

Introducing the 2009 CPT Code Updates!

Winter is here, spring is right around the corner and it is time to spring forward and ensure all coding references and business processes are updated and ready for the New Year. This article introduces new **Orthopaedic** CPT and HCPCS Codes; all physicians and/or practice managers and coding staff should review the entire CPT Manual for changes that may affect their individual practice.

Guideline Changes

- In the **Integumentary Section** of the CPT Manual the changes are specific to Guideline changes only:
- **Skin Replacement and Skin Substitutes:** Guideline changes only
- **Intermediate Repair Codes:** Verbiage change from “Layered Closure of wounds...” to “Repair, intermediate, wounds of...”
- **Flaps:** Guideline change clarifying definition of delay transfer of flap

There are multiple guideline changes within the Musculoskeletal section that did not trigger a revision in a CPT code descriptor or definition. Read the CPT Manual closely to understand AMA Clarifications related to use of CPT codes.

- Guideline change within CPT code 20550, Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar “fascia”) to see the new CPT code(s) 64455 and 64632 for injection of Morton’s neuroma.
- Guideline changes for CPT codes 20930, 20936 and 20937 instructing the physician these three bone graft codes may be reported in addition to the new Category III codes (0195T and 0196T).
- Guideline change for CPT code 20985 referencing the re-instatement of the Category III codes for 0054T and 0055T simultaneously to the deletion of CPT codes 20986 and 20987. Medicare did not assign RVUs to 20986 and 20987 in 2008 and were not reimbursing on these procedures. Review your local Medicare carrier to determine if they will reimburse on CPT code 20985 as some states have medical policies deeming this as a “not medically necessary” procedure.
- Revision of the instrumentation codes (22840-22851) to support changes in codes where the instrumentation may be reported. Add-on codes were deleted from the list as add-on codes may not stand alone.
- Refer to the Guideline Changes specific to injection of contrast and percutaneous lysis of adhesions (62263)
- 62267: Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes (NEW). This code will be used to report the aspiration of fluid and/or cells of a percutaneous disc, nucleus pulposus, or paravertebral diagnostic purposes.

- 62287 Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method, single or multiple levels, lumbar (e.g., manual or automated percutaneous discectomy, percutaneous laser discectomy) (REVISED) This code was revised to *exclude the aspiration of the disc*.
- Codes 63020, 63030, and 63035 were revised to include open and endoscopically assisted approach for cervical and lumbar nerve root decompression procedures. In 2008 and prior years, these codes did not include the reference to the endoscopically assisted approach.
- CPT code 28446, Open osteochondral autograft talus includes a new reference to use CPT code 28899 for open osteochondral allograft or repairs using industrial grafts.
- Revision in CPT code 69990 as inclusive to the new disc arthroplasty codes
- Refer to CPT code 72275 for Guideline changes related to injection procedures.
- Guideline changes for 0092T, 0095T, 0098T with cross references to the new CPT codes for the additional interspaces for cervical arthroplasty procedures.
- Category III codes 0163T, 0164T, and 0165T

Musculoskeletal CPT Code General Changes:

- Introduction of two new codes related to external fixation
 - 20696: Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)
 - 20697: ;exchange (i.e., removal and replacement) of strut, each. This CPT code is reported for each strut exchanged and will be performed more frequently in the office. Append the appropriate modifier during the global period.
- CPT code 23585 was revised to reflect the changes in 2009 related to fractures, ORIFs and external fixation. CPT code 23585 now reads, Open treatment of scapular fracture (body, glenoid or acromion) **includes internal fixation when performed**.
- CPT codes 27396 and 27397 were revised to reflect any transplant or transfer of muscles, including re-direction or re-routing of muscles to any part of the thigh and not just the hamstring to patella. This allows the surgeon to use these codes to report any transplant of any muscles in the thigh. 27396 is for a single tendon while CPT code 27397 defines multiple tendons.

Cervical Disc Arthroplasty Code Additions and Revisions:

- 22856: Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophyctomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical (NEW)
- 22857: Grammatical change “single interspace, lumber” (REVISED)

- 22861: Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace, cervical (NEW)
- 22862: Guideline change only for lumbar revision (REVISED)
- 22864 Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical 22865: Guideline change for lumbar only (NEW)

In 2008 the new codes above were Category III codes and have been converted to Category I codes in 2009. A cervical disc arthroplasty includes the use of the operating microscope and fluoroscopic guidance, so these two services would not be separately reportable. Additionally, interspace preparation (22554), anterior instrumentation (22845) cages (22851) and Discectomy with decompression and osteophylectomy (63075) are all included and not separately reportable. Category III codes continue to exist for the additional cervical interspace (0195T, 0196T).

Decompression Fasciotomies

Two new codes were added in 2009 to reflect the work associated with fasciotomies of the pelvic (buttock) components. The first code 27027 is found in the incisional section and does not include debridement of the non viable muscle. CPT code 27057 is found in the Excisional section and includes debridement of non viable muscle. Both codes may be reported as bilateral procedures by appending the modifier 50 when appropriate.

27027: Decompression fasciotomy(ies), pelvic (buttock) compartment(s), (e.g., gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle), unilateral

27057: Decompression fasciotomy(ies), pelvic (buttock) compartment(s), (e.g., gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tensor fascia lata muscle) with debridement of nonviable muscle, unilateral

CPT codes 11040-11043 are not separately reportable and are considered inclusive to CPT codes 27027 and 27057.

Pelvic Bone Fractures

Revisions to pelvic bone Fractures and Introduction of Medicare “G” Codes.

This is the probably the most significant change for trauma surgeons over the past several years. CPT 2009 includes a Guideline Change for CPT codes 27215, 27216, 27217 and 27218 identifying these four pelvic bone fracture patterns with or without pelvic ring disruption as unilateral procedures. This is good news for the trauma surgeons. But wait, Medicare does not agree with the unilaterality of this anatomic structure and will **no longer recognize CPT codes 27215, 27216, 27217 or 27218 for unilateral or bilateral fractures**. Instead Medicare created new “G” codes to define the treatment of these fractures independent of the fracture occurring unilaterally or bilaterally.

G0412	Open treatment of iliac spine(s), tuberosity avulsion, or iliac wing fractures(s), unilateral or bilateral for pelvic bone fracture patterns which do not disrupt the pelvic ring includes internal fixation, when performed.
G0413	Percutaneous skeletal fixation of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, (includes ilium, sacroiliac joint and/or sacrum).
G0414	Open treatment of anterior pelvic bone fracture and/or dislocation for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation when performed (includes pubic symphysis and/or superior/inferior rami).
G0415	Open treatment of posterior pelvic bone fracture and/or dislocation, for fracture patterns which disrupt the pelvic ring, unilateral or bilateral, includes internal fixation, when performed (includes ilium, sacroiliac joint and/or sacrum).

Please note: *The Medicare G codes are for Medicare patients only as the AMA CPT instructs that the correct codes are Category I codes and may be reported as bilateral procedures. Orthopaedic surgeons and coding staff must avoid the same coding and reimbursement issues as occurred when the G code was created for the chondroplasty /loose foreign body. The use of the “G” code is for Medicare patients only as this is a Medicare reimbursement rule. Continue to report 27215, 27216, 27217 and 27218 to private payors based on the AMA CPT coding rules.*

Spine and Spinal Cord

Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic

- 64455 Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton’s Neuroma) (NEW)
- 64632 Destruction by neurolytic agent; plantar common digital nerve

These services may be reported as bilateral injections, but when multiple injections are done at the same site, the CPT code is reported one time only.

Category III Codes

AMA introduced a new symbol in 2009 that has applicability in the Category III codes. The Hollow Circle symbol: O means that the code is a Recycled/Reinstated Code. This symbol applies to Category III Codes 0054T and 0055T. The computer assisted navigation with fluoroscopic images and imageless began as Category III codes. In 2008, CPT introduced CPT codes 20986 and 20987 to describe these services. CPT codes 20986 and 20987 are deleted in 2009 and reinstated as Category III Codes.

Two New Category III Codes Define Pre-Sacral Interbody Technique Arthrodesis

- 0195T Arthrodesis, pre-sacral interbody technique, including instrumentation, imaging (when performed), and discectomy to prepare interspace, lumbar; single interspace (NEW)
- 0196T each additional interspace (List separately in addition to code for primary procedure) (NEW)

These two new CPT codes describe a new technique that involves both a unique approach and surgical technique for lumbar fusion, and for the treatment of lumbar degenerative disc, annular tear, low back pain, and spondylolisthesis. Per the Guidelines the anterior fusion, instrumentation or image guidance may not be reported in addition to these procedures.