Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Follow These Steps to Code Spinal Bone Grafts

Graft source and extra services are your keys to correct codes.

Coding for spinal bone grafting may leave you perplexed as these procedures involve determining which graft type your surgeon used, identifying any accompanying procedures, and reporting multiple grafts. Read on for advice on how to finesse your spinal graft claims and beat denials.

Use 3 Aspects to Guide Your Graft Code Selection

When reporting spinal bone grafts, you'll choose from the five codes listed below:

- +20930 (Allograft, morselized, or placement of osteopromotive material, for spine surgery only (List separately in addition to code for primary procedure)
- +20931 (Allograft, structural, for spine surgery only [List separately in addition to code for primary procedure])
- +20936 (Autograft for spine surgery only [includes harvesting the graft]; local [eg, ribs, spinous process, or laminar fragments] obtained from same incision [List separately in addition to code for primary procedure])
- +20937 (Autograft for spine surgery only [includes harvesting the graft]; morselized [through separate skin or fascial incision] [List separately in addition to code for primary procedure])
- +20938 (Autograft for spine surgery only [includes harvesting the graft]; structural, bicortical or tricortical [through separate skin or fascial incision] [List separately in addition to code for primary procedure]).

Use this 3-step formula to narrow down to the right code for spinal bone grafting.

1. Confirm the source of the graft. Your surgeon may use an allograft or an autograft. Review the operative note to determine if the bone used for grafting was obtained from the patient's own body (autograft) or was obtained from a donor (allograft).

For example, the surgeon may use a rib or iliac crest to complete a spinal fusion. In this case, you look for a bone graft code describing an autograft. "CPT® also describes the grafts as 'osteopromotive material'," 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. "Another alternate term commonly used for the grafts is 'osteoinductive material'," says **Bill Mallon, MD,** former medical director, Triangle Orthopedic Associates, Durham, N.C.

2. If the graft's an autograft, confirm how the surgeon obtained the bone for grafting. Your surgeon may approach the bone through the same incision (local) or may make a new incision at another site in the skin and/or fascia to obtain the graft.

3. Confirm if a single "structural" piece of bone or if multiple small pieces were used for grafting. If your surgeon used a single bone as a graft, you select a 'structural' bone graft (+20931 and +20938). If, however, your surgeon uses multiple small fragments of bone to promote new bone growth and fill up a cavity in the spine, you select one of the codes for morselized grafts (+20930 and +20937). "Structural grafts are used for support and when large segments of bone are missing. Morselized grafts or cancellous chips are used to heal smaller defects," says Mallon.

Report Grafts with Arthrodesis and Spinal Instrumentation

You individually report codes for bone grafts unless the code descriptor includes grafting as a procedure. The bone graft codes are not bundled into either the arthrodesis or instrumentation codes."

Exception: Medicare does not assign payment for the spinal graft codes 20930 and 20936. You might consider these

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codes as bundled into codes for other services or do not incur physician work, but there are no code edits. Zero relative value units are assigned to these codes in the national Physician Fee Schedule Database.

Appeal Denials for Grafts with Arthrodesis

If your payer denies a separate payment for bone graft codes (+20930-+20938) when reported with arthrodesis, you should appeal the claim. "Bone grafting codes are not bundled by CPT® unless the code descriptor states the procedure includes obtaining the graft. CMS, however, does consider the use of morselized allograft or osteopromotive material (CPT® 20930) and locally harvested autograft (20936) to be included or bundled into the primary spinal procedure and are not separately payable. Both of these codes are assigned a 0.00 RVU. The use of these types of bone grafts should be submitted to other payers, though, for possible payment.

Hint: You can support the claim with specific instructions from CPT® which directs that codes for autogenous bone grafts should be reported separately unless the code descriptor references the harvesting of the graft.

Even though 20930 and 20936 have no assigned relative value units, you should still have a fee schedule for both. While CMS will not pay for these codes, you should still report them when performed, as private payers may pay for them.

Modifier 51 Does Not Apply

You should not append modifier 51 (Multiple procedures...) to +20930-+20938. Spinal bone grafts are add-on procedures associated with a definitive spine surgery. When reporting them with the definitive spine surgery code, you should never use modifier 51. Bone graft codes are modifier 51 exempt because they are add-on codes and need to be reported with the arthrodesis codes. "The CPT® definition of add-on codes can be found in the Introduction section of the CPT® Manual and a complete list of add-on codes is found in Appendix D," adds Stout.

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