Orthopedic Coding Alert

Your practical adviser for ethically optimizing coding, reimbursement, and efficiency for orthopedic practices

December 2011, Vol. 14, No. 12 (Pages 81-88)

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CPT® 2012 Update

Arthrodesis, Laminectomy, Limb Compression, And Palmar Injections Top Your 2012 Changes List

Equip yourself with new codes and revisions

With the 2012 codes being applicable, you will need to know the new and the revised codes to ensure you report correct and earn your deserved payment. You will need to be specifically careful in reporting the procedures and practices that have revised or new codes. Some of the new codes include those for palmar enzyme injections, lumbar arthrodesis, and limb compression.

Report Enzyme Injection in Palm

CPT® introduces a new code for palmar enzyme injections. Your surgeon may report a painless thickening and contracture of tissues beneath the skin in the palmar surface of the hands and fingers. Not all fingers may be involved. In addition your surgeon may document that the finger(s) were bent due to contraction of the skin and underlying tissues. This condition is called Dupuytren’s contracture. The cause of the contraction is not usually known. “A non-operative option to treat this is exercises and splints, but more severe contractures have often needed surgical release in the past, in which surgery is done to release the contracted fascia and other soft issues,” says Bill Mallon, MD, medical director, Triangle Orthopedic Associates, Durham, N.C. A newer approach is collagenase injections given locally into the scarred or fibrous tissue. The enzymes breakdown the fibrosis and ease the contracture. You report these injections as 20527 (Injection, enzyme [eg, collagenase], palmar fascial cord [ie, Dupuytren’s contracture]).

Report Lumbar Arthrodesis

Make sure you use new codes when reporting lumbar arthrodesis. When your surgeon does an arthrodesis adopting a posterior approach in a single interspace of the lumbar segment, you will report this with 22633 (Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace [other than for decompression], single interspace and segment; lumbar). For every additional interspace or segment, you report +22634 (each additional interspace and segment [List separately in addition to code for primary procedure]).

Limb Compression Has New Codes

The application of wound compression systems will become more site specific in 2012. The venous compressions are done for varicose veins, postphlebitis syndrome, atherosclerosis, chronic venous hypertension, or stasis ulcers in the...
There are ten codes you can choose from when you report spinal instrumentation:

1. Insertion, Removal, And Reinsertion Of Spinal Instrumentation

- **22840** — Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) [List separately in addition to the code for primary procedure]

**Report the Percutaneous Spinal Procedures**

Percutaneous decompression of spinal nerves has a new code. You report this irrespective of the laterality, number of levels, or endoscopy. When your surgeon adopts a percutaneous, fluoroscopic, or endoscopic approaches for a unilateral or bilateral laminotomy or laminctomy to decompress the neural elements, you report 0274T (Percutaneous laminotomy/laminctomy [interlaminar approach] for decompression of neural elements, [with or without ligamentous resection, discectomy, facetectomy, and/or foraminotomy], any method, under indirect image guidance [e.g., fluoroscopic, CT], with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic) for the procedure in the cervical or thoracic spine, and 0275T (lumbar) that in the lumbar spine.

**Editor’s note:** Look for more CPT® 2012 orthopedic coding updates and specific instructions in upcoming issues of Orthopedic Coding Alert. 

**Coding Strategies**

**Here’s How to Confidently Code For Insertion, Removal, And Reinsertion Of Spinal Instrumentation**

**Approach, span and devices influence your claim**

If your surgeon provides spinal instrumentation services, you’ll need to identify what instruments were used and whether the physician removed and reinserted the instrumentation. Brush up on your spinal instrumentation coding skills — and improve your claim results for these services by following some important tips.

**Look for Device Your Surgeon Places**

When your surgeon places wires, screws, rods, or any other instruments, you can efficiently select the appropriate code if you know the approach and fixation points.

There are ten codes you can choose from when you report spinal instrumentation:

- **22840** — Posterior non-segmental instrumentation (e.g., Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) [List separately in addition to the code for primary procedure]

**Orthopedic Coding Alert** (USPS 019-035) (ISSN 1524-5756 for print; ISSN 1947-6833 for online) is published monthly 12 times per year by The Coding Institute, LLC 2222 Sedwick Drive, Durham, NC 27713. ©2011 The Coding Institute. All rights reserved. Subscription price is $249. Periodicals postage is paid at Durham, NC 27705 and additional entry offices. POSTMASTER: Send address changes to Orthopedic Coding Alert, 2222 Sedwick Drive, Durham, NC 27713.
Count Fixation Points in Posterior Approach

Once you confirm the posterior approach, the next step is to determine if the device is segmental (22842-22844) or nonsegmental (22840). For this portion, you count the fixation points.

Irrespective of the span, if the instrumentation is done to only two vertebral segments, you consider the instrumentation to be non-segmental and report code 22840. If, however, the instrumentation involves three or more vertebral segments, the instrumentation is considered segmental.

“In order for instrumentation to be considered segmental, there must be a proximal fixation point and a distal fixation point with at least one intervening fixation point,” confirms Stout. “A pedicle screw construct that runs from L2 to S1 with screws placed at all intervening levels constitutes 5 segment instrumentation and is reported with code 22842. On the other hand, if a rod and screw construct spans L2 to S1 but no screws are placed at any intervening level, this is non-segmental fixation and is reported with code 22840,” she adds.

Confirm Removal of Vertebral Portions

Your surgeon may remove a portion of the vertebra and may have used a metal cage or other prosthetic device to stabilize the area. You specifically report this as code 22851.

Remember: When reporting 22851, you count the spinal units and not the instruments. If the surgeon uses multiple devices at one level, you report only a single unit of 22851. If, however, the surgeon places devices at more than one spinal level, you report one unit of 22851 for each individual spinal level.

Example: If your surgeon places two cages at T4-T5, you report one unit of 22851. However, if your surgeon places one cage at T3-T4 and two cages at level T5-T6, you report 22851 x 2.

Distinguish Instrumentation Removal

There are different codes you choose from when your surgeon is removing the spinal instrumentation. You can report the instrumentation removal if the surgeon removes the instrumentation for damage or rejection. You can also report the instrumentation removal if your surgeon did it to adjust the instrumentation. If, however, the surgeon does the removal to explore the spinal fusion, you cannot report the instrumentation removal.

(Continued on next page)
You select from the following codes when reporting the instrumentation removal:

- 22850 — Removal of posterior nonsegmental instrumentation (e.g., Harrington rod)
- 22852 — Removal of posterior segmental instrumentation
- 22855 — Removal of anterior instrumentation.

Report Reinsertions

Your surgeon in some instances like a repeat fusion may reinsert the instrumentation after the procedure is complete; in this case, you would report 22849 (Reinsertion of spinal fixation device).

Be Careful with Modifiers

Confirm with your payer which modifiers are approved for spinal instrumentation services, as not all may be accepted. Some will permit modifier -59 (Distinct procedural service) to the ‘additional’ unit(s) to demonstrate that the surgeon did the instrumentation at separate anatomic location(s).

**Example:** If your surgeon places one cage at T3-T4 and two cages at T5-T6, you report 22851 x 2 and append modifier -59 depending upon your payer. “In this scenario, CPT® advises reporting the cages placed at different spinal interspaces as two line items, 22851 and 22851-59,” says Stout.

ICD-10 Update

**Look For Regions To Report Radiculopathy**

Single ICD-9 code spans to four codes in ICD-10.

Radiculopathy is site-specific for spinal regions in ICD-10. To ensure that your surgeon will be ready when the Oct. 1, 2013 deadline hits, you can reinforce the need for specific region notes in the documentation. Make sure your surgeon mentions the involvement of one or more cervical, thoracic, lumbar or sacral regions.

**Review Anatomical Locations**

The spine is divided into five regions, namely the cervical, thoracic, lumbar, sacral, and coccygeal regions. There are 33 vertebrae that encase the spinal cord. These include the 7 cervical (C1-C7), 12 thoracic (T1-T12), 5 lumbar (L1-L5), 5 sacral (S1-S5), and 4 coccygeal bones (Figure 1).

The last two are fused together and the rest are separated by intervertebral spaces. The coccyx is also called the tail bone. The nerves emerge in the intervertebral spaces and the initial segment of the nerves close to the site of their origin from the spinal cord is called ‘nerve root’. There are 31 pairs of spinal nerve roots.

**Look For the Anatomical Region(s) Involved**

One or more nerves may be inflamed, compressed, or may suffer a compromise in blood supply. This leads to neuropathy in one or more segments called radiculopathy. This may result in pain in the region that is supplied by the individual nerves.
When you report the code(s) for the radiculopathy, you should look for the region involved. The anatomical localization of the neuritis is your best guide.

The regions may overlap though the nerve roots are discrete. You may often come across a numerical representation in your surgeon’s notes. For example, your surgeon may report the involvement of the nerve roots at the junction of the last lumbar and first sacral region as L5-S1. In this case, you would report the lumbosacral regional involvement.

ICD-10 Has 4 Specific Codes

In ICD-9, the code that you use to report radiculitis is 724.4 (Thoracic or lumbosacral neuritis or radiculitis, unspecified). This sole code covers the radiculopathy in the thoracic, lumbar, and sacral regions. In ICD-10, there are four codes that are used for the specific involved region. These are as follows:

- M54.14 (Radiculopathy, thoracic region)
- M54.15 (Radiculopathy, thoracolumbar region)
- M54.16 (Radiculopathy, lumbar region)
- M54.17 (Radiculopathy, lumbosacral region)

Remember: Code 724.2 (Lumbago) refers to lumbago or low back pain. You should never have that overlap with M54.17. Though radiculopathy in the lumbosacral region can present as low back pain, it is important that you determine the cause of the low back pain. Low back pain has myriad causes like degeneration of spine, compression due to lesions like a cancerous growth, and many more.

“In addition, lumbago as a code cannot be used for surgical procedures as insurance companies will deny payment for that diagnosis,” says Bill Mallon, MD, medical director, Triangle Orthopedic Associates, Durham, N.C.

You Be the Coder

Simplify Reporting of Rotator Cuff Repair

Question:
Can we report 29827 with modifier -22 (Increased Procedural Services:...) or -52 (Reduced Services:...) for “partial rotator cuff repair.” The operative note is as follows:

……the greater tuberosity was debrided as was the rotator cuff and old suture material was removed. Anchors were placed in the greater tuberosity. Sutures were passed and tied affecting a nice repair of the anterior portion of the rotator cuff to about the posterior 1/3 of the supraspinatus. The posterior 1/3 of the supraspinatus and subscap were not repairable. The shoulder was then irrigated and wounds were closed.”

New York Subscriber

Answer: See page 87.
Modifier Mythbuster: Clean Up Your Modifier 24 Claims By Learning the Truth About 5 Common Myths: Part 1

Focus on the surgeon’s documentation, not the appointment book.

If you want to ensure you get paid for services your orthopedic surgeon performs after a major procedure while you’re still billing in the global period of the procedure, you need to know the ins and outs of modifier 24 (Unrelated evaluation and management service by the same physician during a postoperative period:…). Even seasoned billers struggle with this modifier at times.

Overcome modifier 24 claim challenges by busting five myths that will lead to denial after denial if you fall into their billing trap. In part one of this two-part series, we’ll bust the first two myths about when you should use modifier 24.

Myth #1: Modifier 24 Applies To Any Service Done In the Post-Op Period

You should only append modifier 24 to an appropriate E/M code when an E/M service occurs during a postoperative global period for reasons unrelated to the original procedure. Modifier 24 tells the payer that the surgeon is seeing the patient for a problem unrelated to surgery. Therefore, the plan should not include the E/M service in the previous procedure’s global surgical package.

Modifier 24 is “only for use on E/M codes, and only for use during the post-operative period (10 days or 90 days),” says Joseph Lamm, office manager with Stark County Surgeons, Inc. in Massillon, Ohio.

“The very definition of the modifier states it plainly: ‘unrelated evaluation and management service,’” points out Charlotte T. Tweed, RHIA, CPC, coding auditor and inpatient/surgery coder in the department of medical education/coding at Florida Hospital in Orlando.

Rule: You cannot bill separately for E/M-related services relating to the original surgery during the global period. The global surgical package includes routine postoperative care during the global period.

Additionally: Modifier 24 only applies to services your physician performs after the surgical procedure. “If your physician performs an E/M service “before a procedure, on the day of that procedure, you would need a 25 (Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service:…) modifier (for minor procedures) or the 57 (Staged or related procedure or service by the same physician during the postoperative period:…)) modifier (for major procedures),” Lamm explains. “The 57 (Decision for surgery) modifier also applies to E/M codes done the day before the major procedure. This is true provided that the E&M code is significant and separately identifiable.”

Myth #2: Scheduled Office Visit Rules Out Modifier 24

Just because a patient was scheduled to come into your office for a follow-up visit related to the surgery, you shouldn’t automatically assume you’re unable to bill separate services using modifier 24.

Example: The surgeon removes a lump near the knee and later confirms the outgrowth to be a sarcoma of the bone. When the patient comes back in to the office for review, the surgeon does an extensive E/M service/office visit with the patient to discuss.

In this case, you “should be able to use modifier 24 to describe an E/M service unrelated to the surgery (only related to the disease process),” says Marcella Bucknam, CPC, CCS-P, CPC-H, CCS, CPC-P, COBGC, CCC, manager of compliance education for the University of Washington Physicians Compliance Program in Seattle. “CPT® would always allow this but even Medicare states that care directed at the underlying disease process is separately billable in the global period.

Key: Even though the visit initiated (was scheduled) as follow-up for surgery (i.e., for the sutures) you shouldn’t think modifier 24 is out of the question. “People put too much emphasis on how a visit was scheduled,” Bucknam says. “No one typically sees your clinic schedule. It’s the documentation that counts. Additionally, no one would think that they shouldn’t bill separately if the patient came in for follow up and also had a broken finger! It’s the same thing, just more subtle.”

Stay tuned: In the next issue of Orthopedic Coding Alert you’ll learn the truth about three more modifier 24 myths and how you should properly use this modifier.
Reader Questions

Report Triceps Tendon Rupture

Question: How do we report a triceps tendon rupture?
Georgia Subscriber

Answer: You report 840.8 (Sprain of other specified sites of shoulder and upper arm) or 727.69 (Nontraumatic rupture of other tendon) for a rupture of triceps tendon.

Select One Code for Arthroscopy in Each Knee Compartment

Question: Our surgeon did an arthroscopic medial meniscus repair and lateral meniscectomy. The scrub on the billing service we use indicates that I need a modifier on 29882 (Arthroscopy, knee, surgical; with meniscus repair ([medial OR lateral]) because it is a component of 29881 (Arthroscopy, knee, surgical; with meniscectomy ([medial OR lateral, including any meniscal shaving])), however, 29882 is higher RVU. How do we report this? Is it not incorrect to have a 59 (Distinct Procedural Service:...) modifier on the primary procedure?
Florida Subscriber

Answer: If your payer follows Medicare NCCI guidelines, you will need modifier 59 on code 29882 as this is considered “mutually exclusive” to code 29881. Only one code is allowed for arthroscopy in each compartment. You cannot report two codes in the medial compartment. Also 29881 and 29882 are bundled together; you can’t do both together. In this case, since the surgeon is doing a meniscus repair, you should report 29882.

Lateral Release is Inclusive in Patellar Reconstruction

Question: For right knee patellar dislocation, tear medial patellofemoral ligament with hemarthrosis, our surgeon did right knee arthroscopic lateral release, open repair of the avulsion, medial patellofemoral ligament, VMO reefing, and evacuation of hematoma. The operative note is as follows: “An arthroscopic lateral release was performed in standard technique using electric Bovie cautery. With this completed, it was then subluxed only 25% and less tilted. The medial patellofemoral ligament avulsion was identified and debrided and a 3-cm incision longitudinally was made hugging the medial side of the patella, dissected down, found the avulsed fragment debrided. Two anchors were placed 2.9 absorbable at the corners, double loaded and the medial patellofemoral ligament avulsion piece was repaired down to bone. Superior VMO reefing was performed, absorbable sutures and then absorbable for the skin, portals nylon. After the repair, arthroscopy showed the patella was well seated.”
Can we report 27422 (Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release [e.g., Campbell, Goldwaite type procedure]). Is code 29873 (Arthroscopy, knee, surgical; with lateral release) bundled with 27422? Does 27422 also include the repair of patellofemoral ligament?
Alaska Subscriber

Answer: You report only 27422 as lateral release is inclusive to this code. This also includes the repair of the medial patellofemoral ligament.

Do Not Report Casts Independently

Question: When correcting club feet by releasing the Achilles and then applying the cast do we need a 59 modifier to bill both. Would the casting be considered separate treatment since a cast is part of the treatment not just part of the surgery?
New York Subscriber

Answer: You will not append modifier 59 to report the cast application with the release procedure. Cast is a part of the postoperative dressing and care and is always a part of the Global Service Data Package.

— Reader Questions and You Be the Coder were reviewed by Heidi Stout, BA, CPC, COSC, PCS, CCS-P, Coder on Call, Inc., Milltown, New Jersey and director of orthopedic coding division, The Coding Network, LLC, Beverly Hills, CA and Dr. Bill Mallon, MD, orthopedic surgeon and medical director at Triangle Orthopedic Associates in Durham, N.C.

You Be the Coder

Simplify Reporting of Rotator Cuff Repair

(Question on page 85)

Answer: You report 29827 (Arthroscopy, shoulder, surgical; with rotator cuff repair) regardless of how many tendons of the rotator cuff are repaired. The rotator cuff repair remains simple even if not fully repaired, so modifier -22 may not be appropriate for every situation. You append modifier 22 only if your surgeon has adequately documented the procedure to be extraordinarily complex.
Orthopedic Coding Alert

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to Orthopedic coding and reimbursement to the Editor indicated below.

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