracture of the Radius and Ulna
In this chapter of the ICD-9 book, the term *and* means "either" or "both." Whereas the term *with* means "both." These codes are 5-digits in the 813 section.

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

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

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

Coding Sports-Related Injuries

Muscle Tears

Although muscle tears can occur anywhere, they tend to happen more often in muscles that cross two joints, such as the hamstrings. Tears can be partial or complete and sometimes involve the fascia (the sheet of fibrous tissue covering the muscle). An important word to note when coding muscle tears is "sprain". For example, an acute injury to a ruptured supraspinatus muscle is coded as 840.6. To locate this code, look in the ICD-9-CM alphabetic index under the main term "Sprain" and the subterm "supraspinatus." Under 840, sprains and strains of shoulder and upper arm, code 840.6 is for the supraspinatus (muscle) (tendon). This same code would be used for a rupture, tear or avulsion of the supraspinatus tendon, as well.

Rotator Cuff Injuries

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

SLAP Lesion

Superior Glenoid Labrum Lesion (SLAP Tears or SLAP Lesions), which is a detachment injury of the superior aspect of the glenoid labrum (the ring of fibrocartilage attached to the rim of the glenoid cavity of the scapula) is coded 840.7 for a Current Injury and use code 726.2 for a Chronic SLAP problem.

Dislocations of the Shoulder Joint
Coding for shoulder joint dislocations depends on whether the injury is open or closed, followed by what area of the shoulder is affected. Shoulder dislocations may be recurrent and shoulder joints also may experience Subluxation (also called anterior capsular insufficiency), from repetitive stretching. Assign code 718.31 for a Recurrent Dislocation of the Shoulder Joint.

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

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

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

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

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

Other Ortho./Neuro. Diagnoses

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

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

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

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

Villonodular Synovitis conditions sometimes seen should not be confused and coded for most Synovitis conditions, as that is another condition (where there is pigmenting of the tissue and the joint lining swells, retaining fluid), which should be coded from the 719.2X section – that is only to be coded when the OP Report or Path. Report specifically states the patient has the *Villonodular* Synovitis condition.

Plica Syndrome is coded 727.83.

Orthopedic Terms and Abbreviations

Arthroplasty – Surgical formation or reformation of a joint, which involves a plastic surgical repair.
Avulsion – The tearing away of a structure or part.
BK – Below the Knee.
AK – Above the Knee.
Bunion – A subluxation lateral deviation of the first metatarsal head.
Carpal – Relating to the Wrist.
CTS – Carpal Tunnel Syndrome (Arthroscopic repair procedure is coded 29848/Open repair is coded 64721).
Caudal – Towards the Feet. Refers to the Lower Lumbar region.
Chondroplasty – Repair, Debridement or plastic surgery of a cartilage.
Cruciate – Shaped like a cross.
Cruciate Ligament Repair – Ligament is sutured or stapled to promote healing.
Cruciate Ligament Augmentation – When a Hamstring Tendon is placed alongside the ligament as a splint.
Cruciate Ligament Reconstruction – Where an Allograft, synthetic ligament, hamstring, or patellar tendon is used to replace the injured ligament.
Decompression – The Release or Removal of pressure.
Exostosis – A Benign protuberance from the long bone surfaces of flat bone.
Fascia – Sheet of connective tissue that covers, supports, and separates the muscle.
Glenoid – Resembles a pit or pocket.
Malleolus – One of the bony constraints of the ankle joint.
Meniscus – Crescent-shaped fibrocartiloginous structure found in the knee, shoulder and temporomandibular joint.
Ossicle – Little bone.
Osteo – Bone.
Reduction – An alignment of the bone back to normal.
Rotator Cuff – The musculotendinous covering of the humeral head.

Synovectomy – Surgical removal of the lining of the joint or tendon cavity.
Talus – Ankle.
Tendon – Strong fibrous band of tissue that attaches muscle to bone.
Tendodesis – Freeing-up of a tendon.
Tenotomy – Transection of a tendon.

Diagnosis Coding in Pain Management/Spine Procedures

It is very important for Pain Management procedures to code these complicated conditions as specifically as possible and to not use the 724.2 Low Back Pain symptom code (or something as equally as general and non-specific) to code every claim. If you cannot locate the patient's true condition in the Procedure Report, review the H & P for this information.

Spinal Stenosis
Spinal Stenosis is the narrowing or stricture of the spinal canal. Cervical Spinal Stenosis is code 723.0 and Lumbar Spinal Stenosis is code 724.02.

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

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

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

Torticollis
A contracted state of the cervical muscles of the neck, which produces a twisting of the neck, resulting in an unnatural position of the head. This condition can be a congenital condition, it can be caused by a birth injury, psychogenic spasm, or due to trauma.

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

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

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

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

Diagnosis Coding for Foot Procedures

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

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

Bursitis
Bursitis is coded as 727.3, which is an inflammation of the fluid-filled sac which cushions bony prominences.

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

Paget's Disease
Paget's Disease (also called osteitis deformans) is coded as 731.0, which involves the slow and progressive enlargement/deformity of multiple bones and resorption of bone, which eventually become thick and dense.

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

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

Other Foot Diagnoses
Hallux Valgus (Acquired) – code 735.0
Hallux Varus (Acquired) – code 735.1
Hallux Rigidus/Hallux Limitus – code 735.2
Hallux Malleus – code 735.3
Hammertoes (Acquired) – code 735.4
Claw Toe (Acquired) – code 735.5

Implants/Devices

While not all Implants will be covered by Medicare, some Implants will be separately reimbursed when billed as a separate line item with a CPT or HCPCS code. However, for a few procedures, the related Implants will be reimbursed as part of the surgical CPT code itself. How this will work for some procedures is that Medicare will take into account the average/standard cost of an implant and build that cost into what they reimburse for the CPT code for the procedure. The Implants billed on those procedures should not be broken out for billing separately. This will primarily affect the specialty of Orthopedics and increases reimbursement in 2008 for many procedures from what they paid under the Medicare Grouper system in 2007. Medicare coverage will vary from state to state, as CMS allows individual Medicare Carriers to use "carrier discretion" in coverage of implants.

Those procedures with high device costs where the cost of the device is equal to or exceeds 50% of the medical cost of the APC amount should be separately reimbursed under the new 2008 payment system. This is described in CMS's Tables 63, 64 and 65. Some of these procedures include Spinal Cord Neurostimulator devices.

Unfortunately, some Implantable devices, such as stents and mesh, which were not covered under the previous Medicare Grouper system, are still not covered under Medicare's new 2008 payment system.

Bill implants to payors other than Medicare unless your facility's contract with the payor specifically prohibits it.

Commonly used codes for Orthopedic Implants include:

C1713 – Anchor/Screw
L8630 – Metacarpophalangeal Joint Implant
L8631 – Metacarpophalangeal Joint Replacement Implant
L8641 – Metatarsal Joint Implant
L8642 – Hallux Implant
L8699 or 99070 – Misc. Implants

Overnight Stays/23-hour Stays

Medicare considers 12 Midnight to be the defining measure of an overnight stay under the new payment system. This has still not been clarified by Medicare, and the ASC Assoc. continues to fight this issue vigorously. To be on the safe side, if it is KNOWN on the front-end that a Medicare patient will require an overnight stay, the case should be diverted to the hospital at the time of scheduling.

FEE EXAMPLES FOR COMMON PROCEDURES

CPT Code	APC No.	Hospital APC Rate 2008	Proposed CY 2008 fully implemented payment	Proposed CY 2008 first transition year payment	Grouper Number	2007 Grouper Fee
24153	0052	$ 5,058.86	$ 3,288.25	No transition $$	None	None
28285	0055	$ 1,326.64		$ 598.08	3	$ 510.00
29827	0042	$ 2,911.27		$ 1,010.83	5	$ 717.00
28296	0057	$ 1,900.32		$ 686.97	3	$ 510.00
29848	0041	$ 1,833.13		$ 1,302.13	9	$ 1,339.00
29807	0042	$ 2,911.27		$ 855.58	3	$ 510.00
29888	0042	$ 2,911.27		$ 855.58	3	$ 510.00
29881	0041	$ 1,833.13		$ 770.38	4	$ 630.00

Procedure for Sequencing CPT Codes for surgical procedure(s) performed in Freestanding ASC Facilities on Medicare Claim Forms:

1. Review the OP Report(s) for the surgical case.
2. Code out the CPT procedure code(s) for all surgical procedures performed.
3. Look up each pertinent CPT procedure code(s) with all of the other pertinent CPT procedure code(s) in the CCI material to determine Unbundling for the case.
4. Determine if those procedures designated as "Separate Procedures" in the CPT book and those CPT codes which are Unbundled in the CCI material are billable using the -59 Modifier or they should not be billed. Arrive at the final CPT procedure code(s) that can be billed for the surgery(s) performed.
5. Look up each CPT code to be billed on the Medicare ASC List for the associated fee.
6. Sequence the CPT codes for billing from Highest to Lowest fee listed on the Medicare ASC List.
7. Remember, the –SG Modifier is not used on CPT codes billed on Medicare claims for dates of service in 2008.
8. Observe Medicare's revised requirements for 2008 for the billing of Bilateral Procedures (i.e., don't use the -50 Modifier). Details are discussed on p. 21-22.
9. Those CPT codes to be billed which are NOT listed on the Medicare ASC List are not covered by the Medicare program and should be billed using the –GY Not Covered Modifier.

Revenue Codes

Revenue Code Descriptions are listed in Field 42 of the UB-04 facility Claim Forms used for payors other than Medicare. For each line item charge listed on the claim, there must be an associated Revenue Code listed. Not all charges on hospital bills will have an associated CPT code. Those charges for ancillary services (such as supplies) are listed with a Revenue Code only and a word description.

For every CPT code listed on a UB-04 Claim Form, the CPT code for procedure(s) performed should be listed with a 360 Revenue Code for Hospital surgical procedures or a 490 Revenue Code for ASC surgical procedures. Implants are listed with the 278 Revenue Code or with 276 for Intraocular Lenses (used in Cataract procedures). When Revenue Codes are listed on claim forms, they are listed with a leading zero, making them 4-digits.

Revenue Codes are 3-digit codes, which affect reimbursement and represent to the payor the services provided by the ASC or surgical hospital facility. There are hundreds of Revenue Codes, many of which are not applicable for ASCs, however, the ones most commonly used are as follows:

Code 250 for Pharmacy Services
Code 270 for Medical/Surgical Supplies
Code 271 for Non-sterile Supplies
Code 272 for Sterile Supplies
Code 274 for Prosthetic/Orthotic Devices
Code 276 for IOL Implants (Cataracts)
Code 279 for Supplies
Code 278 for Other Implants
Code 320 for X-rays (Fluoroscopy)
Code 360 for Surgical Procedures performed in a Surgical Hospital
Code 370 for General Anesthesia
Code 379 for Other Anesthesia
Code 490 ASC Surgical Procedures
Code 710 for Recovery Room Services (PACU)

CPT CODING of ORTHOPEDIC PROCEDURES

Coding Tips:

- CPT codes for procedures and surgeries need to be listed on the claim form in order of descending relative value (from highest to lowest Medicare reimbursement, Payment Groupings for other payors, or RVUs, depending on the facility's contract with the payor). This helps the payors identify the primary procedure and prevents them from placing the procedures in a different order, which could result in lower reimbursement.

- In the CPT book, certain words and descriptions will make a substantial difference in reimbursement and your audit liability. The selection of the appropriate code for the situation is, of course, dependent on the medical record documentation supporting the higher paying code chosen.
  Similar words and phrases that can alter your reimbursement are as follows:

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

Unlisted Procedure Codes
Sometimes, you have no alternative but to use an Unlisted procedure code, when an exact code cannot be found. When an Unlisted procedure code is used, the service or procedure should be described. In the CPT book, identifying words for these codes are "Unlisted" service or code and "Special Report". Drop the claim to paper and submit the claim with medical record documentation (the OP Note) to justify the procedure performed and explain what was done. You might want to contact the Medicare Carrier or BC/BS to ask if they can recommend a code. Remember that for 2008, Medicare does not accept Unlisted Procedure Codes – if it is known on the front-end that the main procedure or only procedure to be performed involves the use of an Unlisted Procedure Code, it is best to divert it at the time of scheduling to another place of service.

Bilateral Procedures
If a surgical procedure is by (CPT) definition unilateral, and is performed bilaterally, the ASC 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 include:

1. Bill the same code as two line items, using the –RT Modifier on one code and the –LT Modifier on the other (same) code.
2. 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).
3. 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.
4. Bill the same code as two line items with no Modifiers. (***Medicare)
5. Bill the code as one line item with a "2" in the Units field of the claim and double the fee. (***Medicare)

*****With the changes in the Medicare program for ASC billing for 2008, these last two methods (#4 and #5) are how Medicare is directing Bilateral procedures should be billed. If you experience denials for Bilateral procedures filing to Medicare with these methods, use method #1.**

Multiple Procedures

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

Add-on Codes

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

Separate Procedures

Those procedures designated as "Separate Procedures" in the CPT book must be treated differently from other procedures. If these procedures are not coded and billed correctly, the facility can experience a denial from the payor similar to a CCI Unbundling denial – even if the codes are not Unbundled in the CCI Unbundling material. A "Separate Procedure", by definition, is a component of a more complex service and is usually not identified separately. These services are typically an integral component of a more extensive service. When these services are performed alone, or not as part of a larger or

more inclusive procedure, then the "separate procedure" should be reported. When the "separate procedure" is carried out independently or distinctly from other procedures, it may be reported by itself or with the -59 modifier, in some instances (i.e., separate site or by a separate incision). The separate procedure designation indicates that a certain procedure or service may be:

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

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

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

Unbundling

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

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

In some (very few) cases, even though one code is Unbundled from another listed procedure, it can be billed anyway using a –59 Modifier (such as a 29877 Chondroplasty done in a *separate compartment* from an Arthroscopic Knee Meniscectomy procedure, as long as the OP Note is very specific about the description of the procedure occurring in a separate area/compartment). If the procedure was done in a separate area, by a separate incision, etc., it might be billable. Check the OP Note and the procedure book descriptions carefully, assess correct modifier usage, and contact the Medical Review or Coding department at the payor for guidance. This situation would not occur very often. Usually, if it is Unbundled, it is not billable.

Fragmenting

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

Modifiers

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

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

-50 Bilateral Procedure P & A

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

-51 Multiple Procedures P

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

-52 Reduced Services P & A

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

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

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

1. Staged;
2. More extensive than the original procedure; or
3. For therapy following a diagnostic surgical procedure.

-59 Distinct Procedural Service P & A

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

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

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

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

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

-76 Repeat Procedure or Service by Same Physician P & A

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

-77 Repeat Procedure or Service by Another Physician P & A

This modifier is used in the situation where a physician repeats a procedure that had previously been performed by another physician. It is usually assumed to occur on the same day that the initial procedure was performed.

-78 Return to the OR for a Related Procedure During the Postoperative Period P & A

This modifier will result in reduced reimbursement for the physician, as the payment will reflect the surgery component only. However, failure to use this modifier when necessary will probably result in a claim denial.

-79 Unrelated Procedure or Service by the Same Physician During the Post-operative Period P & A

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

-RT Right Side **-LT** Left Side P & A

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

-TC P & A

The –TC Modifier reflects that the Technical Component only of an x-ray is being billed for by the ASC. This is billing for the taking of the x-ray by the facility.

Digit Modifiers: P & A

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

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

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

-SG A

While for dates of service through Dec. 31, 2007, ASCs needed to use the –SG Modifier on each CPT code billed on claims filed to Medicare, with the changes to the Medicare program for ASCs, for dates of service Jan. 1, 2008 going forward, Medicare is now directing that ASCs are NOT to use the –SG Modifier. This Modifier may still be required by some payors on claims are filed on CMS-1500 claim forms (such as Medicaid claims, if required). You should continue using it for payors who have previously required its use, unless and until they direct you to do otherwise. It is NOT necessary to use the –SG Modifier on codes listed on claims filed on UB-04 claim forms going to other payors, unless the payor requires its use. Do NOT use the –SG Modifier on HCPCS codes billed for Implants for radiology codes, unless otherwise directed by the payor.

-GA Modifier A

While ASCs used to use the –GA Modifier in the past to indicate to Medicare that the patient was having a procedure not covered in an ASC, ASCs should NOT be using this Modifier now, since CMS changed the rules in 2001 to not allow ASCs to pursue ABNs for non-covered procedures performed in the ASC setting for information on procedures not on the Medicare list of approved procedures.

Billing Everyone the Same – Use the –GY Modifier

If your facility is trying to "bill all payors with the same" codes in the same manner, it can be challenging, since some payors (especially Medicare) do not cover all billed codes for procedures performed. When billing a CPT code to a payor you know is not covered by that payor (for example, billing 77003 Fluoroscopy to Medicare), append the –GY Modifier, which lets the payor know you that you are aware they don't cover the service and you expect a denial for that charge. This code would be billed to Medicare as 77003-GY-TC

There is *verbiage change* for the –GY Modifier effective July 1, 2007. Prior to July 2007 the verbiage stated "The –GY Modifier is to be used when providers need to indicate that the item or service they are billing is statutorily non-covered or is not a Medicare benefit". As of July 1, 2007 the verbiage states "The –GY Modifier is to be used when physicians, practitioners, or suppliers what to indicate an item or service is statutorily excluded, does not meet the definition of any Medicare benefit or Non-Medicare insurers, is not a contract benefit".

Modifier Usage

It is extremely important to append the appropriate -RT and -LT Anatomic Modifiers to CPT codes on claims, when needed (e.g., Orthopedic services). When a patient has a bilateral problem (such as Bunions on both feet), the surgeries to correct the problem may be done one side at a time, with the patient returning months later for the repeat procedure on the other side. If the claim for the first surgery is submitted without the appropriate –LT or –RT Modifier, many times when the payor (or Medicare) receives the

claim for the second surgery, they will deny it as a Duplicate claim. It saves a great deal of time, energy and money to append the appropriate Modifier on the claim the first time through, to avoid these types of unnecessary denials.

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

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

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

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

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

Repair/Reconstruction: This code subheading describes those procedures that surgically improve and repair improperly functioning, deformed, or painful parts of the body. All "orrhaphy" (suturing), or "plasty" (surgical repair) procedures are found under this subheading.

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

Medicare ASC Billing Rules

Terminated Surgical Procedure Rules

- Procedures which are Cancelled or Postponed

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

- Procedures which are Terminated Before Anesthesia has been Induced

If a procedure is terminated due to medical complications after the patient has been prepared for surgery and taken to the OR, but before anesthesia has been induced, Medicare should reimburse at 50% of the allowed amount. Append the –73 Modifier to the billed CPT code for the 1st procedure that was planned, but not performed only. To bill Medicare, the patient MUST physically be located in the treatment room or OR where the procedure was to be performed when the decision was made to cancel the procedure and the ASC must have expended significant resources (i.e., the patient has an IV and has been given pre-operative medication).

- Procedures which are Terminated After Anesthesia has been Induced

If a procedure is terminated due to medical complications after anesthesia has been induced, Medicare should reimburse at 100% of the allowed amount. Whatever the anesthesia was for the case (a block, IV sedation, General Anesthesia, etc.) applies. Append the –74 Modifier to the billed CPT code if the 1st procedure has been started and the patient has received anesthesia for the case.

- Documentation

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

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

- Reason the surgery was terminated
- The services which were actually performed
- The supplies that were actually provided/used
- The services which were not performed (intended)
- The supplies that were not provided/used (intended)
- The time actually spent in each stage of the surgery that was completed (i.e., Pre-op, Operative, and Post-procedure termination)
- The time that would have been spent (intended), and

- The CPT procedure code(s) for the covered procedure, had the intended procedure been performed with the appropriate modifiers appended

- When anesthesia was administered only, but **none** of the procedures which were planned were started at all, bill the code for the 1st procedure scheduled or main procedure with the -74 Modifier and the rest of the planned procedures are not billable.
- If several procedures were to be performed and some (but not all) planned procedures were completed, bill as follows:
    1. Bill procedure(s) which **were** completed at full fee **without** the –74 Modifier.
    2. Bill any procedure(s) which was started but which **was not** completed at full fee with the –74 Modifier.
    3. Those procedures which were planned/scheduled but were **not started** at all are **not billable**.

Claim Forms

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

Medicare Billing for Non-ASC List Procedures

Medicare's direction is that when procedures which are not on Medicare's list of approved procedures are performed in an ASC, the case should be diverted to a covered place of service (the physician's office or the hospital). ASCs **cannot** have the patient sign an ABN and bill the patient directly, unless the procedure would not be reimbursable by Medicare in any place of service. If it is not a Medicare benefit, and it is not just a procedure that is not covered in the ASC setting, the ASC can charge the patient. This is the ONLY circumstance in which the patient can be charged.

If your ASC consistently allows cases for Medicare patients that are not on Medicare's list of approved procedures (where you do not charge the patient [which you can't do, as discussed above] or the physician for the use of the facility), it can cause problems with federal Anti-Kickback laws (related to inducement for referrals), so the surgeon and the ASC should seek legal assistance with this issue, if proper handling is unclear. It is very important for there to be a dialogue between the surgeon and the ASC *on the front-end* regarding these non-covered procedures. It is extremely important to catch these issues at the time of scheduling.

Medical Record Documentation

- Information in the medical record must support the Medical Necessity of the CPT and Diagnosis codes billed.
- All entries in the medical record must be dated with a full date and should be signed by all providers and nurses recording in the record.
- The patient's name and/or Medical Record No. should be on *every page* in the medical record.
- The medical record should be complete and legible.
- Relevant risk factors should be identified.
- The ASC must notify the surgeon if a scheduled procedure is not on Medicare's list of approved procedures for a Medicare patient.
- Advise surgeons to avoid the use of "Canned" OP Reports. Medicare and other payors frown on the use of "Canned" OP Reports to document procedures. If similarities in procedures occur and the physician wishes to use some sort of template, the OP Reports must still be tailored enough to each patient's individual surgery and circumstances for use, and not appear to be "canned".

General Billing Guidelines for Surgery Claims

- It is very important to read the *entire* OP Report for each procedure performed, to be sure all procedures performed during an operative session are captured and properly coded. DO NOT code from the surgery schedule without having the OP Report in hand! Never code a bill for a procedure you are unsure took place (i.e., case was scheduled but cancelled).

- When Multiple Procedures are performed during the same operative session, it is important to look up each code for procedures performed with every other code in the CCI Unbundling material. Use judgement, as some codes (even if Unbundled) can be billed using a –59 Modifier, if the procedure was done in a separate area, by separate incision, or in a separate compartment. Do not, however, overuse the –59 Modifier or use it inappropriately.

Common Orthopedic Procedures
which are Frequently Coded Incorrectly

- **Hardware Removals**

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

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

  There are several methods for how many 20680 implant removal codes to bill when multiple pieces of hardware are removed. The method we recommend is to bill based on the number of incisions made to remove the hardware, rather than the number of pieces of hardware removed. For example, if 4 incisions are made to remove a plate and 6 screws, we would recommend billing the 20680 code four times:

  20680-RT
  20680-59-RT
  20680-59-RT
  20680-59-RT

  The AAOS (American Academy of Orthopedic Surgeons) directs that the 20680 code is to be billed once per fracture site, rather than based on the number of incisions made to remove the hardware from one fracture site. Use the method you are most comfortable with, however, it would be Upcoding to bill based on the number of pieces of hardware removed, if the same number of incisions were not made to remove the pieces of hardware.

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

- Removal of an Implant from the Elbow or Radial Head should be billed with the 24160-24164 codes. However, if only one or two screws are removed and it is not an extensive procedure, use the applicable 20670 or 20680 code.

➢ **Tendon Grafts with ACL Repairs**

The 20924 code for the Harvest of a Patellar or Hamstring Tendon Graft states "from a distance", and billing this code with the 29888 ACL Repair code is usually not allowed and will likely be denied, because the tendon graft is usually obtained from a separate incision on the *same knee,* which does not constitute a far enough distance to bill for it separately, according to the *CPT Assistant* publication, (even though it is not Unbundled in the CCI material and is done through a separate incision). The tendon graft is billable with the 20924 code when the graft is obtained from the opposite knee or either ankle. If the tendon graft is an Allograft, which is purchased, bill for an Implant (code L8699), if allowed by the payor.

➢ **Lipoma Removals**

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

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

- Filleting (also called waste resection) of the Proximal Phalanx – involves a sub-periosteal resection of the phalangeal shaft, closure of the periosteum, and a manual correction of the metatarsophalangeal extension deformity and proximal interphalangeal joint flexion deformity.
- Proximal Phalangectomy – involves an excision of the proximal phalanx and a manual correction of the metatarsophalangeal extension deformity and proximal interphalangeal joint flexion deformity.

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

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

- **Chondroplasty Procedures**

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

Chondroplasty Documentation Tips:

- If the Chondroplasty is performed in the *same* compartment with the other Arthroscopic surgery procedures, it would be considered bundled, and would not be separately-billable.
- The surgeon must document that the Chondroplasty was done in a different compartment than the repair or excision (in order to bill it with other procedures).
- 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 area, when it is billable because 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 the G0289 code 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 –GY 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 vs. Debridement Procedures**

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

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

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

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

Orthopedic Procedures Added to Medicare ASC List
In 2008 Advantageous to Perform/Add

CPT	MC Reimb.	Procedure Description
20150	$1,779.62	Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision
20552	$22.14	Trigger Point Injection of 1-2 Muscles – Low reimbursement – we recommend performing as an Add-on Procedure only and not as the only procedure
20553	$24.87	Trigger Point Injection of 3 or more Muscles – Low reimbursement – we recommend performing as an Add-on Procedure only and not as the only procedure
20555	$1,208.50	Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure) – this is a new CPT code for 2008
20610	$34.41	Joint Injection of Shoulder, Hip, or Knee – Low reimbursement – we recommend performing as an Add-on Procedure only and not as the only procedure
24149	$1,208.50	Radical resection of capsule, soft tissue, and heterotopic bone, elbow, with contracture release (separate procedure)
24152	$1,179.62	Radical resection for tumor, radial head or neck
24153	$3,288.25	Radical resection for tumor, radial head or neck; with autograft (includes obtaining graft)
24300	$611.32	Manipulation, elbow, under anesthesia
24343	$1,208.50	Repair lateral collateral ligament, elbow, with local tissue
24344	$3,288.25	Reconstruction lateral collateral ligament, elbow, with tendon graft (includes harvesting of graft)
24346	$1,779.62	Reconstruction medial collateral ligament, elbow, with tendon graft (includes harvesting of graft)
24357	$1,208.50	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); percutaneous

24358	$1,208.50	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open
24359	$1,208.50	Tenotomy, elbow, lateral or medial (eg, epicondylitis, tennis elbow, golfer's elbow); debridement, soft tissue and/or bone, open with tendon repair or reattachment
25109	$880.55	Excision of tendon, forearm and/or wrist, flexor or extensor, each
25431	$1,089.28	Repair of nonunion of carpal bone (excluding carpal scaphoid (navicular)) (includes obtaining graft and necessary fixation), each bone
25651	$1,083.02	Percutaneous skeletal fixation of ulnar styloid fracture
25652	$1,701.96	Open treatment of ulnar styloid fracture
27416	$1,779.62	Osteochondral autograft(s), knee, open (eg, mosaicplasty) (includes harvesting of autograft[s])
27440	$1,486.46	Arthroplasty, knee, tibial plateau
27446	$11,371.67	Partial Knee Replacement/Arthroplasty of the condyle and plateau; medial OR lateral compartment
27769	$1,701.96	Open treatment of posterior malleolus fracture, includes internal fixation, when performed
29828	$1,892.32	Arthroscopic shoulder biceps tenodesis
29866	$1,892.32	Arthroscopy, knee, surgical; osteochondral autograft(s) (eg, mosaicplasty) (includes harvesting of the autograft[s])
29904	$1,191.53	Ankle Arthroscopy, subtalar joint, with removal of loose body or foreign body
29905	$1,191.53	Ankle Arthroscopy, subtalar joint, with synovectomy
29906	$1.191.53	Ankle Arthroscopy, subtalar joint, with debridement
29907	$1,892.32	Ankle Arthroscopy, subtalar joint, with subtalar arthrodesis

New Orthopedic CPT Codes for 2008

Brachytherapy

- Code 20555 is for the Placement of needles or catheters into muscle and/or soft tissues for the subsequent placement of interstitial radioelements. The brachytherapy seeds can either be placed at the time of this procedure or they can be placed later at a different time.

  Interstitial radioelement application is a form of brachytherapy, which is a treatment for cancers (such as a soft tissue sarcoma) where radioactive isotopes are placed to deliver radiation to the body internally over a period of weeks or months. Needles or catheters are placed into the soft tissues or muscle close to the tumor bed for treatment with tiny seeds, which are the radiation sources.

  - An Example would be a 51 yr. old female with a 7 cm. tumor in her right upper arm, which is growing. A previous biopsy revealed it to be a cancerous mass. The orthopedic surgeon performs a surgical excision of the mass and places catheters in the area, which he will subsequently load with the Brachytherapy radioactive seeds in one week.

  - Please note that the 20555 code would not be used for Brachytherapy procedures performed on the breast, prostate or head and neck areas.
  - For Image Guidance, use codes 76942, 77002, 77012 or 77021, as appropriate.

Computer-Assisted Navigation Guidance for Ortho. procedures

- Add-on code 20985, which is for Computer-assisted navigation guidance for use in musculoskeletal procedures, performed *without* the generation of an *image* when the guidance is used.

- Add-on code 20986 for Computer-assisted navigational guidance during musculoskeletal procedures, which provides image *guidance* based on *intra-operatively-obtained* images.

- Add-on code 20987 is for Computer-assisted navigational guidance during musculoskeletal procedures, which provides image *guidance* based on *pre-operative* images.

- The 20986 and 20987 codes should only be listed once on the claim, even if multiple imaging modalities are used during the procedure.

- Remember that these are Add-on codes, which should only be listed in addition to the code for the primary procedure performed and are never listed as the only code on the claim.

- Do not bill any of these 3 codes with code 61795, which is most often used for guidance in sinus, spinal or brain surgery.

For Ambulatory Surgery Centers, please be aware that these 3 codes are NOT on the 2008 Medicare Payment List as covered procedures.

Treatment of TMJ

- The 21073 code is for the Manipulation of the Temporo-mandibular joint for therapeutic purposes, and the patient would be under General or Monitored anesthesia for the use of this code.

    - This code is used for therapeutic, not diagnostic, purposes. In this procedure, no incisions are made - the surgeon applies manual manipulation to return the mandible to its correct position.

Elbow/Epicondylitis Procedures

CPT made some major changes to the Codes for the Elbow for the treatment of Epicondylitis (also called Tennis Elbow) for 2008.

The AMA deleted the 5 codes previously used for the treatment of Epicondylitis (codes 24350-24356) and replaced them with 3 new codes.

- Code 24357 is 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.

- 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.

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

Treatment of Hip and Pelvis Fractures and Dislocations

- Code 27267 is used for the Closed treatment of a fracture of the proximal end of the femoral head. In this procedure, no incisions are made and no manipulation is used.

- The 27268 code is for the Closed treatment of a fracture of the proximal end of the femoral head using manipulation. In this procedure, no incisions are made and the surgeon uses manipulation to correct the bone to its proper anatomic position. Traction may be used post-operatively in this procedure.

- Code 27269 is for the Open treatment of a fracture of the proximal end of the femoral head, which is an ORIF (Open Reduction/Internal Fixation) procedure, if Internal Fixation is used.

These 3 new procedures would most likely be used for traumatic fractures of the femoral head, and would be seen primarily in younger patients, rather that the elderly population, who may have a hip fracture caused by Osteoporosis.

Knee OCD Lesion Treatment

- The 27416 code is for an Open Osteochondral Autograft (also called a mosiacplasty) of the knee. This code would include harvesting of the autograft.

While we have previously had the 27415 code for an Open Allograft Osteochondral procedure of the knee and the 29866 code for an Osteochondral Autograft procedure when it is performed Arthroscopically, there was no code for an Open Osteochondral autograft procedure.

Use this code for the treatment of small to moderate sized articular cartilage repair procedures. Bill the code only once, regardless of the number of harvests or grafts used in the repair. CPT directs that the 27416 code is not to be billed with the 27415 code (for an Open Allograft Osteochondral procedure of the knee) on the same case.

Fracture Treatment codes for the Tibia, Fibula and Ankle

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

  To define:
  - A Nonunion of a Fracture is where the bones do not heal back together.

  - A Malunion of a Fracture is where the bones heal in an incomplete union or where the bones heal in the wrong position.

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

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

- Code 27767 is for the Closed Treatment of a Posterior Malleolus Fracture performed without manipulation.

- Code 27768 is for the same procedure when it is performed with manipulation.

- Code 27769 is for the Open treatment of a posterior malleolus fracture, which would include internal fixation, if it is used in the procedure.

CPT directs that these codes are not to be used with the bimalleolar or trimalleolar ankle fracture treatment codes, which are 27808-27823.

Ankle OCD Lesion Treatment Code

While we have previously had the 29892 code for this Ankle OCD Lesion procedure when it is performed arthroscopically, there was no code for the open procedure.

- Code 28446 is for an Open osteochondral autograft of the talus. This code would include harvesting of the autograft.

Use this code for the treatment of large osteochondral defects of the talar dome. Bill the code only once, regardless of the number of harvests used in the repair. This code is not to be used with codes for osteotomy procedures of the tibia and/or fibula (codes 27705 and 27707).

Biceps Tenodesis

While we have had the 23430 code for an Open Biceps Tenodesis procedure, the only codes for use previously for billing an Arthroscopic Biceps Tenodesis were the 29999 Unlisted code or S2114, both of which made reimbursement a challenge.

- The new 29828 code is for an Arthroscopic Shoulder Biceps Tenodesis procedure.

Use code for biceps tendon repairs of tears, tendinosis, and subluxation conditions.

CPT directs when billing the 29828 code to not bill separately for:
Diagnostic Shoulder Arthroscopy – code 29805
Arthroscopic Shoulder Synovectomy – code 29820
Arthroscopic Shoulder Debridement – code 29822

Arthroscopic Codes for Ankle Procedures

- Code 29904 is for the Arthroscopic removal of a loose body or a foreign body from the subtalar joint of the ankle.

- The 29905 code is for an Arthroscopic synovectomy of the Ankle, which removes the synovial lining of the joint.

- Code 29906 describes an Arthroscopic Ankle debridement.

- The 29907 code is for an Arthroscopic subtalar arthrodesis, which is a joint Fusion, usually done with Morcellized bone grafting and internal fixation with screws.

The subtalar joint lies between the calcaneus (heel bone) and talus. These procedures are for intra-articular calcaneus fractures, sinus tarsi syndrome, rheumatoid arthritis and synovitis conditions.

2008 Revisions to CPT Codes

- CPT codes 24670, 24675 and 24685 for Ulnar Fracture Treatment have been revised to include the Coronoid Process, in addition to the Olecranon Process. The term "Processes" for these codes indicates that fracture repairs on the olecranon or coronoid processes are included and would not be coded separately for the same limb. These codes previously addressed only the Olecranon Process.

  - Code 24670 for a Closed Treatment of the proximal end of an Ulnar Fracture, the bone fragments are not separated and are fairly stable, so *no Manipulation* is needed.

  - Code 24675 is for the same procedure performed *with Manipulation*, where there is a slight separation in the bone fragments, but the fracture is able to be set without incisions being made, using manipulation and casting/strapping only.

  - Code 24685 is for Open Ulnar Fracture Treatment, which includes internal fixation, if it is used. This code should not be coded with the 24100-24102 codes for Open Arthrotomy procedures performed on the Elbow joint.

- CPT codes 27808, 27810 and 27814 for Bimalleolar Ankle Fracture Treatment have been revised to specify that they are for the lateral and medial malleoli, lateral and posterior malleoli or the medial and posterior malleoli areas.

  - Prior to 2008, these codes were for treatment of the medial and lateral malleoli only.

  - Code 27808 is for the Closed Treatment of a Bimalleolar Ankle Fracture *without Manipulation*.

  - Code 27810 is for the same procedure performed *with Manipulation*.

  - Code 27814 is for Open Treatment of a Bimalleolar Ankle Fracture and includes Internal Fixation, if it is used.

  - The 27808 and 27810 codes previously included reference to a Potts Fracture, and that reference is no longer listed in the CPT book for 2008.

Major Revisions in the Fracture Care Verbiage

If your ASC performs Fracture Care, there is new language on many of the fracture codes for 2008 where CPT revised the descriptor to say "Includes Internal Fixation when performed" and the codes now exclude External Fixation. The previous language on many of the fracture codes was "with or without internal or external fixation."

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

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

Orthopedic Diagnosis Code Changes for 2008

There were not very many changes in orthopedic diagnosis codes for 2008. The changes include:

- **New Codes**

  - Code V68.01, which is for a Disability Exam

  - Code V68.09, which is for use when the physician is performing physicals for reasons other than disability – specifically stated as "Other issue of Medical Certificates"

  These two codes replace the deleted V68.0 code, which was for the Issue of medical certificates, which had a more general description.

  - New codes for Myotonic Disorders, which are more specific than the 359.2 code they replaced:

    1. Use code 359.21 for Myotonic Muscular Dystrophy.

    2. Code 359.22 is for Myotonia Congenita, which is a dominant form of Thomsen's Disease and a Recessive form of Becker's Disease.

    3. The 359.23 code is for Myotonic Chondrodystrophy (also called Schwartz-Jampel Disease).

4. The 359.24 code is for Myotonia which was brought on by a side-effect or poisoning by Drugs.

5. The 359.29 code would be used for Other specified Myotonic Disorders, such as Myotonia Fluctuans, Myotonia Levior, Myotonia Permanens, and Paramyotonia Congenita.

Coding Other Orthopedic Procedures

Injection Procedures in Orthopedics

Trigger Point Injections

Trigger Point Injection (TPI) CPT Codes:

- 20552–Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
- 20553–Injection(s); single or multiple trigger point(s), 3 or more muscle(s)

Do not bill trigger point injection as a local anesthetic for surgery
Not allowed on the same day as any surgery
High utilization in a short period could be a Medicare "red flag" for audits. However,

Injections of tendon sheaths, ligaments and ganglion sheaths should be limited to 1-2 per site, except in very unusual circumstances. Medical necessity will always need to be supported. If initial symptoms are not resolved within 3 weeks, a paper claim with documentation supporting the medical necessity of the injections may be requested. Also, medical documentation for all tendon sheath, ligament, or trigger point injections is expected to indicate the clear and concise medical necessity with the patient's medical record, should review become necessary.

Since Medicare does cover these procedures, but reimburses at a low amount, we recommend performing TPIs as an Add-on Procedure only and not as the only procedure.

Bone and Other Types of Grafts

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

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

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

Most bone, cartilage and fascia graft procedure codes include obtaining of the graft by the operating surgeon. When a surgical associate obtains the graft for the operating surgeon, the additional service should be coded and reported separately using codes from the 20900-20926 range. In addition, a surgical modifier for assistant surgeon or co-surgeon should be included when billing the associated services.

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

The 20924 code for a Tendon Graft states "from a distance", and billing this code with the 29888 ACL Repair code is usually not allowed and will likely be denied, because the tendon graft is usually obtained from a separate incision on the *same knee,* which does not constitute a far enough distance to bill for it separately, according to the *CPT Assistant* publication. It is billable with the 20924 code when the graft is obtained from the opposite knee or either ankle.

Other Procedures

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

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

Fracture Care

Fracture Treatment Diagnosis Coding

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

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

GENERAL INFORMATION

- Dislocations are located in the coding book in the same section as fractures.
- With **Closed** fractures, there is no open wound into the skin. Examples – comminuted, greenstick, simple, impacted.
- Fractures are considered "Closed" unless specified to be an Open Fracture in the medical records.
- "Closed treatment" of a fracture specifically means that the fracture site is not surgically opened (exposed to the external environment and directly visualized). Fractures are treated using three methods:
  1. Without manipulation
  2. With manipulation
  3. With or without traction
- With **Open** fractures, there is an open wound into the skin. Examples – compound, infected, puncture, with foreign body.
- "Open treatment" of a fracture (called ORIF) is used when the fracture is surgically opened (exposed to the external environment). In this instance, the bone is visualized and internal fixation may be used.
- Stress fractures are not to be billed using fracture codes.
- Fracture care is coded based on the way the fracture is treated by the physician. The type of fracture (e.g., open/compound, closed) does not always correlate with the type of treatment (e.g., closed, open, or percutaneous) provided. The codes for treatment of fractures and joint injuries (dislocations) are categorized by the type of manipulation (reduction) and stabilization (fixation or immobilization). These codes can apply to either open (compound) or closed fractures or joint injuries.
- When coding for fracture care, consider the following:
  1. Where is the site of fracture or dislocation?
  2. Is the treatment open or closed?
  3. Was manipulation involved?
  4. Was skin or skeletal traction applied?
  5. Was skeletal fixation (percutaneous, external, or internal) applied?
  6. Was soft tissue closure performed?
  7. Were any grafts used?

- The term manipulation refers to the "attempted" reduction or restoration of a fracture or joint dislocation to its normal, anatomical alignment by manual application of applied forces (traction) – so even if the reduction procedure is not successful, the code for treatment with manipulation may be used.
- In keeping with the policy on most extensive procedures, when a fracture requires closed reduction followed by open reduction at the same patient encounter (e.g., inability to accomplish the closed reduction), only the open reduction service is billed.

Dislocating Patella

When the patient has a chronically Dislocating Patella, the Reconstruction procedures for correction of that condition are in the 27420-27424 codes.

- Use code 27420 for the Reconstruction of a Dislocating Patella; (also referred to as the Hauser procedure).
- Use code 27422 for a Reconstruction of a Dislocating Patella when an Extensor Realignment and/or Muscle Advancement/Release are performed (also referred to as the Campbell or Goldwaite procedures).
- Use code 27424 when the Reconstruction of a Dislocating Patella procedure is performed with a Patellectomy.

Foot Procedures (28001 – 28899)

Foot Anatomy

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

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

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

Foot Procedures

Bunionette

Tailor's Bunion Correction Procedure – Coded as 28110, which is a bunion correction done with a partial ostectomy of the 5th metatarsal head and soft tissue release of the 5th metatarsal joint. This procedure is performed only on the 5th Toe. This code is designated as a Separate procedure. This procedure would be billable (even though it is a "Separate Procedure"), as long as all of the other procedures are performed on other Toes. If this procedure is done in conjunction with the 28308 procedure (Osteotomy of the mid-shaft of the 5th metatarsal with screw fixation-sometimes referred to as the Weil procedure), only the 28308 procedure would be billable.

Bunions

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

If any of the following procedures are done in conjunction with a Bunion procedure, they should be coded *in addition to the Bunion procedure* (unless this is contraindicated by CCI material), and may require the use of a –59 Modifier or Toe Modifiers:
CPT code 28113 – Ostectomy of the 5th Metatarsal Head
CPT codes 28230-28234 – Tenotomy Procedures
CPT codes 28270-28272 – Capsulotomy MTP Joint
CPT code 28280 – Syndactylization of Toes - done for "webbed" toes
CPT code 28285 – Hammertoe Correction done on a toe other than where the Bunionectomy was performed – thus, it is very important to append the appropriate Toe Modifier, to indicate the Hammertoe procedure was done on a separate toe area than the Bunionectomy, from which it is Unbundled
CPT code 28286 – Cock-up 5th Toe Deformity
CPT code 28288 – Lesser Metatarsal Ostectomy, each Metatarsal Head
CPT code 28645 – Dislocated MTP Joint Open Treatment – with or without internal or external Fixation

Bunion Surgery

It is very important with Bunion procedures for the surgeon to indicate in the OP note the Type and Name of the procedure he/she is performing to assist the ASC in coding these procedures properly. All Bunion deformities are not the same, and their surgical

correction involves different techniques, with varying levels of complexity. Codes 28290-28299 are reported for the correction of Bunion deformities. It is very important to know the type of procedure used, and verify its components before selecting a Bunionectomy code which include the following:

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

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

Types of Bunion Procedures:

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

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

- The **Keller** procedure is a simple resection of the base of the proximal phalanx with removal of the medial eminence.
- The **McBride** procedure is a distal soft tissue release, done by releasing the tight lateral capsule, ligament complex and adductor tendon, and reefing the loose medial capsule, with resection of the medial eminence.

- The **Mayo** procedure (seldom performed), involves a resection of the 1st metatarsal head.

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

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

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

- The **Austin** Osteotomy procedure is performed for patients who do not have degenerative joint disease, who enjoy pain-free range of motion, and still have dorsiflexion of the 1st metatarsal, but have mild to moderate hallux abducto valgus. It is also used to shorten or lengthen the 1st metatarsal segment.

- The **Mitchell** procedure is a complex, biplane, double step cut (transpositional) osteotomy, which runs through the neck of the 1st Metatarsal, with a lateral step-down and removal of the head of the 1st metatarsal, with both distal and proximal osteotomies. It is used to correct moderate bunions, with a subluxed MTP joint.

- The **Distal Chevron** procedure consists of a resection of the medial eminence, a medial longitudinal arthrotomy, combined with a transverse osteotomy of the coronal plane of the metatarsal neck, which is done to lateralize the head.

- The **Concentric Osteotomy** procedure combines a modified McBride procedure with a proximal metatarsal osteotomy procedure.

- A **Tricorrectional Bunionectomy** procedure uses a technique to correct all 3 planes with a distal metatarsal osteotomy, involving a transverse V-osteotomy and long plantar hinge using cannulated bone screws for fixation.

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

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

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

Proximal Osteotomy Procedures – Coded 28306. This procedure is done at the base of the 1st Metatarsal for severe Metatarsus Primus Varus of more than 15 degrees. The procedure may be done with or without lengthening, shortening or angular correction of the metatarsal. If the procedure involves a separate incision at a more proximal anatomic area, use a –59 Modifier. If the procedure is done at the 1st metatarsal with an autograft to correct the alignment of the 1st metatarsal shaft and it is attached with wire or screws, use code 28307. If the procedure is done on a metatarsal other than the 1st metatarsal, use the 28308 code for *each* toe. Use code 28309 for multiple toes. These codes are alternative procedures to codes 28111, 28112, 28113 and 28288.

Arthrodesis Procedures – For an Arthrodesis of the Great Toe of the Metatarso-phalangeal Joint, use code 28750, which is done for arthritic changes at the 1st MTP joint associated, with severe Hallux Valgus. If the Arthrodesis is performed on the Interphalangeal Joint of the Great Toe, use code 28755.

Other Foot Procedures

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

- CPT code 28113 – Ostectomy with complete excision of the 5th Metatarsal Head
- CPT codes 28230-28234 – Tenotomy Procedures for the flexor or extensor tendons
- CPT codes 28270 – Capsulotomy, metatarsophalangeal joint, with or without a tenorrhaphy. This is designated as a "Separate Procedure" in the CPT book and may require a -59 Modifier

- CPT code 28280 – Syndactylization of the Toes is performed to close an abnormal gap in the toes
- CPT code 28285 – Hammertoe Correction – when this procedure is performed on a toe other than where a Bunionectomy is performed, it is billable. It is very important to append the appropriate Toe Modifier, to indicate the Hammertoe procedure was done on a separate toe from other procedures (especially Bunionectomy procedures, from which it is Unbundled)
- CPT code 28286 – Cock-up 5th Toe Deformity corrects the bones of the 5th toe from pointing upward
- CPT code 28288 – Ostectomy, partial, exostectomy or condylectomy, metatarsal head – bill for each metatarsal head and use the Toe Modifiers
- CPT code 28645 – Open Treatment of MTP Joint dislocation, with or without internal or external fixation.
- Incision & Drainage below the fascia, with or without tendon sheath involvement of the foot, is coded with CPT code 28002 in the single bursal space, and 28003 for multiple areas.
- Incision of the bone cortex of the foot for Osteomyelitis or a bone abscess is coded as 28005.
- Use CPT code 28008 to report a Fasciotomy of the Foot and/or Toe (also called a Percutaneous Plantar Release), which is a Correction of a Flexion Contraction of the Foot or Toe. Use code 29893 for an Endoscopic Plantar Fasciotomy procedure.
- Plantar Fasciectomy procedures are coded using CPT codes 28060 for a partial procedure, and 28062 for a radical procedure. These codes are considered Separate procedures, and they may be Unbundled from other procedures done at the same surgical session. If the procedure is performed in a separate area from a code from which it is listed as Unbundled, append a –59 Modifier and bill it anyway, and enclose the OP Report with the claim.
- Excisions of Tumors in the subcutaneous tissue of the foot are coded as 28043, with those excised from deep tissue, subfascial or intramuscular tissue would be coded using code 28045.
- Excisions of Interdigital Neuromas (also called Morton Neuromas) are coded as 28080 for the single excision of each neuroma. Use –RT or –LT (not Toe) Modifiers on these codes.
- For Cysts or Ganglions, use code 28090 for an Excision of Lesion, Tendon Sheath, or Capsule (which includes a Synovectomy) of the Foot, which may be done for cysts or ganglions. For the same procedure of the toe(s), use code 28092 for each toe.
- Use code 28104 for Excision or Curettage of a Bone Cyst or Benign Tumor of the Tarsal or Metatarsal (which does not include the Talus or Calcaneus).

Ostectomy Procedures

- Use code 28110 for those procedures involving a partial excision of the 5th metatarsal head (also called a Bunionette or Tailor's Bunionectomy procedure). This is designated as a "Separate Procedure" in the CPT book.

- Code 28111 is for a complete excision of the 1st metatarsal head.
- Code 28112 is used for a complete excision of other (2nd, 3rd, or 4th) metatarsal head.
- Code 28113 is used for a complete excision of the 5th metatarsal head. This code has two alternative codes to check (select the most appropriate code for the procedure performed) – codes 28288 and 28308.
- Code 28114 is for the complete excision of all metatarsal heads, done with a partial proximal phalangectomy, but excluding the 1st metatarsal – this procedure is also called a Clayton type procedure).
- An Ostectomy involving the calcaneus is coded using code 28118. This procedure is performed for Bone Spurs, which is also known as Haglunds or "pump bumps".
- For Bone Spurs on the bottom of the heel, use code 28119 for an Ostectomy of the calcaneus done with or without a plantar fascial release.
- Use code 28288 for a Partial Ostectomy, Exostectomy or Condylectomy of the metatarsal head. Code it once for each metatarsal head. This code has two alternative codes to check (select the most appropriate code for the procedure performed) – codes 28113 and 28308.
- Code 28122 is used for a partial excision of the tarsal or metatarsal bone. These procedures can be done by craterization, saucerization, sequestrectomy, or diaphysectomy technique. This code does not include the talus or calcaneus areas – for these areas, use code 28120.
- Use code 28124 for a Partial Excision of the Phalanx of the Toe procedure.
- A Reconstruction or advancement procedure of the posterior tibial tendon (which includes an excision of the accessory tarsal navicular bone) is coded as 28238. This procedure if often referred to as a Kidner type of procedure.

- Tenotomy Procedures

  - Code 28230 is for an Open Tenotomy procedure of the flexor tendon of the foot, involving single or multiple tendon(s). This code is considered a Separate procedure.
  - Use code 28232 for an Open Tenotomy procedure of the flexor tendon of the toe for a single tendon (also a Separate procedure).
  - Use code 28234 for an Open Extensor Tenotomy of the foot or toe for a division of the extensor tendon. Code it once for each tendon. This procedure may be done for a repair of a hammertoe. This is also called a release of the extensor tendon. If this procedure is done in conjunction with a Hammertoe (28285) procedure, it would be considered bundled and should not be billed separately (even with a –59 modifier), unless it is done at a different anatomical site.
  - A Tenotomy done for lengthening or release of the Abductor Hallucis muscle is coded as 28240. This procedure is done to help correct the alignment of the big toe involving a bunion.

- Steindler Stripping - use CPT code 28250 for a Steindler Stripping procedure, which is usually performed for high arches. It is designated as a "Separate Procedure".

- Capsulotomy procedures:

  - Use code 28260 for a Capsulotomy procedure of the Midfoot with a Medial Release. This is a Separate procedure. If the procedure is performed with unrelated procedures/ services, it can be billed with a –59 Modifier.
  - For a Capsulotomy of the Midfoot performed with Tendon Lengthening, use code 28261.
  - A Midtarsal Capsulotomy procedure is coded using CPT code 28264, and may be referred to as a Heyman type procedure.
  - A Metatarsophalangeal Joint Capsulotomy procedure (each joint) done with or without Tenorrhaphy is coded as 28270. It is a Separate procedure. This code is used is the joint capsule released lies between the tarsal and the toe. If this procedure is done in conjunction with a Hammertoe (28285) procedure, it can be billed separately (with a –59 modifier), as long as it is performed through a separate incision.
  - Capsulotomy procedures of the Interphalangeal Joint are billed using code 28272 for each joint. It is a Separate procedure. This code is used is the joint capsule released is between the small bones of the toe. This procedure is often performed to correct Club Foot deformities. If this procedure is done in conjunction with a Bunionectomy procedure, it would be considered bundled and should not be billed separately (even with a –59 modifier), unless it is done on a separate toe (in which case, use the appropriate Toe Modifier).

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

  - Interphalangeal Fusion – 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.
  - Filleting (also called waste resection) of the Proximal Phalanx – involves a sub-periosteal resection of the phalangeal shaft, closure of the periosteum, and a manual correction of the metatarsophalangeal extension deformity and proximal interphalangeal joint flexion deformity.
  - 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** on the 28285 code when the Hammertoe procedure is performed on a **different toe** from the toe upon which the bunion procedure is performed.*

- Cock-up 5th Toe Corrections done with plastic skin closure (also called Ruiz-Mora type procedures) are coded using code 28286.
- A Hallux Rigidus or Cheilectomy Correction procedure with debridement and capsular release of the 1st metatarsophalangeal joint is coded as 28289.
- The Swanson Type Cavus Foot Osteotomy Procedure is done for patients suffering from High Arches, and the surgeon performs osteotomies on the metatarsal bones of the foot. It is coded as 28309. The procedure may be done with or without shortening, lengthening, or angular correction of the metatarsal. It is a multiple digit procedure.
- An Osteotomy performed by the Shortening, Angular or Rotational Correction of the Proximal Phalanx of the 1st Toe is coded as 28310. It is a Separate procedure. If the procedure is performed on any toe other than the 1st toe, use code 28312.
- Sesamoidectomy procedures are coded using code 28315 for the 1st Toe. It is a Separate procedure. It is often performed during a Bunion correction surgical procedure (in which case it is NOT separately-billable). This procedure involves removal of the sesamoid bone, which lies under the metatarsal heads of each toe.
- Subluxations of the Foot are partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles. Medicare does not pay for surgical or non-surgical treatment which has "the sole purpose" of correcting this problem. Medicare will reimburse for:
  - Surgical correction of a subluxated foot structure when this is part of the treatment of a foot injury.
  - Surgical correction of a subluxated foot structure to improve the function of the foot.
  - For the diagnosis and treatment of "symptomatic conditions" such as tendinitis, bursitis, osteoarthritis, and bunions, which result from the partial displacement of foot structure.

Shock Wave Therapy

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

Arthroscopic Procedures

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

When both a Diagnostic and Surgical Arthroscopy procedure are performed in the same Joint area, the Diagnostic Arthroscopy is included in the Surgical Arthroscopy, and would not be billed separately. For procedures involving both an Arthroscopy and an Arthrotomy, both may be billed, as long as the procedures are in different compartments

for different diagnoses, and the OP Note clearly documents this fact. Those CPT codes which list the procedure as being performed "by any method" may be used for either open or arthroscopic procedures. Those procedures performed arthroscopically for which there is no specific CPT code should be billed with the Unlisted CPT code from the Arthroscopy section, and it is advisable to send the OP Report with the claim. Coding an Open Procedure for an Arthroscopic one is considered Fraudulent by Medicare.

Shoulder Procedures

Shoulder Anatomy

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

The three bones which make up the shoulder are the clavicle (collarbone), humeral head (upper arm bone), and the scapula (shoulder blade), which meet at the top of the shoulder joint. The scapula is an unusually-shaped bone, which extends up and around the shoulder joint in the back and over the shoulder joint, creating a "roof" at the shoulder joint (called the acromion), and around the front to the coracoid process. The clavicle forms the front of the shoulder girdle and extends from the sternum to the scapula. The humeral head is joined to the scapula in the glenohumeral joint, which is a ball-and-socket type of joint. The *ball* (the head of the humerus) fits into the part of the scapula known as the *socket* (or glenoid), which is lined with the labrum. The labrum is a ring of fibrous cartilage that makes the glenoid more "cuplike". The capsule, which is lined with synovium, encircles the glenohumeral joint. It is these muscles, tendons, and ligaments that hold the shoulder bones in place. It is a complicated structure, which can experience problems that can cause patients to have impingement, weakness and/or tingling extending down the arm, limited motion, and severe pain.

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

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

Shoulder Manipulations

Manipulations (code 23700) should only be billed when it is the only procedure performed. If a surgical arthroscopy is performed on the same joint, the Manipulation should not be billed.

Rotator Cuff Tears

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

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

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

1. When the physician performs multiple or extensive releases during the procedure
2. If the physician performs mobilization during the rotator cuff release
3. When a fascial graft or synthetics are used in the repair
4. A large tear with extensive retraction

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

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

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

Acromioclavicular Conditions

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.

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.

Topaz Procedures

The AAOS directs that when a Modified Lateral Epicondylar Release procedure is performed with the Topaz Thermal Cautery device, the 24351 code is to be used.

Synovectomy Procedures

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

Instability of the Shoulder Joint

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

For an arthoscopic repair to the capsule, code 29806 would be used. If the repair performed is an arthoscopic Thermal Capsulorrhaphy, the unlisted arthoscopic 29999 code, would be used. There are 6 codes for OPEN capsular repairs: Codes 23450, 23455, 23460, 23462, 23465, or 23466. The open shoulder codes are specific for anterior, posterior, or multi-directional instability, so read the code descriptors carefully.

SLAP Tears

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

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

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

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

Clavicle Procedures

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

Shoulder Debridements

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

Post-Operative Shoulder Surgery Pain Control

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 to Medicare (and some other payors).

- The Injection/Catheterization procedure must be performed by a *different physician* (usually the anesthesiologist) from the surgeon who performs the Shoulder 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).
- If there is a separate report for the Injection/Catheterization procedure and the Injection/Catheterization procedure was performed by a different physician, you may bill for the Injection/Catheterization procedure. Use a different claim form from the Shoulder surgery procedure and bill the Injection/Catheterization procedure claim in the name of the anesthesiologist (or other physician) who performed the Injection/Catheterization procedure.
- Codes for billing Injection/Catheterization post-operative pain procedures:
    1. 64415 – Brachial Plexus Block (also use this code for an Interscalene Block) for a Single Injection
       OR
    2. 64416 – Brachial Plexus Infusion by Catheter

  It is not necessary to use a -59 Modifier on the code.

  Medicare has recently 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 with a Catheter would be used.

Tenodesis Procedures

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

- Use code 23430 for an Open Tenodesis of the long tendon of the biceps.

- Use code 29828 code (released by the AMA for 2008) for an Arthroscopic Shoulder Biceps Tenodesis procedure.

Use the 29828 code for Biceps Tendon Repairs of tears, tendinosis, and subluxation conditions.

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

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

Knee Procedures

Knee Anatomy

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

- Knee Joint Manipulations procedures (code 27570) should only be billed when it is the only procedure performed. If a surgical arthroscopy is performed on the same joint, the Manipulation should not be billed.
- Lateral Releases performed Arthroscopically should be billed with code 29873. The Open Lateral Release is coded 27425.
- If CPT codes 29875-29881 are billed, and the surgeon also performs Arthroscopic Removal of Loose or Foreign Bodies (CPT code 29874) in the same compartment, the 29874 code would be considered bundled and not separately billable. If the 29874 procedure occurred in a different compartment, it might be separately-billable with a –59 Modifier or the G0289 code for Medicare. The G0289 code is not presently on the Medicare list of covered procedures.

- **Synovectomy Procedures**

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

- **OATS Procedure** – Use code 29866 for an Arthroscopic Osteochondral Autograft. Use code 29867 for an Arthroscopic Osteochondral Allograft. Use code 29868 for an Arthroscopic Meniscal Transplantation procedure. A Mosiacplasty procedure is coded using the OATS procedure codes.

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

- **Meniscus Procedures**

  - Meniscectomy procedures are performed for Meniscal Tears. A motorized cutter or shaver is used through the arthroscope to remove the meniscus in either the Medial OR Lateral Compartments of the Knee and is billed with code 29881.

- If a Meniscectomy procedure is performed in both the Medial AND Lateral Compartments arthroscopically, use code 29880.

- Meniscal Repairs are billed with code 29882 for an arthroscopic repair in the Medial OR Lateral Compartment. If an arthroscopic Meniscal Repair is performed in both the Medial AND Lateral Compartments, it is coded 29893.

- 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.

- **ACL Repairs/Reconstructions**

  Acromioclavicular Clavicular Ligament (ACL) Repair 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.

  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.

  There is no code for a Re-do ACL Reconstruction procedure – thus, the 29999 Unlisted code should be used. Unlisted codes are not covered by Medicare.

- The 29884 Knee Arthroscopy with **Lysis of Adhesions** procedure may be performed with or without manipulation of the knee. The manipulation is done to break up any additional adhesions. This code is also designated as a "Separate Procedure", thus it should not be billed separately, if performed with another major knee procedure.

- **Capsular Shrinkage** – There is not a specific CPT code for Arthroscopic Medial Capsular Shrinkage procedures. The Unlisted CPT code for the Arthroscopy section of 29999 should be used to bill this procedure, and include the OP Report with the claim. Unlisted codes are not covered by Medicare.

Leg and Ankle Procedures

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

- **Arthroscopic Ankle procedures**
  - Codes for Arthroscopic Ankle procedures performed in the Tibiotalar and Fibulotalar Joints:
    - Use code 29894 for an Ankle Arthroscopy for the Removal of Loose or Foreign Bodies in the Tibiotalar and Fibulotalar Joints
    - Use code 29895 for an Ankle Arthroscopic Partial Synovectomy in the Tibiotalar and Fibulotalar Joints
    - Use code 29897 for an Ankle Arthroscopic Limited Debridement in the Tibiotalar and Fibulotalar Joints
    - Use code 29898 for an Ankle Arthroscopic Extensive Debridement in the Tibiotalar and Fibulotalar Joints

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

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

Elbow/Wrist Procedures

- Cubital Tunnel Release (which is a Neuroplasty of the ulnar nerve at the elbow) procedures are coded 64718.
- A Radial Repair of the lateral collateral ligament at the elbow is coded 24343.
- An Ulnar Repair of the medial collateral ligament at the elbow is coded 24345.

- Elbow Codes for the Treatment of Epicondylitis (also called Tennis Elbow)
  In 2008, the AMA deleted the 5 codes previously used for the treatment of Epicondylitis (codes 24350-24356) and replaced them with 3 new codes.
  - The 1st code is 24357 for a Percutaneous Tenotomy of the Proximal Extensor Carpi Radialis Brevis Tendon at its insertion in the Elbow, which can be performed on the lateral (or outer) side or the medial (inner) side of the elbow. During this procedure, the surgeon makes a small incision and uses a needle to break up the abnormal fibrotic tissue on the tendon to stimulate new blood flow and healing.
  - The 24358 code is for the Open Debridement of soft tissue and/or bone in the Elbow. Use this code when the surgeon removes damaged soft tissue and sometimes bone, which would be billed for an Epicondylectomy.
  - The 24359 code is similar to the 24358 code, except that in addition to the Open Debridement of soft tissue and/or bone, the surgeon also repairs the affected tendon or does a tendon reattachment, which would be billed for an Epicondylectomy performed with a tendon repair/reattachment.

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

- Guyon's Canal procedures (which is a Neuroplasty of the ulnar nerve at the wrist) are coded 64719.
- Carpal Tunnel Procedures - It is important to distinguish Carpal Tunnel Release procedures between those performed Endoscopically (use CPT code 29848) and those done by Open Repair (use CPT code 64721). If an Injection is performed, use code 20526 for a Therapeutic Injection of the Carpal Tunnel area.

QUESTIONS?

6/08

RESOURCES

National Uniform Billing Committee Official UB-04 Data Specifications Manual 2008
Ingenix's *2008 ICD-9-CM for Hospitals, Vols. 1, 2, & 3 Coding Expert*
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*
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*
UCG *Part B News*
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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' First 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
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.
HMI's CPT Coding Seminar Material
FASA published seminar material (specifically-referenced) and coding guidance
CIGNA Medicare Bulletins and LCDs
Lessons on Coding for ASCs FASA CPT Coding Seminar
AMA's *CPT 2008 Professional Edition*
AAOS Bulletin Article "Accurately Code Shoulder Procedures" by Robert Haralson, III, MD, MBA, Richard Friedman, MD, & Margie Vaught, CPC, CCS-P, ASC-OR, MSC-P
AAOS *Global Service Data for Orthopaedic Surgery, Volumes 1 & 2*

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