# Introduction

Overview of the code sets and other resources used in this manual

In order to code for orthopedic services, coders will be required to understand and use three primary code sets:

- **Current Procedural Terminology (CPT®)**, maintained by the American Medical Association, where you will find the bulk of your surgical and medical procedure codes, as well as clinician visit codes. These codes are also referred to as Health Care Common Procedure Coding System (HCPCS) Level I codes.
- **International Classification of Diseases – 10th Revision – Clinical modification (ICD-10-CM)**, maintained jointly by the Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS), where all your diagnosis codes reside, and
- **HCPCS Level II**, maintained by CMS. Here you will find codes for durable medical equipment and supplies, as well as injectable drugs, quality measures and certain medical and surgical procedures.
- Below you will find a brief overview of each of these three code sets.

## CPT codes – HCPCS Level I

Each year in the United States, health care insurers process more than 5 billion claims for payment. For Medicare and other health insurance programs to ensure that these claims are processed in an orderly and consistent manner, standardized coding systems are essential. HCPCS codes were developed for this purpose. HCPCS is divided into two principal subsystems, referred to as Level I and Level II.

HCPCS Level I is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the AMA and published each year in the CPT manual. CPT is a uniform coding system consisting of five-character codes and descriptive terms and that are used primarily to identify surgical and medical services furnished by physicians and other qualified health care professionals. Clinicians use the CPT code set to identify services and procedures for which they bill both public and private health insurance programs. Decisions regarding the addition, deletion, or modification of CPT codes are made by the AMA.

Within the CPT code set, there are three separate code categories, as well as a set of two-digit modifiers.

The largest of the categories is Category I, encompassing clinician visit services, anesthesia, surgery, radiology and medicine procedures as well as pathology and clinical laboratory tests. Category I codes are widely performed by U.S. physicians and other qualified health care professionals and are consistent with current medical practice. In addition, all devices and drugs necessary for performance of Category I codes have been approved by the FDA. The vast majority of CPT Category I codes are five digit codes made up of numbers only, though a small number of proprietary laboratory analysis codes in the Pathology and Laboratory chapter end with the letter "U." Category I codes are for the most part updated annually, though vaccine codes may be updated more frequently.

CPT Category II codes are designed to report compliance with clinician quality measures, such as for Medicare's Quality Payment Program. Category II codes are five-digit alphanumeric codes ending with the letter "F."

Category I and II CPT codes take effect each year on Jan. 1.

CPT Category III codes describe temporary codes that describe emerging therapies and technologies. For

many of these services, FDA approval may be pending. Category III codes may later become Category I CPT codes if their procedures receive FDA approval and their use is widely adopted by clinicians. However, codes in this category may be deleted from the codes set after five years if utilization is low. Category III codes are updated twice a year in January and July. Category III codes issued in January take effect July 1, while those issued in July take effect the following January. CPT category III codes are five-character alpha-numeric codes that end with the letter "T."

Orthopedic coders typically use more than half of the sections in the CPT manual on a regular basis, including:

- Evaluation and Management (E/M) codes for office and hospital visits,
- Integumentary codes (10000 series),
- Musculoskeletal codes (20000 series),
- Nervous system codes (60000 series),
- Radiology codes (70000 series) and
- Medicine codes (90000 series).

This manual will instruct you in correct usage of the applicable codes for orthopedic practices in each of the above sections. However, coders should also carefully review the CPT coding guidelines contained in those sections of the CPT manual to ensure appropriate usage.

# ICD-10-CM

To report diagnoses – the reasons for the services you are reporting – practices employ codes from the ICD-10-CM code set. These codes allow practitioners to describe not only the illness or condition they are treating in specific detail, but also any manifestations and/or underlying conditions that may complicate that care, such as diabetes, obesity or smoking.

ICD-10 codes were originally developed by the World Health Organization (WHO), which retains the copyright to them. However, the WHO authorized an expansion of the code set for use in the United States. This expanded code set – International Classification of Diseases 10th Revision Clinical Modification –has been reported by providers since Oct. 1, 2015.

The clinical modification represents a significant improvement over ICD-9-CM, which had been in use prior to October 2015. Specifically, ICD-10-CM includes the addition of information relevant to ambulatory and managed care encounters; expanded injury codes; the creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition; the addition of sixth and seventh characters; the addition of laterality; and greater specificity in code assignment. The new structure allows further expansion than was possible with ICD-9-CM.

ICD-10-CM codes are alphanumeric and active codes may have between three and seven characters.

ICD-10-CM is maintained by the ICD-10-CM Coordination and Maintenance Committee – funded jointly by CMS and the CDC. Proposed changes to the code set are released each year in April as part of Medicare's proposed inpatient hospital payment rule. Finalized changes and revisions to the ICD-10-CM code set and Official Coding Guidelines are issued in August. ICD-10-CM code changes take effect Oct. 1.

Orthopedic coders typically select codes from the following chapters within the ICD-10-CM manual.

- Chapter 2: Neoplasms (C00-D49)
- Chapter 4: Endocrine, Nutritional and Metabolic Diseases (E00-E99)
- Chapter 6: Diseases of the Nervous System (G00-G99)
- Chapter 12: Diseases of the Skin and Subcutaneous Tissue (L00-L99)
- Chapter 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99)
- Chapter 17: Congenital Malformations, Deformations and Chromosomal Abnormalities (Q00-Q99)
- Chapter 18: Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere

Classified (R00-R99)
- Chapter 19: Injury, Poisoning and Certain Other Consequences of External Causes (S00-T88)
- Chapter 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99)

# HCPCS Level II Codes

Level II HCPCS codes primarily represent items and supplies and non-physician services not covered by the AMA's CPT codes (HCPCS Level I). Medicare, Medicaid and private health insurers use HCPCS procedures and modifiers for claims processing.

The HCPCS code set, which is made up of five-character alphanumeric codes, is updated quarterly, with cumulative annual changes issued each November. Updates are released on the CMS website.

Orthopedic practices typically make use of the following types of HCPCS codes:
- Medical and surgical supplies (A4206-A8004)
- Durable Medical Equipment (E0100-E8002)
- Temporary Codes for Procedures and Professional Services (G0008-G9977)
- Drugs Administered (J0120-J8999)
- Temporary Durable Medical Equipment (K0001-K0900)
- Orthotic Procedures and Devices (L0112-L4631)
- Temporary Codes (Q0035-Q9989)
- HCPCS Modifiers

# Authoritative coding resources

Coding guidance in the *Orthopedic Coding & Documentation Trainer* draws on a range of coding resources that are considered authoritative for the code sets described above. The reader will find the following resources cited within the text of the book:

**AMA CPT codes**
CPT Manual
CPT Assistant newsletter (published monthly by the AMA)
CPT Changes – An Insider's View

The above products are available from the AMA: https://www.ama-assn.org/practice-management/cpt

**ICD-10-CM codes:**
ICD-10-CM manual index and tabular coding instructions
ICD-10-CM Official Guidelines for Coding and Reporting

Both documents are available here:
https://www.cdc.gov/nchs/icd/icd10cm.htm#FY%202019%20release%20of%20ICD-10-CM

American Hospital Association Coding Clinic: http://www.ahacentraloffice.org/

**HCPCS codes:**

American Hospital Association Coding Clinic (HCPCS codes)

**Payer resources**

National Medicare Correct Coding Initiative Policy Manual
Medicare physician fee schedule

Medicare national coverage determinations
Medicare administrative contractor local coverage determinations
Medicare Claims Processing Manual (CMS 100-04)

All of the above are available on the CMS site: https://www.cms.gov/

**HHS Office of Inspector General:**
OIG Work Plan
OIG audits

Available here: https://oig.hhs.gov/

**Professional Societies:**

The American Academy of Orthopaedic Surgeons (AAOS) publishes its code bundling policy in the Global Service Data Book for Orthopaedic Surgery and CodeX software: www.aaos.org

North American Spine Society: https://www.spine.org/
Arthroscopy Association of North America: https://www.aana.org/
American Association of Neurological Surgeons: https://www.aans.org

**Anatomic and Physiological references:**

"A Manual of Orthopaedic Terminology", 8th Ed, by Carolyn Taliaferro Blauvelt and Fred R.T. Nelson ISBN # 978-0-323-22158-0
Medical Abbreviations: 13th, Neil M Davis, www.neilmdavis.com

Gray's Anatomy online www.bartleby.com/107

Coding Line – Podiatry coding: www.codingline.com

# Surgical Procedures

Surgical procedures may be performed in a number of different places of service.

Minor procedures may be performed in the physician's office setting, others may occur in the emergency department, endoscopy suite, outpatient clinic, ambulatory surgery center, ancillary departments of the hospital or hospital-owned satellite facilities such as provider-based centers.

It is important to have a well-designed charge form to capture the information needed to select the accurate code for a surgical procedure.

## Locating the Appropriate Procedure Codes in the Musculoskeletal Section

The codes in the musculoskeletal system section of the CPT manual cover procedures to the bones, muscles, tendons and soft tissue. The musculoskeletal system has key phrases that a coder must recognize and understand for an accurate code to be assigned. It is important to have an understanding of anatomy and physiology to avoid coding errors.

The front of the CPT musculoskeletal section includes extensive definitions and guidelines on proper coding of fractures, dislocations and excision of soft tissue and bone tumors.

These notes are followed by codes in the "General" procedures section, including incision, excision, introduction or removal, replantation, grafts and "other procedures."

Following the general codes section, you'll find musculoskeletal procedure codes organized by anatomic area, from head to toe.

For the most part, these anatomic procedures are organized in the following order:

- Incisions
- Excisions
- Introduction or removal
- Repair, Revision and/or reconstruction
- Fractures and/or dislocations

Note that the spine subsection is a bit more extensive, with additional procedure types including osteotomy, manipulation, percutaneous vertebroplasty and vertebral augmentation, percutaneous augmentation and annuloplasty, arthrodesis and spinal instrumentation.

If the appropriate code cannot be found under an anatomic site heading (e.g., shoulder) refer to the codes following the "general" section at the beginning of the musculoskeletal system.

When using the index of the CPT manual, first look up the general term for what was done (e.g., excision or repair) and under that term find the appropriate body part.

**Tip:** For incision or excision procedures, remember to check the musculoskeletal anatomic sections of the CPT manual for procedure codes before looking at the 10000 series codes in the integumentary section.

At the back of the CPT manual's musculoskeletal system section, you'll find the casting and strapping codes, followed by the endoscopy/arthroscopy procedure codes.

This chapter explores surgical procedure coding, following roughly the order the procedure codes appear in the CPT manual, beginning with general procedures.