Optum

Coding Companion

Orthopaedics: Upper - Spine & Above

A comprehensive illustrated guide to coding and reimbursement

SAMPLE

2024

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Contents

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Getting Started with Coding Companion

Coding Companion for Orthopaedics — Upper: Spine and Above is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to orthopaedics — upper: spine and above are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT/HCPCS code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum *Coding Companion* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features.

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT code description, followed by an easy-to-understand explanation.

The codes in the appendix are presented in the following order:

- HCPCS
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 28.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2024 edition password is: **23SPECIALTY.** Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

24138 Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process

could be found in the index under the following main terms:

Abscess
Excision
Olecranon Process, 24138

or

Excision
Abscess
Olecranon Process, 24138

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xiv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

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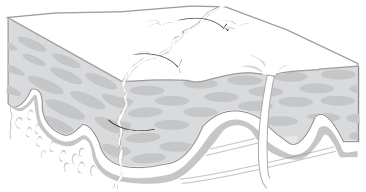
12020-12021

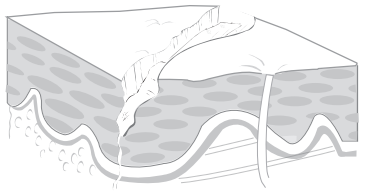
1

12020 Treatment of superficial wound dehiscence; simple closure
12021 with packing

2



Example of a simple closure involving only one skin layer



Example of a wound left open with packing due to infection

Explanation

3

There has been a breakdown of the healing skin either before or after suture removal. The skin margins have opened. The physician cleanses the wound with irrigation and antimicrobial solutions. The skin margins may be trimmed to initiate bleeding surfaces. Report 12020 if the wound is sutured in a single layer. Report 12021 if the wound is left open and packed with gauze strips due to the presence of infection. This allows infection to drain from the wound and the skin closure will be delayed until the infection is resolved.

Coding Tips

4

For extensive or complicated secondary closure of surgical wound or dehiscence, see 13160. Medicare and some other payers may require G0168 be reported for wound closure by tissue adhesives only. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

5

T81.31XA Disruption of external operation (surgical) wound, not elsewhere classified, initial encounter

T81.32XA Disruption of internal operation (surgical) wound, not elsewhere classified, initial encounter

T81.33XA Disruption of traumatic injury wound repair, initial encounter

Associated HCPCS Codes

6

G0168 Wound closure utilizing tissue adhesive(s) only

AMA: **12020** 2022,Aug; 2022,Feb; 2021,Aug; 2019,Nov **12021** 2022, 2022,Feb; 2021,Aug; 2019,Nov

7

Relative Value Units/Medicare Edits

8

Non-Facility RVU	Work	PE	MP	Total
12020	2.67	5.9	0.41	8.98
12021	1.89	3.08	0.31	5.28
Facility RVU	**Work**	**PE**	**MP**	**Total**
12020	2.67	2.44	0.41	5.52
12021	1.89	1.95	0.31	4.15

	FUD	Status	MUE	Modifiers				IOM Reference
12020	10	A	2(3)	51	N/A	N/A	N/A	None
12021	10	A	3(3)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

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dehiscence. Complication of healing in which the surgical wound ruptures or bursts open, superficially or through multiple layers.

infection. Presence of microorganisms in body tissues that may result in cellular damage.

irrigation. To wash out or cleanse a body cavity, wound, or tissue with water or other fluid.

packing. Material placed into a cavity or wound, such as gels, gauze, pads, and sponges.

subcutaneous tissue. Sheet or wide band of adipose (fat) and areolar connective tissue in two layers attached to the dermis.

superficial. On the skin surface or near the surface of any involved structure or field of interest.

suture. Numerous stitching techniques employed in wound closure.

buried suture. Continuous or interrupted suture placed under the skin for a layered closure.

continuous suture. Running stitch with tension evenly distributed across a single strand to provide a leakproof closure line.

interrupted suture. Series of single stitches with tension isolated at each stitch, in which all stitches are not affected if one becomes loose, and the isolated sutures cannot act as a wick to transport an infection.

purse-string suture. Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen.

retention suture. Secondary stitching that bridges the primary suture, providing support for the primary repair; a plastic or rubber bolster may be placed over the primary repair and under the retention sutures.

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1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2024.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- ✚ This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 93 or 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services, when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96160	96161	97802	97803	97804
99406	99407	99408	99409	99497	99498	

2. Illustrations

The illustrations that accompany the *Coding Companion* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most pages will have an illustration, there will be some pages that do not.

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes the most common method of performing each procedure.

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2023.

The 2024 Medicare edits were not available at the time this book went to press. Updated 2024 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2023 edition password is **23SPECIALTY**.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled

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Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

▶The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◀

Classification of Evaluation and Management (E/M) Services

▶The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.◀

New and Established Patients

▶Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

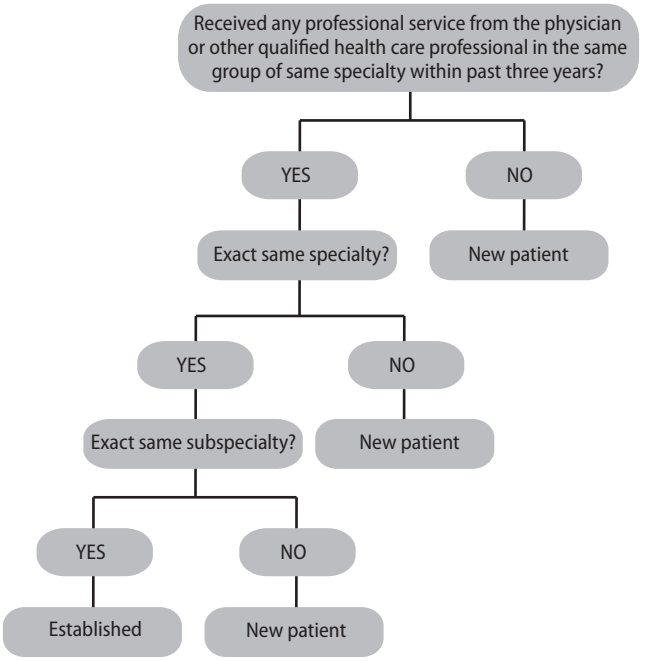
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.◀

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



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▶◀ = Contains new or revised text

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99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99203** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99204** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99205** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.12	0.09	2.14
99203	1.6	1.52	0.17	3.29
99204	2.6	2.06	0.24	4.9
99205	3.5	2.66	0.32	6.48
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.17	2.44
99204	2.6	1.11	0.24	3.95
99205	3.5	1.54	0.32	5.36

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

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20200-20205

20200 Biopsy, muscle; superficial
20205 deep

A biopsy sample is taken from muscle tissue of the upper extremity, by incision or percutaneously

Explanation

The physician secures a sample of tissue from a muscle for biopsy. The physician incises the overlying skin and bluntly dissects to the suspect muscle. The muscle tissue is obtained. Bleeding is controlled and the wound is sutured in layers. Report 20200 if the muscle site sampled is superficial and 20205 if the muscle site sampled is deep.

Coding Tips

Local anesthesia is included in these services. An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session. For excision of a muscle tumor, deep, see the specific anatomic site. For percutaneous needle biopsy, see 20206. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

C49.11 Malignant neoplasm of connective and soft tissue of right upper limb, including shoulder ☑
C49.3 Malignant neoplasm of connective and soft tissue of thorax
C49.4 Malignant neoplasm of connective and soft tissue of abdomen
C49.5 Malignant neoplasm of connective and soft tissue of pelvis
G71.01 Duchenne or Becker muscular dystrophy
G71.02 Facioscapulohumeral muscular dystrophy
G71.031 Autosomal dominant limb girdle muscular dystrophy
G71.032 Autosomal recessive limb girdle muscular dystrophy due to calpain-3 dysfunction
G71.033 Limb girdle muscular dystrophy due to dysferlin dysfunction
G71.0341 Limb girdle muscular dystrophy due to alpha sarcoglycan dysfunction
G71.0342 Limb girdle muscular dystrophy due to beta sarcoglycan dysfunction
G71.0349 Limb girdle muscular dystrophy due to other sarcoglycan dysfunction
G71.035 Limb girdle muscular dystrophy due to anoctamin-5 dysfunction
G71.09 Other specified muscular dystrophies
G71.21 Nemaline myopathy
G71.220 X-linked myotubular myopathy
G71.228 Other centronuclear myopathy
G71.29 Other congenital myopathy
G72.81 Critical illness myopathy
M05.411 Rheumatoid myopathy with rheumatoid arthritis of right shoulder ☑
M05.421 Rheumatoid myopathy with rheumatoid arthritis of right elbow ☑
M05.431 Rheumatoid myopathy with rheumatoid arthritis of right wrist ☑
M05.441 Rheumatoid myopathy with rheumatoid arthritis of right hand ☑
M05.49 Rheumatoid myopathy with rheumatoid arthritis of multiple sites
M33.02 Juvenile dermatomyositis with myopathy
M33.22 Polymyositis with myopathy
M34.82 Systemic sclerosis with myopathy
M35.03 Sjögren syndrome with myopathy
M60.011 Infective myositis, right shoulder ☑
M60.021 Infective myositis, right upper arm ☑
M60.031 Infective myositis, right forearm ☑
M60.041 Infective myositis, right hand ☑
M60.044 Infective myositis, right finger(s) ☑
M60.111 Interstitial myositis, right shoulder ☑
M60.121 Interstitial myositis, right upper arm ☑
M60.131 Interstitial myositis, right forearm ☑
M60.141 Interstitial myositis, right hand ☑
M60.19 Interstitial myositis, multiple sites
M61.311 Calcification and ossification of muscles associated with burns, right shoulder ☑
M61.321 Calcification and ossification of muscles associated with burns, right upper arm ☑
M61.331 Calcification and ossification of muscles associated with burns, right forearm ☑
M61.341 Calcification and ossification of muscles associated with burns, right hand ☑
M79.11 Myalgia of mastication muscle
M79.12 Myalgia of auxiliary muscles, head and neck
M79.7 Fibromyalgia

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
20200	1.46	4.83	0.35	6.64
20205	2.35	6.23	0.62	9.2
Facility RVU	**Work**	**PE**	**MP**	**Total**
20200	1.46	0.98	0.35	2.79
20205	2.35	1.58	0.62	4.55

	FUD	Status	MUE	Modifiers				IOM Reference
20200	0	A	2(3)	51	N/A	N/A	N/A	100-04,13,80.2
20205	0	A	3(3)	51	N/A	N/A	N/A	

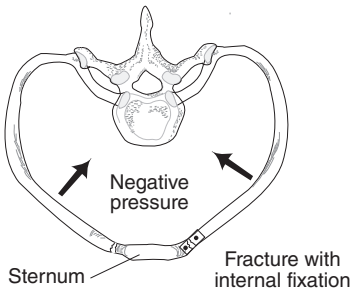
* with documentation

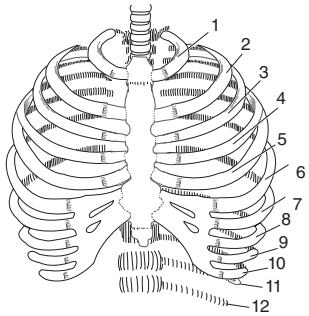
SAMPLE

© 2023 Optum, Inc. **N Newborn: 0** **P Pediatric: 0-17** **M Maternity: 9-64** **A Adult: 15-124** ♂ **Male Only** ♀ **Female Only** CPT © 2023 American Medical Association. All Rights Reserved.

21811-21813

21811 Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs
21812 4-6 ribs
21813 7 or more ribs





Explanation

The physician performs surgery on one or more unilateral rib fractures requiring internal fixation. With the patient under anesthesia, the physician makes an incision overlying the fractured rib. This is carried deep to the bone. The fracture is found, the pieces are identified, and dead tissue is debrided as needed. The physician manipulates and aligns the fracture fragments into an acceptable position and stabilizes the fragments using devices such as pins, rods, screws, or wires. The wound is irrigated and closed in layers. Report 21811 for treatment of one to three ribs; 21812 for four to six ribs; and 21813 for seven or more ribs. This includes thoracoscopic visualization when utilized.

Coding Tips

These are unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). For treatment with external rib fixation, see 21899. For closed treatment of a rib fracture, see the E/M codes.

ICD-10-CM Diagnostic Codes

M96.A2 Fracture of one rib associated with chest compression and cardiopulmonary resuscitation
M96.A3 Multiple fractures of ribs associated with chest compression and cardiopulmonary resuscitation
S22.31XA Fracture of one rib, right side, initial encounter for closed fracture ☑
S22.31XB Fracture of one rib, right side, initial encounter for open fracture ☑
S22.31XG Fracture of one rib, right side, subsequent encounter for fracture with delayed healing ☑
S22.31XK Fracture of one rib, right side, subsequent encounter for fracture with nonunion ☑
S22.41XA Multiple fractures of ribs, right side, initial encounter for closed fracture ☑
S22.41XB Multiple fractures of ribs, right side, initial encounter for open fracture ☑
S22.41XG Multiple fractures of ribs, right side, subsequent encounter for fracture with delayed healing ☑
S22.41XK Multiple fractures of ribs, right side, subsequent encounter for fracture with nonunion ☑

AMA: **21811** 2022,May **21812** 2022,May **21813** 2022,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21811	10.79	4.27	2.5	17.56
21812	13.0	5.29	3.0	21.29
21813	17.61	7.12	4.45	29.18
Facility RVU	**Work**	**PE**	**MP**	**Total**
21811	10.79	4.27	2.5	17.56
21812	13.0	5.29	3.0	21.29
21813	17.61	7.12	4.45	29.18

	FUD	Status	MUE	Modifiers				IOM Reference
21811	0	A	1(2)	51	50	N/A	80	None
21812	0	A	1(2)	51	50	N/A	80	
21813	0	A	1(2)	51	50	N/A	80	

* with documentation

Terms To Know

closed fracture. Break in a bone without a concomitant opening in the skin.

internal fixation. Wires, pins, screws, and plates placed through or within the fractured area to stabilize and immobilize the injury.

open fracture. Exposed break in a bone, always considered compound due to its high risk of infection from the open wound leading to the fracture.

unilateral. Located on or affecting one side.

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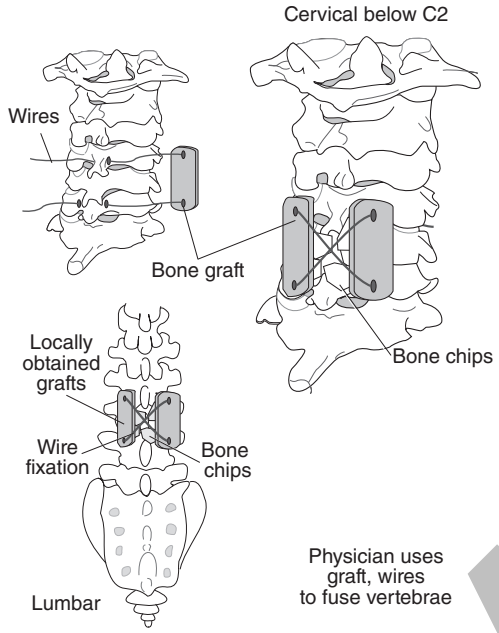
22600-22614

22600 Arthrodesis, posterior or posterolateral technique, single interspace; cervical below C2 segment
22610 thoracic (with lateral transverse technique, when performed)
22612 lumbar (with lateral transverse technique, when performed)
+ 22614 each additional interspace (List separately in addition to code for primary procedure)



Explanation

Spinal arthrodesis, or fusion, may be done for conditions of herniated disc; degenerative, traumatic, and/or congenital lesions; or to stabilize fractures or dislocations of the spine. These codes represent arthrodesis (or fusion) using a posterior or posterolateral technique. The physician makes an incision overlying the vertebrae and separates the fascia and the supraspinous ligaments in line with the incision. The physician prepares the vertebrae and lifts ligaments and muscles out of the way. A chisel elevator is used to strip away the capsules of the lateral articulations, and the articular cartilage and cortical bone are excised. Separately reportable bone chips are cut from the fossa below the lateral articulations and from the laminae, or fragments of the spinous process are taken for grafting. The graft is placed alongside (lateral) the vertebrae to be fused to fill the interlaminar space and the gap left by the articular cartilage removal. Also reported separately are additional bone grafts that may be taken from the ilium or other donor bone through a separate incision and used to join the laminae, as well as spinal fusion instrumentation placed to stabilize the graft. The periosteum, ligaments, and paravertebral muscles are sutured to secure the bone grafting. The skin and subcutaneous tissues are closed in layers with sutures. Report 22600 for cervical arthrodesis; 22610 for thoracic arthrodesis; 22612 for lumbar arthrodesis; and 22614 for each additional vertebral interspace.

Coding Tips

Arthrodesis codes are assigned according to the surgical approach used (e.g., posterior or posterolateral, posterior interbody, lateral transverse process, anterior interbody); if more than one approach is used, each is reported separately. Report 22614 in addition to 22600–22612, 22630, or 22633. Do not report 22612 with 22630 for the same interspace, report 22633. For a posterior interbody fusion arthrodesis at an additional interspace, see 22632. For a combined posterior or posterolateral technique with posterior interbody arthrodesis at an additional interspace, see 22634. When performed, spinal instrumentation is listed separately, see 22840–22855 and 22859.

ICD-10-CM Diagnostic Codes

M43.02	Spondylolysis, cervical region
M43.03	Spondylolysis, cervicothoracic region
M43.12	Spondylolisthesis, cervical region
M43.13	Spondylolisthesis, cervicothoracic region
M48.02	Spinal stenosis, cervical region
M48.03	Spinal stenosis, cervicothoracic region
M48.04	Spinal stenosis, thoracic region
M48.05	Spinal stenosis, thoracolumbar region
M48.061	Spinal stenosis, lumbar region without neurogenic claudication
M48.062	Spinal stenosis, lumbar region with neurogenic claudication
M51.A1	Intervertebral annulus fibrosus defect, small, lumbar region
M51.A2	Intervertebral annulus fibrosus defect, large, lumbar region
M51.A4	Intervertebral annulus fibrosus defect, small, lumbosacral region
M51.A5	Intervertebral annulus fibrosus defect, large, lumbosacral region
M96.0	Pseudarthrosis after fusion or arthrodesis

AMA: **22600** 2021,Dec; 2021,Jul; 2020,May; 2018,Jul; 2018,May; 2017,Mar **22610** 2021,Dec; 2021,Jul; 2020,May; 2018,Jul; 2018,May; 2017,Mar **22612** 2022,Jun; 2022,Mar; 2021,Dec; 2021,Jul; 2020,May; 2018,Jul; 2018,May; 2017,Mar; 2017,Feb **22614** 2022,Mar; 2021,Dec; 2021,Jul; 2020,May; 2018,Jul; 2017,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
22600	17.4	15.51	5.69	38.6
22610	17.28	15.27	5.38	37.93
22612	23.53	17.02	6.51	47.06
22614	6.43	3.16	1.94	11.53
Facility RVU	**Work**	**PE**	**MP**	**Total**
22600	17.4	15.51	5.69	38.6
22610	17.28	15.27	5.38	37.93
22612	23.53	17.02	6.51	47.06
22614	6.43	3.16	1.94	11.53

	FUD	Status	MUE	Modifiers				IOM Reference
22600	90	A	1(2)	51	N/A	62	80	None
22610	90	A	1(2)	51	N/A	62	80	
22612	90	A	1(2)	51	N/A	62	80	
22614	N/A	A	13(3)	N/A	N/A	62	80	

* with documentation

Terms To Know

bone graft. Bone that is removed from one part of the body and placed into another bone site without direct re-establishment of blood supply.

fusion. Union of adjacent tissues, especially bone.

posterior. Located in the back part or caudal end of the body.

transverse. Crosswise at right angles to the long axis of a structure or part.

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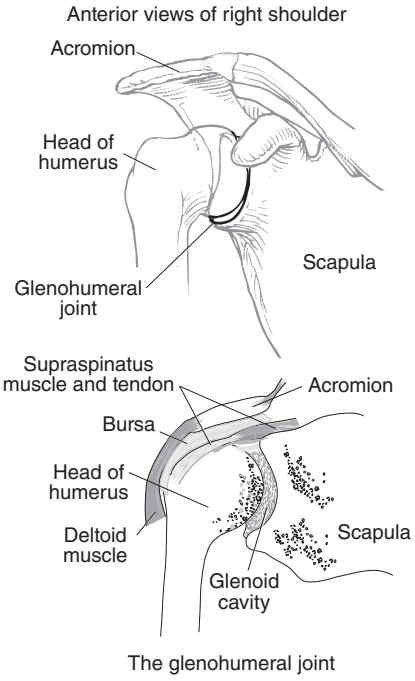
23107

23107 Arthrotomy, glenohumeral joint, with joint exploration, with or without removal of loose or foreign body



The glenohumeral joint

Explanation

The physician performs an arthrotomy of the glenohumeral joint with joint exploration and removal of any loose or foreign bodies. An incision is made over the glenohumeral joint. The soft tissues are dissected away and the joint capsule is exposed and incised. The joint space is explored and any loose or foreign body (e.g., free cartilage, bone fragments, gravel) is exposed and removed. The wound is irrigated with antibiotic solution. The physician may leave the wound packed open with daily dressing changes to allow for further drainage and secondary healing by granulation. If the incision is repaired, drain tubes may be inserted and the incision is repaired in layers with sutures, staples, and/or Steri-strips. A splint may be applied to limit shoulder motion.

Coding Tips

For exploration of a penetrating wound, see 20103. For arthroscopic removal of a loose or foreign body from the shoulder, see 29819.

ICD-10-CM Diagnostic Codes

M24.011 Loose body in right shoulder ☑
M24.012 Loose body in left shoulder ☑
M24.111 Other articular cartilage disorders, right shoulder ☑
M24.112 Other articular cartilage disorders, left shoulder ☑
S41.041A Puncture wound with foreign body of right shoulder, initial encounter ☑
S41.042A Puncture wound with foreign body of left shoulder, initial encounter ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
23107	8.87	9.04	1.78	19.69
Facility RVU	**Work**	**PE**	**MP**	**Total**
23107	8.87	9.04	1.78	19.69

	FUD	Status	MUE	Modifiers				IOM Reference
23107	90	A	1(2)	51	50	62*	80	None

* with documentation

Terms To Know

arthrotomy. Surgical incision into a joint that may include exploration, drainage, or removal of a foreign body.

dissection. (dis. apart; -section, act of cutting) Separating by cutting tissue or body structures apart.

exploration. Examination for diagnostic purposes.

foreign body. Any object or substance found in an organ and tissue that does not belong under normal circumstances.

granulation. Formation of small, bead-like masses of cytoplasm or granules on the surface of healing wounds of an organ, membrane, or tissue.

soft tissue. Nonepithelial tissues outside of the skeleton.

SAMPLE

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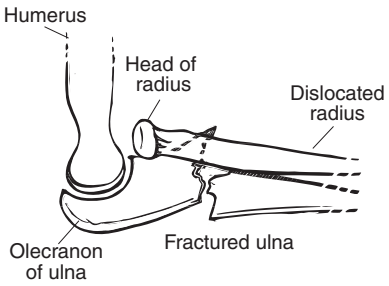
24635

24635 Open treatment of Monteggia type of fracture dislocation at elbow (fracture proximal end of ulna with dislocation of radial head), includes internal fixation, when performed

Lateral depiction of Monteggia's fracture



Explanation

The physician openly treats a Monteggia type fracture dislocation at the elbow (fracture of the proximal end of the ulna with dislocation of the radial head), with or without internal fixation. The physician makes a longitudinal incision along the lateral aspect of the elbow. Dissection exposes the radial head and proximal ulna. The physician determines the status of the annular ligament. If the ligament is intact, the physician incises it so the radial head can be reduced. The ligament is repaired with nonabsorbable sutures. More commonly, the ligament is torn or avulsed, requiring reconstruction. If so, a strip of fascia 1.3 cm wide and 11 cm long is dissected from the muscles of the forearm. If the ulnar fracture is stable, no internal fixation is required. If the fracture is unstable, internal fixation is typically applied. A compression plate or an intramedullary nail may be utilized for internal fixation. The new annular ligament (fascial strip) is sutured about the radial neck. The incision is repaired in layers with sutures, staples, and/or Steri-strips. The elbow is placed in a posterior splint or cast at 120 degrees of flexion, preventing redislocation of the radial head.

Coding Tips

According to CPT guidelines, the application and removal of the first cast, splint, or traction device are included in the codes that appear in the Musculoskeletal System section of CPT. Supplies may be reported separately. Modifier 56 should not be reported for preoperative management of a fracture. Removal of a cast by a provider, other than the provider who applied the cast, can be reported with cast removal codes 29700, 29705, and 29710. Cast, splint, or strapping (29000-29750) and/or traction device (20690, 20692) replacement during or after the global period of a procedure may be reported separately. For closed treatment of a Monteggia type fracture dislocation, see 24620. For treatment of a radial head subluxation (nursemaid elbow), see 24640. For closed treatment of an elbow dislocation, see 24600–24605. For a periarticular fracture dislocation of the elbow, see 24586 or 24587.

ICD-10-CM Diagnostic Codes

S52.271A Monteggia's fracture of right ulna, initial encounter for closed fracture ☑

S52.271B Monteggia's fracture of right ulna, initial encounter for open fracture type I or II ☑

S52.271C Monteggia's fracture of right ulna, initial encounter for open fracture type IIIA, IIIB, or IIIC ☑

S52.271K Monteggia's fracture of right ulna, subsequent encounter for closed fracture with nonunion ☑

S52.271M Monteggia's fracture of right ulna, subsequent encounter for open fracture type I or II with nonunion ☑

S52.271N Monteggia's fracture of right ulna, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with nonunion ☑

S52.271P Monteggia's fracture of right ulna, subsequent encounter for closed fracture with malunion ☑

S52.271Q Monteggia's fracture of right ulna, subsequent encounter for open fracture type I or II with malunion ☑

S52.271R Monteggia's fracture of right ulna, subsequent encounter for open fracture type IIIA, IIIB, or IIIC with malunion ☑

AMA: **24635** 2022,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
24635	8.8	9.57	1.73	20.1
Facility RVU	**Work**	**PE**	**MP**	**Total**
24635	8.8	9.57	1.73	20.1

	FUD	Status	MUE	Modifiers				IOM Reference
24635	90	A	1(2)	51	50	62*	80	None

* with documentation

Terms To Know

internal fixation. Wires, pins, screws, and plates placed through or within the fractured area to stabilize and immobilize the injury.

Monteggia's fracture. Break in the proximal half of the ulnar shaft accompanied by a dislocation of the radial head.

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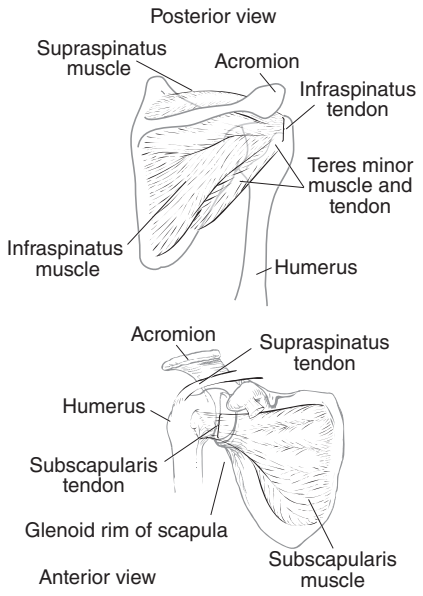
29827

29827 Arthroscopy, shoulder, surgical; with rotator cuff repair



Four rotator cuff tendons (supraspinatus, infraspinatus, teres minor, and scapularis) work together to hold the head of the humerus in the glenoid cavity

Explanation

The physician performs a surgical arthroscopy of the shoulder to repair a torn rotator cuff. The patient is positioned side-lying with the arm suspended. Small percutaneous poke hole incisions are made around the shoulder through which the arthroscopic instruments are inserted. A solution is pumped through one of these incisions to cleanse and expand the joint for better visualization. The physician first performs a diagnostic arthroscopic exam to assess the joint. A limited bursectomy may be performed with a subacromial decompression in which the undersurface of the anterolateral acromion is cleared of soft tissue, if necessary. A small percutaneous incision may be made laterally incorporating one of the portholes to facilitate the arthroscopic repair. The deltoid muscle is split from its acromion attachment about 5 cm and the tendon edge is debrided and mobilized. A transverse bony trough 3 to 4 mm is made and tunnels are drilled through the bone trough to the lateral cortex of the greater tuberosity. The tendon edge is brought into the trough with permanent sutures and anchor sutures are placed. Sutures are placed into the bone and brought through the tendon. A hemostat is placed on the cuff to retract the tendon and take tension off the sutures. The anchor sutures are tied down, followed by the sutures to the bony trough. The free ends of the sutures are passed through the tunnels and tied over a bony bridge. The longitudinal portions of the tear are closed with absorbable suture and a range of motion check is done on the arm. The deltoid splits, subcutaneous tissue, and skin are closed with suture, band aid, or Steri-strip, and the arm is placed in a sling to maintain abduction.

Coding Tips

When arthroscopy is performed in conjunction with arthrotomy, add modifier 51. Medicare, as well as some commercial payers, may not allow payment of diagnostic arthroscopy at the same time as an open procedure on the same joint. Since surgical arthroscopy includes any diagnostic arthroscopy, do not report separately. When arthroscopic decompression (29826) and/or distal claviculectomy (29824) are performed on the same shoulder at the same session, report each as appropriate in addition to 29827 and append modifier 51 to the secondary procedure. For an open or a mini-open rotator cuff tear, see 23412.

ICD-10-CM Diagnostic Codes

M12.511 Traumatic arthropathy, right shoulder ☑
M12.512 Traumatic arthropathy, left shoulder ☑
M19.111 Post-traumatic osteoarthritis, right shoulder ☑
M19.112 Post-traumatic osteoarthritis, left shoulder ☑
M75.111 Incomplete rotator cuff tear or rupture of right shoulder, not specified as traumatic ☑
M75.112 Incomplete rotator cuff tear or rupture of left shoulder, not specified as traumatic ☑
M75.121 Complete rotator cuff tear or rupture of right shoulder, not specified as traumatic ☑
M75.122 Complete rotator cuff tear or rupture of left shoulder, not specified as traumatic ☑
M75.51 Bursitis of right shoulder ☑
M75.52 Bursitis of left shoulder ☑
S43.421A Sprain of right rotator cuff capsule, initial encounter ☑
S43.422A Sprain of left rotator cuff capsule, initial encounter ☑
S46.011A Strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder, initial encounter ☑
S46.021A Laceration of muscle(s) and tendon(s) of the rotator cuff of right shoulder, initial encounter ☑
S46.091A Other injury of muscle(s) and tendon(s) of the rotator cuff of right shoulder, initial encounter ☑

AMA: 29827 2022,May; 2020,Dec; 2016,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
29827	15.59	13.06	3.06	31.71
Facility RVU	**Work**	**PE**	**MP**	**Total**
29827	15.59	13.06	3.06	31.71

	FUD	Status	MUE	Modifiers				IOM Reference
29827	90	A	1(2)	51	50	62*	80	None

* with documentation

SAMPLE

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N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only
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Correct Coding Initiative Update 28.3

❖Indicates Mutually Exclusive Edit

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