Orthopaedics: Upper - Spine & Above

A comprehensive illustrated guide to coding and reimbursement

2021

optum360coding.com
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Getting Started with Coding Companion

Coding Companion for Orthopaedics — Upper: Spine and Above is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT Codes
For ease of use, evaluation and management codes related to Orthopaedics — Upper: Spine and Above are listed first in the Coding Companion. All other CPT codes in Coding Companion are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT code is followed by its official CPT code description.

Resequencing of CPT Codes
The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum360 Coding Companion series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM
Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

Detailed Code Information
One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the pages following the sample.

Appendix Codes and Descriptions
Some CPT codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

The codes in the appendix are presented in the following order:
- HCPCS
- Surgery
- Pathology and Laboratory
- Medicine Services

- Radiology
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edit Updates
The Coding Companion series includes the list of codes from the official Centers for Medicare and Medicaid Services’ National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from the most current version available at press time. The CCI edits are located in a section at the back of the book. Optum360 maintains a website to accompany the Coding Companions series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is http://www.optum360coding.com/ProductUpdates/. The 2021 edition password is: XXXXXXXXX. Log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

Index
A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

Abscess
Excision
Olecranon Process, 24138

Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process

could be found in the index under the following main terms:

Abscess
Olecranon Process, 24138
Excision

General Guidelines
Providers
The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under “Instructions for Use of the CPT Codebook” on page xiii of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies
Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.
20670

20670  Removal of implant; superficial (e.g., buried wire, pin or rod) (separate procedure)

Example of superficial implants

An implant is removed

Explanation
The physician makes a small incision overlying the site of the implant. The implant is located. The physician removes the implant by pulling or unscrewing it. The incision is closed with sutures and/or Steri-strips.

Coding Tips
This separate procedure by definition is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services, it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59 or an X (EPSU) modifier. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

T84.110A  Breakdown (mechanical) of internal fixation device of right humerus, initial encounter
T84.111A  Breakdown (mechanical) of internal fixation device of left humerus, initial encounter
T84.112A  Breakdown (mechanical) of internal fixation device of bone of right forearm, initial encounter
T84.113A  Breakdown (mechanical) of internal fixation device of bone of left forearm, initial encounter
T84.216A  Breakdown (mechanical) of internal fixation device of vertebrae, initial encounter
T84.220A  Displacement of internal fixation device of bones of hand and fingers, initial encounter
T84.226A  Displacement of internal fixation device of vertebrae, initial encounter
T84.310A  Breakdown (mechanical) of electronic bone stimulator, initial encounter
T84.320A  Displacement of electronic bone stimulator, initial encounter
T84.328A  Displacement of other bone devices, implants and grafts, initial encounter
T84.418A  Breakdown (mechanical) of other internal orthopedic devices, implants and grafts, initial encounter
T84.428A  Displacement of other internal orthopedic devices, implants and grafts, initial encounter
T84.610A  Infection and inflammatory reaction due to internal fixation device of right humerus, initial encounter
T84.611A  Infection and inflammatory reaction due to internal fixation device of left humerus, initial encounter
T84.612A  Infection and inflammatory reaction due to internal fixation device of right radius, initial encounter
T84.613A  Infection and inflammatory reaction due to internal fixation device of left radius, initial encounter
T84.614A  Infection and inflammatory reaction due to internal fixation device of right ulna, initial encounter
T84.615A  Infection and inflammatory reaction due to internal fixation device of left ulna, initial encounter
T84.63XA  Infection and inflammatory reaction due to internal fixation device of spine, initial encounter
T84.7XXA  Infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts, initial encounter
T84.82XA  Fibrosis due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
T84.84XA  Pain due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
T84.85XA  Stenosis due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
Z47.1  Aftercare following joint replacement surgery
Z47.2  Encounter for removal of internal fixation device
Z47.82  Encounter for orthopedic aftercare following scoliosis surgery
Z47.89  Encounter for other orthopedic aftercare

AMA: 20670 2018, Jan, 3; 2018, Jan, 8; 2017, Jan, 8; 2016, Jan, 13; 2015, Jan, 16; 2014, Jan, 11

Relative Value Units/Medicare Edits

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Terms To Know

complication. Condition arising after the beginning of observation and treatment that modifies the course of the patient's illness or the medical care required, or an undesired result or misadventure in medical care.

implant. Material or device inserted or placed within the body for therapeutic, reconstructive, or diagnostic purposes.

internal skeletal fixation. Repair involving wires, pins, screws, and/or plates placed through or within the fractured area to stabilize and immobilize the injury.

rod. Straight, slim, cylindrical metal instrument for therapeutics.

superficial. On the skin surface or near the surface of any involved structure or field of interest.
22010-22015

22010  Incision and drainage, open, of deep abscess (subfascial), posterior spine; cervical, thoracic, or cervicothoracic

22015  lumbar, sacral, or lumbosacral

Necrotic tissue and debris may be removed

Explanation
The physician performs an open incision and drainage of a deep abscess of the posterior spine. Once a paraspinal soft tissue abscess or a lumbar psoas muscle abscess is identified by MRI or CT scan, an aspiration biopsy may be performed prior to open surgical drainage. The extent of the surgery depends on the size of the abscess and the area affected. The deep fascia is incised and the wound opened, irrigated, and debrided. Necrotic tissue and debris are removed and the cavity is irrigated with antibiotic solution. The wound is closed in layers and a drain or wound vacuum device may be placed. Report 22010 for incision and drainage of a deep abscess in the cervical, thoracic, or cervicothoracic region of the posterior spine and 22015 for the lumbar, sacral, or lumbosacral region.

Coding Tips
Local anesthesia is included in these services. Do not report 22015 with 22010 unless a separate anatomical area is treated. If multiple areas are biopsied, report codes for each site and append modifier 59 to additional codes. Incision and drainage performed at the thoracolumbar junction should be reported separately. For posterior instrumentation removal, see 22850 and 22852. For incision and drainage of a superficial abscess, hematoma, or fluid collection, see 10060 and 10140. Do not report 22015 in addition to 10180, 22010, 22850, or 22852.

ICD-10-CM Diagnostic Codes

- G06.1  Intraspinal abscess and granuloma
- G07  Intracranial and intraspinal abscess and granuloma in diseases classified elsewhere
- L02.212  Cutaneous abscess of back [any part, except buttok]
- L03.211  Cellulitis of neck
- L03.312  Cellulitis of back [any part except buttok]
- M35.4  Diffuse (eosinophilic) fascitis
- M46.21  Osteomyelitis of vertebra, occipito-atlanto-axial region
- M46.22  Osteomyelitis of vertebra, cervical region
- M46.23  Osteomyelitis of vertebra, cervicothoracic region
- M46.26  Osteomyelitis of vertebra, lumbar region
- M46.27  Osteomyelitis of vertebra, lumbosacral region
- M46.28  Osteomyelitis of vertebra, sacral and sacrococcygeal region
- M46.31  Infection of intervertebral disc (pyogenic), occipito-atlanto-axial region
- M46.32  Infection of intervertebral disc (pyogenic), cervical region
- M46.33  Infection of intervertebral disc (pyogenic), cervicothoracic region
- M46.36  Infection of intervertebral disc (pyogenic), lumbar region
- M46.37  Infection of intervertebral disc (pyogenic), lumbosacral region
- M46.38  Infection of intervertebral disc (pyogenic), sacral and sacrococcygeal region
- M72.6  Necrotizing fasciitis
- M72.8  Other fibroblastic disorders
- M86.08  Acute hematogenous osteomyelitis, other sites
- M86.18  Other acute osteomyelitis, other site
- M86.28  Subacute osteomyelitis, other site
- M86.38  Chronic multifocal osteomyelitis, other site
- M86.48  Chronic osteomyelitis with draining sinus, other site
- M86.58  Other chronic hematogenous osteomyelitis, other site
- M86.68  Other chronic osteomyelitis, other site

AMA: 22010 2018,Sep,7 22015 2018,Sep,7

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FUD Status MUE Modifiers IOM Reference

| 22010 | 90 | A | 2(3) | 51 | N/A | N/A | 80* | None |
| 22015 | 90 | A | 2(3) | 51 | N/A | N/A | N/A | None |

Terms To Know

- abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.
- aspiration. Drawing fluid out by suction.
- blunt dissection. Surgical technique used to expose an underlying area by separating along natural cleavage lines of tissue, without cutting.
- debridement. Removal of dead or contaminated tissue and foreign matter from a wound.
- fascia. Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.
97032
97032 Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes

Explanation
The health care provider applies electrical stimulation to one or more areas to promote muscle function and/or pain control. This treatment requires direct contact by the provider and can be billed in multiple, 15-minute units.

Relative Value Units/Medicare Edits

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97033
97033 Application of a modality to 1 or more areas; iontophoresis, each 15 minutes

Explanation
The health care provider uses electrical current to administer medication to one or more areas. Iontophoresis is usually prescribed for soft tissue inflammatory conditions and pain control. This code requires constant attendance by the clinician and can be billed in 15-minute units.

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97034
97034 Application of a modality to 1 or more areas; contrast baths, each 15 minutes

Explanation
The health care provider uses hot and cold baths in a repeated, alternating fashion to stimulate the vasomotor response of a localized body part. This code requires constant attendance and can be billed in 15-minute units.

Relative Value Units/Medicare Edits

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97035
97035 Application of a modality to 1 or more areas; ultrasound, each 15 minutes

Explanation
The health care provider applies ultrasound to increase circulation to one or more areas. A water bath or some form of ultrasound lotion must be used as a coupling agent to facilitate the procedure. The delivery of corticosteroid medication via ultrasound is called phonophoresis and is reported using this code. The medication as a supply may or may not be paid by the payer. Ultrasound or phonophoresis requires constant attendance and can be billed in 15-minute units.

Relative Value Units/Medicare Edits

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97036
97036 Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes

Explanation
Hubbard tank is used when it is necessary to immerse the full body into water. Care of wounds and burns may require use of the Hubbard tank to facilitate tissue cleansing and debridement. This code requires constant attendance of a health care provider and can be billed in 15-minute units.

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97110
97110 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

Explanation
The health care provider and/or patient perform therapeutic exercises to one or more body areas to develop strength, endurance, and flexibility. This code requires direct contact with a health care provider and may be billed in 15-minute units.

Relative Value Units/Medicare Edits

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97112
97112 Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

Explanation
The health care provider and/or patient perform activities to one or more body areas that facilitate reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception. This code requires direct contact with a health care provider and may be billed in 15-minute units.