

ORTHOPEDIC CODING ALERT

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

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CCI 16.1:

Think You Can Never Report Fluoro With Ortho Procedures? Think Again

▶ ***This deletion could add \$69 to your practice's bottom line—but make sure you adhere to this criteria.***

If claims involving fluoroscopy, anesthesia, and disc procedures often land on your desk, then you should pay attention to the more than 200 orthopedic edits included in the Correct Coding Initiative (CCI) version 16.1, which went into effect April 1.

That's a fairly big chunk of the "2,054 new edit pairs, with 1,947 modifier indicator changes" you'll find in CCI 16.1, says **Frank Cohen, MBB, MPA**, of MIT Solutions, Inc., in Clearwater, Fla.

Don't be caught with a denial because you've overlooked these changes. Here's the lowdown, broken into deleted edits, new non-mutually exclusive edits, and mutually exclusive edits.

Deleted Edits Give New Coding Opps

Good news: A few deleted edits in CCI 16.1 could mean reimbursement for additional services.

Until now, using fluoroscopic guidance during hip and knee arthrography was considered standard practice. New edits allow you to report 77002 (*Fluoroscopic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device]*) in addition to three procedures:

- 27093 — *Injection procedure for hip arthrography; without anesthesia*
- 27095 — *... with anesthesia*
- 27370 — *Injection procedure for knee arthroscopy.*

Pay boost: Being able to code 77002 in addition to the injection could bring \$69.64 (or 1.93 total RVU, based on the current national conversion factor of 38.0846) to your bottom line if your physician owns the equipment, based on the national average Medicare fee. Reporting only the professional component (which you designate on your claim with modifier 26, *Professional component*) still adds \$27.06.

(continued on next page)

Watch for Ortho/Ortho Edit Pairs

Mutually exclusive edits from CCI 16.1 list some orthopedic services on both sides of the component/comprehensive equation. For example, 22856 is a component of 22802 (*Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments*), 22818 (*Kyphectomy, circumferential exposure of spine and resection of vertebral segment[s] [including body and posterior element[s]; single or 2 segments]*), and 22861.

Again, these edits carry a “1” modifier indicator, so you can override the pairing and report both services in some circumstances.

Ortho Work Is Part of Disc Procedures

While the edits involving anesthesia list the orthopedic procedure as more comprehensive, other non-mutually exclusive edits designate orthopedic services as the “less important” component service.

- Aspiration code 62267 (*Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes*) overrides several biopsy codes. These include 20220 (*Biopsy, bone, trocar, or needle; superficial [e.g., ilium, sternum, spinous*

process, ribs]), 20240 (*Biopsy, bone, open; superficial [e.g., ilium, sternum, spinous process, ribs, trochanter of femur]*), 20250 (*Biopsy, vertebral body, open; thoracic*), and similar procedures.

- Injection procedure 64455 (*Injection[s], anesthetic agent and/or steroid, plantar common digital nerve[s] [e.g., Morton’s neuroma]*) includes splint and strapping services 29515 (*Application of short leg splint [calf to foot]*), 29540 (*Strapping; ankle and/or foot*), and others.
- Disc arthroplasty code 22856 (*Total disc arthroplasty [artificial disc], anterior approach, including discectomy with end plate preparation [includes osteophylectomy for nerve root or spinal cord decompression and microdissection], single interspace, cervical*) includes manipulation 22505 (*Manipulation of spine requiring anesthesia, any region*). Similarly, related procedures 22861 (*Revision including replacement of total disc arthroplasty [artificial disc], anterior approach, single interspace; cervical*) and 22864 (*Removal of total disc arthroplasty [artificial disc], anterior approach, single interspace; cervical*) also include 22505.

Breakage allowed: CCI assigns a modifier indicator of “1” to each of these edit pairs, meaning you can override the edit by reporting the appropriate modifier (such as modifier 59, *Distinct procedural service*). For

CONTACT INFORMATION

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Remember the Difference Between ME and NME Edits

CCI edits fall into two camps: mutually exclusive and non-mutually exclusive.

Mutually exclusive edits are those where the code pair “represent procedures or services that could not reasonably be performed at the same session by the same provider on the same beneficiary,” according to CMS. Medicare will only reimburse you for the *lesser-valued* of the two procedures.

Non-mutually exclusive edits pair codes for two services that physicians often perform during the same session. CCI lists one code as the comprehensive procedure — meaning it’s considered the larger procedure — and the second code as the component, which is a piece of the comprehensive. □

example, you might see this situation if the physician performs disc biopsy at L2-L3 and needle biopsy of the iliac crest, say s **Heidi Stout, CPC, CCS-P**, director of orthopedic coding services at The Coding Network.

Arthroscopy Overrides Anesthesia

The majority of non-mutually exclusive edits for orthopedics involve anesthesia codes 01400 (*Anesthesia for open or surgical arthroscopic procedures on knee joint; not otherwise specified*) and 01402 (... *total knee arthroplasty*).

CCI 16.1 lists the anesthesia service as part of knee and upper leg procedures ranging from 27301 (*Incision and drainage, deep abscess, bursa, or hematoma, thigh or knee region*) and 27437 (*Arthroplasty, patella; without prosthesis*) to 27496 (*Decompression fasciotomy, thigh and/or knee, 1 compartment [flexor or extensor or adductor]*). A whopping 180 edits fall in this category.

Watch out: All of the anesthesia-related edits carry a “0” modifier indicator, so you cannot report the procedures together under any circumstances.

Fixation fix: Other non-mutually exclusive edits clarify that fluoroscopic guidance is part of fixation procedures 20696 (*Application of multiplane [pins or wires in more than one plane], unilateral, external fixation with stereotactic computer-assisted adjustment [e.g., spatial frame], including imaging; initial and subsequent alignment[s], assessment[s], and computation[s] of*

adjustment schedule[s]) and 20697 (... *exchange [i.e., removal and replacment] of strut, each*). □

Let Treatment Method, Digit Number Direct You to Correct Dupuytren Codes

► **Find out why “otomy” versus “ectomy” makes all the difference.**

Watch your surgeon’s documentation for clues regarding partial or complete treatment and the number of digits involved, and you’ll be on your way to clean Dupuytren contracture release claims every time.

What happens: Dupuytren contracture release involves excising contracted fibrotic bands of the palmar fascia. Surgeons can either use a standard open incision with fasciectomy (known as the McCash technique) or percutaneous fasciotomy (known as the Luck technique), says **Janet Vanderpuije** with OrthoMaryland in Baltimore.

Here’s how to break down these techniques into coding realities.

Fasciotomy Can be Open or Percutaneous

If the surgeon completes fasciotomy to treat Dupuytren’s contracture (728.6, *Contracture of palmar fascia*), check the operative notes for whether he used an open or percutaneous approach. Then, choose between 26040 (*Fasciotomy, palmar [e.g., Dupuytren’s contracture]; percutaneous*) or 26045 (... *open, partial*) and report the correct code for each finger the surgeon treats.

Extra codes: Your orthopedist can perform percutaneous or minimally invasive treatment of Dupuytren’s contracture in an office setting, which means you’ll need to report additional codes. Report 26040 for the procedure, along with the appropriate E/M choice. Because of the work involved, your most likely options are 99203 (*Office or other outpatient visit for the evaluation and management of a new patient ...*) or 99213 (*Office or other outpatient visit for the evaluation and management of an established patient ...*).

The most common type of percutaneous treatment is needle aponeurotomy, or NA. The physician uses the tip

(continued on next page)

of a hypodermic needle as a very small knife to divide the contracting cords of Dupuytren's disease.

Count Digits With Fasciectomy

Your surgeon might opt for fasciectomy to treat more extensive cases of Dupuytren's contracture. Base your codes on whether he completes a palm-only procedure or also accesses the digits:

- 26121 — *Fasciectomy, palm only, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)*

- 26123 — *Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft).*

When reporting 26123, append +26125 (... *each additional digit [List separately in addition to code for primary procedure]*) as needed. Code "26125 is an add-on code required to identify each additional digit," says **Gloria Moran**, practice manager for Jacksonville Orthopaedic Institute, University Division, in Florida.

CPT directs you to report +26125 with 26123. Because 26121 applies to palm-only procedures, you don't need codes specifically for digits.

Tip: When coding these cases, you're looking at "otomy" versus "ectomy," Moran adds. "If coders will watch for the wording, they'll know which codes to use," she says. □

Try Your Hand at This Fracture/Fixation Case Study

► *Don't trip over the service you can't report.*

Most of your orthopedic coding cases begin and end with your own physicians, but sometimes exceptions apply. Decide how you would code the orthopedist's role in this case involving an American survivor of the Haitian earthquake. Then, check our experts' advice.

The scenario: The patient suffered a compound fracture to the left tibial shaft. A Navy physician stabilized it on the transport ship and applied an external fixator. When the patient arrived at a U.S. hospital, the plastic surgeon on duty was called in to complete skin and muscle grafts. He discovered a gap between the bones in the patient's leg and thought she would need a bone graft. He called in an orthopedist who was already in the OR and had him take a look. The orthopedist consulted with the patient about needing to perform a bone graft and reset the bone. The orthopedist debrided the site and used cadaver bone to complete the graft. He placed internal fixation and reapplied external fixation (the plastic surgeon handled the grafting and closures).

The patient stayed in the hospital several days, then went to a local rehabilitation facility. She saw the orthopedist for follow-up care. The orthopedist later removed the fixator and continued monitoring her progress until she healed and returned home.

Consider Each Surgical Component

The orthopedist completed several steps during the surgery, ranging from an inpatient consultation to the bone grafting.

Consult: Report 99253 (*Inpatient consultation for a new or established patient ...*) for the initial consultation in the Emergency Room. Append modifier 57 (*Decision for surgery*).

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Fixate: Choose 27758 (*Open treatment of tibial shaft fracture [with or without fibular fracture], with plate/screws, with or without cerclage*) for the new fixator. “It’s not uncommon to do both internal and external fixation of these fractures,” says **Ruby O-Brochta-Woodward, BSN, ACS-OR**, compliance and research specialist with Twin Cities Orthopedics in St. Louis Park, Minn. “External fixation holds the fracture out to length and provides stabilization so the fracture ends are not moving around. The internal fixation would provide more stability to the graft and added compression to the fracture.”

If the surgeon had not placed internal fixation, you would append modifier 52 (*Reduced services*) to 27758.

Clean: Select 1101x (*Debridement including removal of foreign material associated with open fracture[s] and/or dislocation[s] ...*) for wound cleaning. Include modifier 59 (*Distinct procedural service*) to report the debridement in addition to the fixator application.

Graft: “From the physician’s side of billing, we can only bill for autograft, if grafting is not included in the CPT description,” says **Jacqui Jones**, office manager for an orthopedic physician practice in Klamath Falls, Ore. Because this case involves an allograft, you could only report the graft if “There was documented, substantial difficulty with the allograft,” Jones says.

Capture Possible Postoperative Services

When the patient sees your orthopedist for follow-up care, those visits are part of the surgical global period so won’t be coded separately. You might be able to code for the external fixator’s removal, however, depending on the circumstances.

You Be the Coder

Double Diagnose Heterotopic Calcification

Question: *A patient underwent AC joint reconstruction due to a chronic grade-4 joint separation with heterotopic ossification. What diagnosis should we submit?*

Arkansas Subscriber

Answer: Consider your answer, then turn to page 31 for the answer. □

“Subsequent removal of the external fixator would be billable only if this was done in the operating room under anesthesia,” explains O’Brochta-Woodward. “If the physician performed this in his office it would not be separately reportable even though he did not place the fixator.”

Code choice: If the patient returns to surgery for the fixator’s removal, report 20694 (*Removal, under anesthesia, of external fixation system*). Internal fixation can be removed, but usually is left in situ, says **Bill Mallon, MD**, an orthopedic surgeon and medical director of Triangle Orthopaedic Associates in Durham, N.C. If the internal fixation is removed, the surgeon typically does not complete it until about six months after the initial procedure. □

READER QUESTIONS

Check for Fracture Diagnosis Before Coding Repair

Question: *Our orthopedist saw a patient in the emergency department for a gunshot wound and diagnosed a metacarpal fracture. He irrigated the site and removed a foreign body. Can we also report a fracture code even though he didn’t manipulate the fracture?*

Oregon Subscriber

Answer: If the documentation lists the fracture as a diagnosis (815.xx, *Fracture of metacarpal bone[s]*), you can code fracture care along with irrigation 20103 (*Exploration of penetrating wound [separate procedure]; extremity*). If the notes document debridement, you might be able to report 11012 (*Debridement including removal of foreign material associated with open fracture[s] and/or dislocation[s]; skin, subcutaneous tissue, muscle fascia, muscle, and bone*) instead of 20103.

Watch out: When dealing with a contaminated wound, definitive fracture fixation would likely be delayed until the immediate threat of infection passes. Because of this, don’t automatically submit a closed fracture treatment code unless you have more information to guide your choices. Report a code for closed treatment without manipulation such as 26600 (*Closed treatment of metacarpal fracture, single; without manipulation, each bone*) unless the fracture required additional treatment while performing the open debridement.

Choose 27698 or 27659 for Brostrom Repair

Question: *The surgeon completed a modified Brostrom repair with repair of the peroneus brevis ligament. It appears that he only repaired the lateral side. I think the correct code is 27696, but don't completely understand the descriptor: Does "both ligaments" mean medial and lateral ligaments, or can it mean more than one lateral ligament?*

Idaho Subscriber

Answer: Many coders interpret the phrase "both collateral" in 27696's descriptor to mean medial and lateral ligaments instead of multiple ligaments on the same side. Code 27696 (*Transfer or transplant of single tendon [with muscle redirection or rerouting]; both collateral ligaments*), however, is not your best choice in this case. The more accurate code for the procedure you describe would be either 27698 (*Repair, secondary, disrupted ligament, ankle, collateral [e.g., Watson-Jones procedure]*) or 27659 (*...secondary, with or without graft, each tendon*).

Explanation: An orthopedist generally performs a Brostrom repair after longstanding ligament instability, not a recent injury. That makes the Brostrom a secondary repair. In addition, the peroneus brevis is a tendon, not a ligament.

Future reference: The lateral collateral ligaments include the anterior talofibular, calcaneofibular, and the posterior talofibular. The medial collateral ligaments (which are often called the deltoid ligaments) include the tibionavicular, calcaneotibial, anterior talotibial, and posterior talotibial.

Say No to 76003 With Paravertebral Injection

Question: *CPT 2010 states that fluoroscopy is included with paravertebral facet joint injections, but one of our physicians says we can bill it separately. What's the latest information?*

Nebraska Subscriber

Answer: You could bill 77003 (*Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures [epidural, transforaminal epidural, subarachnoid, or*

Newsletter Question or Comment?



If you have a question or comment about the contents of this publication, please contact the editor, Leigh DeLozier, CPC, at leighd@inhealthcare.com.

sacroiliac joint], including neurolytic agent destruction) in conjunction with these injections through Dec. 31, 2009, but that's no longer the case.

Changes: CPT deleted codes 64470-64476 (*Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve ...*) in favor of new additions 64490-+64492 (*Injection[s], diagnostic or therapeutic agent, paravertebral facet [zygapophyseal] joint [or nerves innervating that joint] with image guidance [fluoroscopy or CT], cervical or thoracic ...*) and 64493-+64495 (*Injection[s], diagnostic or therapeutic agent, paravertebral facet [zygapophyseal] joint [or nerves innervating that joint] with image guidance [fluoroscopy or CT], lumbar or sacral ...*). The new codes became effective Jan. 1, 2010, and include fluoroscopy, so you cannot report it in addition to the injection.

Arthro Posterior Remplissage = 29999

Question: *The orthopedic surgeon completed an arthroscopic Bankart repair and arthroscopic posterior remplissage procedure of the shoulder. What codes can I submit?*

Texas Subscriber

Answer: Arthroscopic Bankart repair is 29806 (*Arthroscopy, shoulder, surgical; capsulorrhaphy*). CPT does not have a code for arthroscopic posterior remplissage, so report 29999 (*Unlisted procedure, arthroscopy*). For reimbursement purposes, compare the procedure to 23465 (*Capsulorrhaphy, glenohumeral joint, posterior; with or without bone block*), which has a national average Medicare reimbursement of \$1,057.64 (or 29.31 total RVU, based on the current national conversion factor of 36.0846).

Separate Procedures Allow Scope and Open Codes

Question: *Our surgeon completed an arthroscopic SLAP repair, acromioplasty, and distal clavicle excision. Then he converted to an open procedure to perform rotator cuff repair. Is there any way to recoup for all the arthroscopic work before the open repair?*

Colorado Subscriber

Answer: Because the surgeon shifted from arthroscopic to open techniques to complete different procedures, you can code for everything. Report the rotator cuff repair with 23410 (*Repair of ruptured musculotendinous cuff [e.g., rotator cuff] open; acute*) or 23412 (...)

chronic) as appropriate. Then code each of the arthroscopic procedures with modifier 59 (*Distinct procedural service*).

Guideline: If the surgeon converts from an arthroscopic to open approach for the same procedure during a session, you'll only code the open approach. For example, he might start with the scope to perform debridement for better visualization, then convert to an open approach for the primary procedure. In that case, the scope work is included in the overall procedure.

Know 57/58 Difference for Surgical Return

Question: *A patient presented to the Emergency Room and the surgeon performed closed reduction and manipulation for a trimalleolar ankle fracture. The closed reduction didn't work so he returned to surgery to repair the fracture the next day. How should I code both surgeries?*

Montana Subscriber

Answer: You'll need to code for three services: the initial visit and examination, the first surgery, and the second surgery.

If the patient was treated in the Emergency Room, choose from 99283-99285 (*Emergency department visit for the evaluation and management of a patient ...*). If the patient was admitted to the hospital before the decision for surgery was made, report 99222 (*Initial hospital care, per day, for the evaluation and management of a patient ...*) instead. Append modifier 57 (*Decision for surgery*) to the correct E/M code.

For the original ankle repair, submit 27818 (*Closed treatment of trimalleolar ankle fracture; with manipulation*). Include modifier LT (*Left side*) or RT (*Right side*) as appropriate.

Submit 27822 or 27823 (*Open treatment of trimalleolar ankle fracture, includes internal fixation when performed, medial and/or lateral malleolus; without fixation of posterior lip or with fixation of posterior lip*) for the second surgery. Again, include either modifier LT or RT. Also append modifier 58 (*Staged or related procedure or service by the same physician during the postoperative period*) because the return procedure was more extensive than the original surgery.

Generic Code Best for Budin Toe Splint

Question: *What supply code should we report for a Budin toe splint (toe straightener)?*

Missouri Subscriber

Answer: HCPCS doesn't include a code specifically for a Budin toe splint, so your only option is a generic supply code. The closest choice is temporary code Q4051 (*Splint supplies, miscellaneous [includes thermoplastics, strapping, fasteners, padding and other supplies]*).

Remember G0289 for Some Patelloplasties

Question: *The surgeon performed a lateral retinacular release with patelloplasty, where he smoothed the medial facet of the patella. How should we code the patelloplasty?*

Delaware Subscriber

Answer: Because the release and patelloplasty were in different compartments, submit G0289 (*Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage [chondroplasty] at the time of other surgical knee arthroscopy in a different compartment of the same knee*). Include a note in Box 19 of the claim form indicating the patellofemoral compartment ("G0289 patellofemoral compartment"). The lateral retinacular release documentation is self-explanatory.

Look to 730.3x Family for Periostitis

Question: *What is the correct diagnosis for "periostitis secondary to enlarged plantar condyle of fifth metatarsal"?*

North Carolina Subscriber

(continued on next page)

You Be the Coder

(Question on page 29)

Double Diagnose Heterotopic Calcification

Answer: Because the physician is treating the heterotopic ossification associated with the shoulder problem, you'll report two diagnoses: 728.13 (*Postoperative heterotopic calcification*) and 905.6 (*Late effect of dislocation*).

Tip: Although you might sometimes see the condition called "heterotopic calcification," orthopedists commonly call it "heterotopic ossification," or HO. □

Answer: The correct choice is 730.37 (*Periostitis without mention of osteomyelitis; ankle and foot*). You would choose a different fifth digit for periostitis in other regions.

Definition: Periostitis is inflammation of the periosteum in which the membrane may become detached from the underlying bone. Patients usually develop periostitis because of overuse and severe strain at the tendon insertions where the muscle fibers or tendons pull, stretch, or tear. Periostitis of the lower leg is particularly common among athletes who change from one playing surface to another, or who change techniques or equipment.

Check Edits for Ostectomy, Osteotomy Claim

Question: *The surgeon performed an ostectomy/bunionectomy and osteotomy of the fifth toe. Can we code for both procedures?*

Louisiana Subscriber

Answer: National Correct Coding Initiative edits bundle 28308 (*Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each*) and 28110 (*Ostectomy, partial excision, fifth metatarsal head [bunionette] [separate procedure]*) when a surgeon completes both procedures on the same toe. If Medicare is the patient's primary carriers, you can only report 28308 if the surgeon performs both procedures on the same toe. Some other payers, however, allow you to report both codes if your surgeon includes sufficient documentation of each procedure or if he treats separate toes. If so, append modifier 59 (*Distinct procedural service*) to 28110 on the claim.

— Reader Questions and You Be the Coder were reviewed by **Heidi Stout, CPC, CCS-P**, director of orthopedic coding services at *The Coding Network LLC*; and **Bill Mallon, MD**, orthopedic surgeon and medical director at *Triangle Orthopaedic Associates in Durham, N.C.* □

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