Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Streamline Maze of New Orthopedic Codes With These 4 Groupings

CMS prices two new codes at over $1,000 -- will you recoup that pay?

You can stop feeling overwhelmed by the slew of new orthopedic-specific codes that will affect your practice in 2009 by simplifying the multitude of changes into four subjects:

• multiplane external fixation,

• arthroplasty,

• pelvic fasciotomy, and

• plantar common digital nerve injection.

1. Apply New Multiplane External Fixation Codes

First of all, you've got two new codes for multiplane external fixation. They are:

• 20696 -- Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer -assisted adjustment (e.g., spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)

• 20697 -- ... exchange (i.e., removal and replacement) of strut, each.

Highlight: These codes include a lot of services (such as "subsequent alignments" and "removal and replacement"). For that reason, CMS prices these codes with high relative value units (RVU). Code 20696 has 28.14, and 20697 has 33.09. If you multiply that by 36.0666, the 2009 conversion factor, you'll equal more than $1000 per procedure.

2. Add New Arthroplasty Codes to Your CPT Cache

If you use Category III codes when your orthopedic surgeon reports cervical total disc replacements, then you will have regular CPT codes at your disposal in 2009.

Rationale: Until recently, the data lagged behind to create Cate-gory I codes for cervical total disc arthroplasty, explained **Charles Mick, MD,** a Northampton, MA-based Pioneer Spine and Sports physician in "Spine Surgery/ Neurosurgery" at the CPT and RBRVS 2009 Annual Symposium in Chicago.

CPT deletes codes 0090T, 0093T, and 0096T. Instead, you'll report these three regular (Cate-gory I) cervical disc replacement codes:

• 22856 -- Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical

• 22861 -- Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical

• 22864 -- Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical.

The descriptors are almost identical to the Category III versions.

Be careful: Be cautious about 22856, which includes the term "decompression." Why: You should consider the decompression performed at the interspace where the physician is placing the artificial disc as an inclusive part of the procedure. In other words, you should not report it separately. "Decom-pression codes are difficult to apply to dictated reports," warns **Pat Tietz, CPC,** coder for The Twin Cities Spine Center in Minneapolis. Also, remember "your physician needs to qualify the 'segment.'"

Many coders are hopeful this will change how payers view these procedures. "The transition to regular codes" at least suggests "insurance payers can pay for the total disc arthroplasty more easily," says **Lori Montanez, CPC,** coder at Spine Orthopaedic & Rehabilitation Center (SORC) in Albuquerque, N.M. "Many payers said, due to the Category III code, their system automatically denied it for 'procedure experimental.'"

Other experts are dubious. "I am glad CPT changed these services into regular CPT codes; it's a step in the right direction -- but unfortunately this doesn't mean insurers will reimburse for them," warns **Regina H. Tinney, CPC,** coding specialist at Crossroads Healthcare Management in College Station, Texas.

For instance, Blue Cross of Idaho already lists these new codes in its "Artificial Disc: Cervical Spine" Medical Policy (www.bcidaho.com/providers/medical_policies/sur/mp_701108.asp). The policy, however, continues to state, "Artificial intervertebral discs are considered investigational for treatment of disorders of the cervical spine, including degenerative disc disease."

3. Fixate on These Fasciotomy Codes

If your practice deals with trauma medicine, you have a new code describing fasciotomies for pelvic compartments. They are:

• 27027 -- Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (e.g., gluteus medius-minimus, gluteus maximus, iliopsoas, and/or tenso fascia lata muscle), unilateral

• 27057 -- Decompression fasciotomy(ies), pelvic (buttock) compartment(s) (e.g., gluteus medius-minimus, gluteus maximus, iliopsoas and/or tensor fascia lata muscle) with debridement of nonviable muscle, unilateral.

4. No More Mystery for Morton's Neuroma Injections

When your physician treats a condition affecting plantar common digital nerves, you'll have two codes to use. They are:

• 64455 -- Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g., Morton's neuroma)

• 64632 -- Destruction by neurolytic agent; plantar common digital nerve.

If your physician injects a steroid or anesthetic agent for pain relief in 2009, use 64455. In contrast, 64632 describes nerve destruction or chemodenervation.