Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Are You Using the 22520 Series When Your Surgeon Performs Kyphoplasty?

Get up to speed with these 4 tips

With the addition of three new kyphoplasty CPT codes in 2006, you should make sure you-re differentiating between percutaneous vertebroplasty and kyphoplasty. If you-re coding them the same way, you could be losing reimbursement you deserve and you could open yourself up to denials.

Kyphoplasty (22523-22525) is similar to vertebroplasty (22520-22522), but the two are not identical, and you should not code them in the same way, says **Eric Sandhusen, CHC, CPC**, director of compliance for the Columbia University Department of Surgery in New York.

For information on the differences between the two procedures, see inset in the following article.

1. Choose Primary Vertebroplasty Code by Location

When your surgeon performs percutaneous vertebroplasty, select a single code to describe the -primary level- that the surgeon addressed. Code choices include 22520 (Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection; thoracic) for levels T1-T12 or 22521 (... lumbar) for levels L1-L5. During the vertebroplasty, the surgeon injects methylmethacrylate (a cement-like substance) into one or more weakened vertebral bodies. When the substance hardens, it reinforces the bone and helps to relieve pain.

2. Use Add-on Code for Multiple-Level Vertebroplasty

If the surgeon performs vertebroplasty at more than one spinal level during the same operative session, report each additional level using add-on code +22522 (... each additional thoracic or lumbar vertebral body).

Code the primary level and then use this add-on code for the subsequent levels. For example, if the surgeon injects methylmethacrylate into vertebral bodies L2, L3 and L4, you should report 22521 (for the first lumbar level) and 22522 x 2 (for additional levels L3 and L4).

Note: You need not apply modifier 51 (Multiple procedures) to code 22522 because it is a designated add-on code and is not subject to a multiple-procedure fee reduction.

On occasion, the surgeon will treat vertebrae in both the thoracic and lumbar areas during the same operative session. In such cases, you must still choose only a single -primary- code (either 22520 or 22521) and use 22522 for each level beyond the first, even though the surgeon crosses spinal areas.

The primary code describes the injection, the physician's approach and closure, and the surgery's global fee. The add-on code covers only the additional-level injection.

For example, osteoporosis, a common condition treated using percutaneous vertebroplasty, often occurs at the thoracic/lumbar junction. If the physician injects vertebrae T12 and L1 in such a case, you should report 22520 (for the primary thoracic level T12) and 22522 for the additional lumbar level L1. In a second example, the surgeon provides vertebroplasty at vertebrae T10, T11, T12, L1 and L2. In this case, your coding should be 22520, 22522 x 4.

Note: Medicare assigns a slightly higher value to 22520 than to 22521. Therefore, always choose 22520 as the primary

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code when the surgeon repairs vertebrae in both spinal areas.

3. Unlisted Code May Be Best for Cervical Procedures

CPT does not provide a code for percutaneous vertebroplasty of a cervical vertebra(e), although such procedures are possible. Before CPT added 22520-22522 in 2001, most payors recommended that coders report all vertebroplasty procedures using 22899 (Unlisted procedure, spine), says **Jennifer Schmutz, CPC**, health information coder in Salt Lake City, Utah. Most payors still recommend this code for cervical vertebroplasties, although you should check with your payor prior to billing to be sure about individual guidelines.
When the surgeon treats -additional- levels in the cervical area, you are justified in reporting 22899. For example, for treatment to levels L4, L5 and C1, your claim should read: 22521, 22522 and 22899. The surgeon's documentation should explain that 22899 represents an -additional level- in the cervical area.

Pointer: When reporting an unlisted-procedure code, include a full description of the procedure so the payor can make an appropriate payment determination. -As always when using unlisted-procedure codes, the report should be included to identify the specific effort involved, using 22520-22522 as a reference,- Schmutz says.

4. Report Radiologic Supervision and Interpretation

You can also report the operating surgeon's imaging for needle positioning and injection assessment using either 76012 (Radiological supervision and interpretation, percutaneous vertebroplasty or vertebral augmentation including cavity creation, per vertebral body; under fluoroscopic guidance) or 76013 (... under CT guidance) depending on whether the surgeon uses computed tomography (CT) in addition to fluoroscopic guidance. CPT revised these codes for 2006 to use with either vertebroplasty or kyphoplasty.

Note: If the surgeon does not personally perform the guidance, he cannot bill for it. Rather, the healthcare professional who provides the service will bill for it.

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