INGENIX®

Coding Companion for Orthopaedics—Upper: Spine & Above

A comprehensive illustrated guide to coding and reimbursement

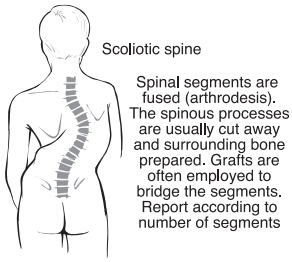
Contents

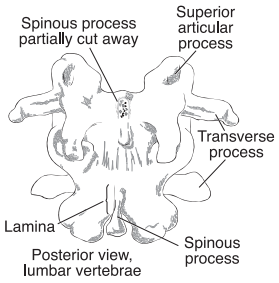
22800-22804

22800 Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments

22802 7 to 12 vertebral segments

22804 13 or more vertebral segments





Explanation

Spinal arthrodesis, or fusion, is done here to correct a spinal deformity. The patient is placed prone. A midline posterior incision is made overlying the affected vertebrae. The fascia and the paravertebral muscles are incised and retracted. The physician uses a curette and rongeur to clean interspinous ligaments. One of several techniques may be used. In one, the spinous processes are split and removed and a curette is used to cut into the lateral articulations. Thin pieces of separately reportable iliac or other donor bone graft are placed in these slots. Grafts are obtained, prepared, and packed on both sides of the spinal curve, with more bone chips on the concave sides. Separately reportable instrumentation may be affixed to the spine. The incision is closed with layered sutures. A cast may be applied to stabilize the spine. Report 22800 for fusion of up to six vertebral segments; 22802 for fusion of seven to 12 vertebral segments; and 22804 for 13 or more vertebral segments.

Coding Tips

Only one spinal arthrodesis code is used per operative session. Codes 22800-22804 identify arthrodesis for spinal deformities by the approach used (e.g., posterior, anterior). The spinal deformity may be congenital (e.g., scoliosis) or acquired due to a disease or other process (e.g., kyphosis). These codes should not be used to report fusion for spinal deformity due to a fracture or previous arthrodesis. If spinal instrumentation is performed, it is listed separately in addition to the code for the arthrodesis, see 22840-22847. Any bone graft is also reported separately, see 20930-20938. If the services of two primary surgeons performing separate and distinct components of the arthrodesis are required, each surgeon should report the procedure code(s) for the cosurgery and append modifier 62.

ICD-9-CM Procedural

81.00 Spinal fusion, not otherwise specified

81.01 Atlas-axis spinal fusion

81.03 Other cervical fusion, posterior technique

81.05 Dorsal and dorsolumbar fusion, posterior technique

81.07 Lumbar and lumbosacral fusion, lateral transverse process technique

81.08 Lumbar and lumbosacral fusion, posterior technique

81.31 Refusion of Atlas-axis spine

81.33 Refusion of other cervical spine, posterior technique

81.35 Refusion of dorsal and dorsolumbar spine, posterior technique

81.37 Refusion of lumbar and lumbosacral spine, lateral transverse process technique

81.38 Refusion of lumbar and lumbosacral spine, posterior technique

81.62 Fusion or refusion of 2-3 vertebrae

81.63 Fusion or refusion of 4-8 vertebrae

81.64 Fusion or refusion of 9 or more vertebrae

Anesthesia

00670

ICD-9-CM Diagnostic

138 Late effects of acute poliomyelitis — (Note: This category is to be used to indicate conditions classifiable to 045 as the cause of late effects, which are themselves classified elsewhere. The "late effects" include those specified as such, as sequelae, or as due to old or inactive poliomyelitis, without evidence of active disease.)

237.71 Neurofibromatosis, Type 1 (von Recklinghausen's disease)

237.72 Neurofibromatosis, Type 2 (acoustic neurofibromatosis)

356.1 Peroneal muscular atrophy

731.0 Osteitis deformans without mention of bone tumor

732.0 Juvenile osteochondrosis of spine

733.01 Senile osteoporosis — (Use additional code to identify major osseous defect, if applicable: 731.3) (Use additional code to identify personal history of pathologic (healed) fracture: V13.51)

737.0 Adolescent postural kyphosis

737.10 Kyphosis (acquired) (postural)

737.20 Lordosis (acquired) (postural)

737.30 Scoliosis (and kyphoscoliosis), idiopathic

737.32 Progressive infantile idiopathic scoliosis

737.33 Scoliosis due to radiation

737.34 Thoracogenic scoliosis

737.8 Other curvatures of spine associated with other conditions

738.5 Other acquired deformity of back or spine

754.2 Congenital musculoskeletal deformity of spine

756.10 Congenital anomaly of spine, unspecified

756.12 Congenital spondylolisthesis

CCI Version 15.3

22505, 22830, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 51701-51703, 62310-62319, 64400-64435, 64445-64450, 64470, 64475, 64479, 64483, 64505-64530, 69990, 76000-76001, 92585, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95822, 95829, 95860-95861, 95867-95868, 95870, 95900, 95904, 95920, 95925-95934, 95936-95937, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

Also not with 22800: 22802❖, 22810-22812❖

Also not with 22802: 22857❖, 22862❖, 32100

Also not with 22804: 22800, 22802, 22857❖, 22862❖, 32100

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Assist
22800	36.62	36.62	90	80
22802	57.2	57.2	90	80
22804	65.85	65.85	90	80

Medicare References: 100-3,150.2

0019T

0019T Extracorporeal shock wave involving musculoskeletal system, not otherwise specified, low energy

Explanation

Low energy extracorporeal shock wave delivery involves the application of pressure waves that travel through fluid and soft tissue, with effects of the shock wave occurring at sites where there is a change in impedance, such as the bone-soft tissue interface. The clinician can deliver this therapy in various ways: piezoelectric, electromagnetic, and electrohydraulic. The piezoelectric system utilizes a crystalline material, which when stimulated with high-voltage electricity can expand or contract to initiate a pressure wave in the surrounding fluid. The electromagnetic mechanism has coils that create opposing magnetic fields when an electric current is applied to them, causing a submerged membrane to move, and starting a pressure wave within the fluid. The electrohydraulic method uses a high voltage spark gap. The spark generates a plasma bubble that compresses the liquid, initiating the pressure wave. Each mechanism creates a characteristic waveform and energy density. Extracorporeal shock wave therapy is used in Europe to treat common orthopedic conditions (i.e., plantar calcaneal spurs, epicondylopathic humeri radialis) because of the therapy's stimulatory effect on bone formation. The Food and Drug Administration (FDA) is currently studying the feasibility for similar use in the United States. Other potential uses of extracorporeal shock wave therapy include treating bone marrow hypoxia and subperiosteal hemorrhage, increasing regional blood flow, and activating osteogenic factors such as bone morphogenic protein, direct cellular effects, and mechanical effects as a result of strain gradients.

0054T-0055T

0054T Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (List separately in addition to code for primary procedure)

0055T Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (List separately in addition to code for primary procedure)

Explanation

Computer-assisted musculoskeletal navigation techniques are used with many orthopedic procedures, especially for accurate placement of the acetabular component during hip replacement surgery. Preoperative images of patient-specific bone geometry are first obtained for the surgical plan in whatever imaging modality is to be used. The patient-specific surgical plan and images are used during surgery to guide the surgeon by combining these with intraoperative navigation capabilities. Optical targets, or trackers, such as digitizing or LED-equipped probes, are attached to points on the bone anatomy or to surgical tools. An optical camera tracks the position of these for accurate navigation and measurement in relation to any bone or instrument movement as the surgery is performed. The software in these navigational systems matches or "registers" the position of the patient on the operating table to the geometric description of the bony surface derived from the images already used to plan the surgery. Multiple images are simultaneously displayed on the monitor. The "virtual" tool trajectory that corresponds to the tracked tool movements is displayed over the previously saved views in real-time as the surgeon operates. These are add-on codes to be used in addition to the primary procedure. Report 0054T for image-guidance based on fluoroscopic imaging and 0055T for CT/MRI imaging. If CT and MRI are both performed, 0055T is reported only once.

0092T

0092T Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), each additional interspace, cervical (List separately in addition to code for primary procedure)

Explanation

Total disc arthroplasty is done to replace a severely damaged or diseased intervertebral cervical disc, most often caused by degenerative disc disease. The physician uses an anterior approach to reach multiple damaged cervical vertebrae by making an incision through the neck, avoiding the esophagus, trachea, and thyroid. Retractors separate the intervertebral muscles. The affected intervertebral location is confirmed by separately reportable x-ray. The physician cleans out the intervertebral disc space with a rongeur, removing the cartilaginous material to be replaced in preparation for inserting the implants. This may include osteophytectomy for nerve root or spinal cord decompression, as well as microdissection. One type of implant for total disc replacement has two endplates made of a metal alloy and a convex weight-bearing surface made of ultra high molecular weight polyethylene. The endplates are inserted in a collapsed form and seated into the vertebral bodies above and below the interspaces. Minimal distraction is applied to open the intervertebral spaces, and the polyethylene disc material is snap-fit into the lower endplates. With the disc assemblies complete, the wound is closed and a drain may be placed. Report 0092T for each additional cervical interspace treated with total disc arthroplasty in conjunction with 22856.

0095T

0095T Removal of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)

Explanation

The physician removes an artificial disc prosthesis placed during a previous disc arthroplasty by anterior approach. The physician approaches the cervical vertebrae by making an incision through the neck, avoiding the esophagus, trachea, and thyroid. Retractors separate the intervertebral muscles. The implant is located and any adhesions are freed. Distraction is applied to open the intervertebral space and the implant is removed. The area is explored and debrided. When the procedure is complete, the fascia and vertebral muscles are repaired and returned to their anatomical positions, drains are placed, and the wound is closed. Code 0095T must be reported in conjunction with 22864; assign once for each additional cervical interspace.

0098T

0098T Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, each additional interspace, cervical (List separately in addition to code for primary procedure)

Explanation

The physician revises an artificial disc prosthesis placed during a previous disc arthroplasty through anterior approach. The prosthesis may be migrating from a lack of fixation and require components to be replaced or adjusted. The physician approaches the cervical vertebrae by making an incision through the neck, avoiding the esophagus, trachea, and thyroid. Retractors separate the intervertebral muscles. The implant is located, the area is explored, and any adhesions are freed. Distraction is applied to open the intervertebral space. The arthroplastic disc is removed, and the endplates of the vertebral body are reshaped and prepped for reinsertion. New height, depth, and width dimensions may also be taken with the vertebral body distracted in cases where another, more appropriately sized disc prosthesis is required. The components are reinserted, and the fascia and vertebral muscles are repaired and returned to their anatomical positions. The incision is closed. Code 0098T must be reported in conjunction with 22861; assign once for each additional cervical interspace.

0101T-0102T

0101T Extracorporeal shock wave involving musculoskeletal system, not otherwise specified, high energy

0102T Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, involving lateral humeral epicondyle

Explanation

High-energy extracorporeal shock wave delivery involves the application of pressure waves that travel

Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $29 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services
- Hospital inpatient services—initial care
- Hospital inpatient services—subsequent care
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician's office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the same specialty has seen the patient within three years, the patient is considered established.

If a physician is on call or covering for another physician, the patient's encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient's attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as "observation status" in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician "admitting" the patient for observation.

Codes 99234-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and