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Part B Insider (Multispecialty) Coding Alert

Unlisted Codes: Use 22899 For Kyphoplasty, But Make Your Case For Extra Pay

Boost your reimbursement by scanning carrier policies

Often, many of the fastest-growing procedures are the ones which don't have a code of their own. It takes the **Centers for Medicare & Medicaid Services** and the **American Medical Association** a while to catch up with the advance of technology.

That's the way it is with kyphoplasty. You still have to use unlisted **CPT 22899** for this increasingly popular alternative to percutaneous vertebroplasty. But that doesn't mean that you can't make your case for a greater reimbursement for your efforts.

In kyphoplasty, the physician inserts a balloon into a vertebra and then inflates the balloon to expand it, then injects cement into the vertebral space, explains **Jeff Fulkerson**, certified coder for the department of radiology at **The Emory Clinic** in Atlanta. The procedure is a bit more complicated than vertebroplasty, which involves "straight injection of cement into the body" without any balloon, Fulkerson explains.

Because of the additional complexity, physicians would like to obtain more reimbursement for their services. Here are some tips for boosting your payments:

Push for higher reimbursement than percutaneous vertebroplasty. Sometimes payors will pay more for kyphoplasty than for vertebroplasty code 22520, notes Fulkerson.

Bill for multiple vertebra. No matter how many injections or balloon tamps the physician places into a single vertebra, you can only bill one unit of 22899 per vertebra. But "if more than one level is treated, multiple surgery billing guidelines apply," says **Cahaba GBA** in its local medical determination. Also, when the physician treats "multiple vertebral bodies," you should bill each additional vertrebral body as a separate line item using the -51 and -59 modifiers, Cahaba advises. (Check to see if your carrier allows this approach.)

Check carrier policy for extras. Some carriers will allow you to bill a bevy of associated services apart from kyphoplasty. For example, **NHIC's** local coverage determination says it'll pay for injection, CT, fluoroscopy, intraosseous venography, plus all follow-up evaluation and management services separately. But **Empire Medicare** and **Noridian** considers all those services to be bundled, except for E/M services.

But both NHIC and Noridian will pay separately for radiological supervision and interpretation using CPT codes 76012 or 76013, until specific kyphoplasty codes emerge. Cahaba prefers 76499 with the -26 modifier.

Noridian's new draft policy, effective June 1, says it'll cover kyphoplasty for "osteolytic vertebral metastasis and myeloma with severe back pain related to a destruction of the vertebral body, not involving the major part of the cortical bone," or for "osteoporotic vertebral collapse with persistent debilitating pain which has not responded to accepted standard medical treatment for several weeks."

Document procedure fully. "We have to send them the medical record, [including] the report showing the procedure and any backup documentation for it," Fulkerson says.

Be aware of safety concerns. The **Food & Drug Administration** has warned of "serious injuries and deaths"

associated with the use of acrylic bone cements in vertebroplasty and kyphoplasty procedures. The FDA is seeking more data before it performs a final assessment, but carriers are already paying attention and Part B carrier **HGS Administrators** revoked its coverage policy for vertebroplasty and canceled its draft policy for kyphoplasty in late 2002.

(You can read the FDA warning at www.fda.gov/cdrh/safety/bonecement.html.)