Part B Insider (Multispecialty) Coding Alert

ORTHOPEDICS: Total Disc Arthroplasty Gets Totally New Codes

Say goodbye to unlisted codes for IDET, extensor tendon excision

You can finally stop billing category III codes 0090T-0098T for total disc arthroplasty (TDA). Starting in January, you-ll have three new codes to report this cutting-edge procedure: 22857 (arthroplasty), 22862 (revision) and 22865 (removal).

The presence of a CPT code, instead of a category III code, may help you get paid for these procedures. It also means Medicare will probably assign relative value unit (RVU) values to the codes, which may be better than whatever carriers decided to pay for category III codes. However, many Part B carriers still regard TDA as an experimental procedure, complains coder **Kim Barnard** with **The Spine Institute** at the **Cleveland Clinic** in Cleveland, OH.

The new codes only cover TDA for the lumbar area, not the cervical area, because the **Food & Drug Administration** has approved the Charite artificial disc only for the lumbar area, says Barnard.

Barnard hopes Medicare eventually issues a national coverage determination for TDA. For now, you should expect to submit supporting documentation with these codes. According to the FDA criteria, the patient must:

- be skeletally mature;
- have degenerative disc disease in the lumbar spine, anywhere from L4 to S1;
- have undergone at least six months of non-surgical treatment; and
- have no more than three millimeters of spondylolysthesis.

The FDA didn't approve TDA to replace a damaged intervertebral disc, or for patients who have allergy or sensitivity to implant materials. You also can't use the procedure for systemic infection, osteoporosis, osteopenia, bony lumbar stenosis or isolated radicular compression systems, especially due to disc herniation.

IDET codes: CPT 2007 also includes two new codes for the intradiscal electrothermal annuloplasty procedure, known as IDET. The codes cover a single level (22526) and each additional level (22527). A code for IDET has been long awaited, says **Denise Paige,** coding and billing manager at **Beach Orthopedic Associates** in Long Beach, CA.

Also, CPT 2007 adds one new tendon excision code (25109) and clarifies two others. In general, when excising a tendon in the hand, wrist or forearm, your surgeon can now bill one unit per tendon. Also, you can stop using an unlisted code when billing for tendon excision on an extensor because 26170 and 26180 now include both extensors and flexors.

Clarification: Fracture-care coding also became a lot easier with new codes for closed, open and skeletal fixation of distal radial fractures (25600-25609). The descriptors for these codes no longer contain the phrase -with or without external fixation,- which had led to confusion as to whether you could bill for external fixation separately, says coding consultant **Margie Vaught** in Ellensburg, WA.

The **American Academy of Orthopedic Surgeons** had argued that when you performed both internal and external fixation, you should be able to bill for the external fixation separately, and now you can with these codes.

Another change: The new codes also differentiate between intra-articular and extra-articular fractures. An intra-articular fracture will be more work for the surgeon because the fracture is inside the joint, Vaught says. She hopes the RVUs for these new codes will reflect that extra work. -We never had that before. It was all lumped together,- she says.

Nerve repair codes: CPT 2007 also adds two codes for the Sotereanos procedure, named after hand surgeon **Dean**

Sotereanos. CPT code 64910 covers nerve repair with synthetic conduit or vein allograft, while 64911 covers nerve repair with autogenous vein graft.

This procedure involves revision surgery, mostly on the ulnar nerve at the elbow, but also sometimes on the median nerve at the carpal tunnel. The surgeon harvests the saphenous vein and wraps it around the nerve to decrease sensitivity, says **Bill Mallon**, an orthopedic surgeon and medical director at **Triangle Orthopaedic Associates** in Durham, NC. Some companies also make a synthetic conduit that the surgeon can wrap the nerve in to avoid having to harvest a vein.

Also, there are two new codes for anesthesia for procedures on the thoracic spine and cord, via an anterior transthoracic approach. CPT code 00625 covers procedures that don't employ one lung ventilation, and 00626 is for procedures that do.