Part B Insider (Multispecialty) Coding Alert

CPT® 2013: 4 New Codes Upgrade Your Coding for Revision Arthroplasty of Shoulder And Elbow

Tip: Determine if one or both components of joint are revised.

2013 brings you a new array of codes for revision in shoulder and elbow arthroplasty which should help streamline your reporting as these include the removal of prior prostheses.

Starting Jan. 1, you'll be able to report the following for your surgeon's revision arthroplasty services in the shoulder or elbow joint:

- 23473 -- Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component
- 23474 -- Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component
- 24370 -- Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component
- 24371 -- Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component

You Needn't Report Prosthesis Removal Any Longer

Your options in 2012 for shoulder revision include the codes for removal of foreign body and those of arthroplasty, depending upon whether humeral, glenoid, or both components were revised. Currently, in order to bill these scenarios for revision of the total shoulder if revising either just the humeral or glenoid component, you would bill CPT® 23331 (Removal of foreign body, shoulder; deep [e.g., Neer hemiarthroplasty removal]) and CPT® 23470 (Arthroplasty, glenohumeral joint; hemiarthroplasty). If revising both components, you would bill CPT® 23332 (Removal of foreign body, shoulder; complicated [e.g., total shoulder]) and CPT® 23472 (Arthroplasty, glenohumeral joint; total shoulder [glenoid and proximal humeral replacement (e.g., total shoulder)]).

In 2012, you've adopted a similar approach for the elbow joint. The current options allow only for a total elbow CPT® 24363 (Arthroplasty, elbow; with distal humerus and proximal ulnar prosthetic replacement [e.g., total elbow]), distal humerus CPT® 24361 (Arthroplasty, elbow; with distal humeral prosthetic replacement) or radial head 24366 (Arthroplasty, radial head; with implant), if not related to a fracture.

You have limited options for reporting implant removal in the elbow joint. You report code 24160 (Implant removal; elbow joint), regardless of whether both humeral and ulnar components or only one is being removed. However, you have a definite code for the removal of the radial implant. Removal options only allow for implant generic CPT® 24160 or removal of radial head implant 24164 (Implant removal; radial head) which is generally not a component of a total elbow arthroplasty.

Ulnar limitations: Currently, you have no option available for reporting the removal or insertion of an ulnar component. Insertion of an ulnar component alone would need to be billed using the unlisted code CPT® 24999 (Unlisted procedure, humerus or elbow) since there is currently no existing CPT® for insertion of an ulnar component. Because there is no code for the insertion of an ulnar component or a code for a revision of the ulnar component, you may bill a revision of the ulnar component alone with a single unlisted code comparing it either to a revision of a single component (femoral) in the hip or the combination codes for the shoulder."

Another alternative approach for you is to bill it with a total elbow code and append modifier 52 (Reduced services...), says **Bill Mallon, MD**, former medical director with Triangle Orthopedic Associates in Durham, N.C.

Good news: You now have more specific revision codes for the shoulder and needn't turn to unlisted procedure codes any longer. The new codes are inclusive of the removal of the prior prosthesis and grafts. Allograft, which is commonly utilized and has always been listed as inclusive by AAOS, is also clearly listed as inclusive in these services. What guides your choice of a code will be the component(s) that your surgeon is revising. Coders will need to make the code choice based upon the component(s) revised.

Missing item: Interestingly enough, the new codes for 2013 do not provide you any code for the removal and replacement of radial head. Coders will need to continue to bill these services with a removal code for the prosthesis and a primary radial head replacement service with the 22 modifier, when supported -- the unlisted procedure code like 24999 (Unlisted procedure, humerus or elbow) is a second alternative.

Modifiers May Not Be the Right Choice

Since you have not had CPT® codes for revision arthroplasty services (shoulder and elbow) in the past, many coders have been forced to use modifier 22 (Increased procedural services...) or unlisted procedure codes to represent the increased work value for the revision procedures.

You are not always correct to append modifier 22 to 24160 if both humeral and ulnar components are being removed. Modifier 22 could conceivably be appended if the removal was both components, but the documentation would have to clearly support the added complexity and not be strictly based upon the fact that two components are being removed since this code does not specify the type of implant. This may be possible on a revision total elbow - but you need to document why it was so difficult, usually the ulnar component, and how much extra time was needed to remove the components vs. a simple hardware removal.

You may not need to add modifier 59 (Distinct procedural service) with the removal or insertion codes in the elbow. There is currently no edit for the removal and insertion codes for either the total elbow or the distal humerus. Thus, there would be no need for the 59 modifier.

Similarly, you may not need modifier 51 (Multiple procedures...) with the removal and insertion codes. But check with your payers as policies may vary on this. The use of the 51 modifier would be dependent upon your internal and health plan policies, as many health plans consider this an informational only modifier and do not require its use. In fact, most Medicare carriers, do not want the 51 modifier appended. "Modifier 51 usage has definitely become an area where CPT® guidelines and payers' guidelines differ as many payers apply the modifier internally and no longer want it submitted on the claim. Researching payer reporting policies for modifier 51 is a must," says **Heidi Stout, BA, CPC, COSC, PCS, CCS-P**, Coder on Call, Inc., Milltown, New Jersey and orthopedic coding division director, The Coding Network, LLC, Beverly Hills, CA.

NCCI guidelines for 2012 prohibited reporting the removal with the revision for the shoulder services this year, leaving the surgeon with limited means for obtaining reimbursement for the increased complexity of a revision total shoulder for federal payers. "Once the code edit was put in place, the only viable reporting options were an unlisted code or the 'first-time around' arthroplasty code with modifier 22 appended. With either method, convincing a payer to increase reimbursement was a battle," says Stout.