

Surgery

Musculoskeletal System

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 20000-29999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this Chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this Chapter.

B. Evaluation and Management (E&M) Services

Medicare Global Surgery Rules define the rules for reporting evaluation and management (E&M) services with procedures covered by these rules. This section summarizes some of the rules.

All procedures on the Medicare Physician Fee Schedule are assigned a global period of 000, 010, 090, XXX, YYY, ZZZ, or MMM. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the MAC. All procedures with a global period of ZZZ are related to another procedure, and the applicable global period for the ZZZ code is determined by the related procedure. Procedures with a global period of MMM are maternity procedures.

Since National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits are applied to same day services by the same provider to the same beneficiary, certain Global Surgery Rules are applicable to NCCI. An E&M service is separately reportable on the same date of service as a procedure with a global period of 000, 010, or 090 days under limited circumstances.

If a procedure has a global period of 090 days, it is defined as a major surgical procedure. If an E&M service is performed on the same date of service as a major surgical procedure for the purpose of deciding whether to perform this surgical procedure, the E&M service is separately reportable with modifier 57. Other preoperative E&M services on the same date of service as a major surgical procedure are included in the global payment for the procedure and are not separately reportable. The NCCI program does not contain edits based on this rule because MACs have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical procedure. In general, E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service. However, a significant and separately identifiable E&M service unrelated to the decision to perform the minor surgical procedure is

separately reportable with modifier 25. The E&M service and minor surgical procedure do not require different diagnoses. If a minor surgical procedure is performed on a new patient, the same rules for reporting E&M services apply. The fact that the patient is “new” to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure. The NCCI program contains many, but not all, possible edits based on these principles.

For major and minor surgical procedures, postoperative E&M services related to recovery from the surgical procedure during the postoperative period are included in the global surgical package as are E&M services related to complications of the surgery. Postoperative visits unrelated to the diagnosis for which the surgical procedure was performed may be reported separately on the same day as a surgical procedure with modifier 24 (“Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period”), unless related to a complication of surgery.

Procedures with a global surgery indicator of “XXX” are not covered by these rules. Many of these “XXX” procedures are performed by physicians and have inherent pre-procedure, intra-procedure, and post-procedure work usually performed each time the procedure is completed. This work should **not** be reported as a separate E&M code. Other “XXX” procedures are not usually performed by a physician and have no physician work relative value units associated with them. A physician should never report a separate E&M code with these procedures for the supervision of others performing the procedure or for the interpretation of the procedure. With most “XXX” procedures, the physician may, however, perform a significant and separately identifiable E&M service that is above and beyond the usual pre- and postoperative work of the procedure on the same date of service which may be reported by appending modifier 25 to the E&M code. This E&M service may be related to the same diagnosis necessitating performance of the “XXX” procedure but cannot include any work inherent in the “XXX” procedure, supervision of others performing the “XXX” procedure, or time for interpreting the result of the “XXX” procedure.

C. Anesthesia

With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, 62320-62327, or 64400-64530 for anesthesia for a procedure. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), drug administration (CPT codes 96360-96377) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare generally allows separate reporting for moderate conscious sedation services (CPT codes 99151-99153) when provided by the same physician performing a medical or surgical procedure except when the anesthesia service is bundled into the procedure, e.g., radiation treatment management.

Injections of local anesthesia for musculoskeletal procedures (surgical or manipulative) are not separately reportable. For example, CPT codes 20526-20553 (therapeutic injection of carpal tunnel, tendon sheath, ligament, muscle trigger points) should not be reported for the administration of local anesthesia to perform another procedure. The NCCI program contains many edits based on this principle. If a procedure and a separate and distinct injection service unrelated to anesthesia for the former procedure are reported, the injection service may be reported with an NCCI PTP-associated modifier if appropriate.

CPT codes 64450 (Injection, anesthetic agent; other peripheral nerve or branch) and 64455 (Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (e.g., Morton's neuroma)) should not be reported by a surgeon for anesthesia for a surgical procedure. If performed as a therapeutic or diagnostic injection unrelated to the surgical procedure, these codes may be reported separately.

D. Biopsy

A biopsy performed at the time of another more extensive procedure (e.g., excision, destruction, removal) is separately reportable under specific circumstances.

If the biopsy is performed on a separate lesion, it is separately reportable. This situation may be reported with anatomic modifiers if applicable, and or modifier 59 or XS.

The biopsy is not separately reportable if used for the purpose of assessing margins of resection or verifying resectability.

If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.

E. Arthroscopy

1. Surgical arthroscopy includes diagnostic arthroscopy which is not separately reportable. If a diagnostic arthroscopy leads to a surgical arthroscopy at the same patient encounter, only the surgical arthroscopy may be reported.
2. If an arthroscopy is performed as a "scout" procedure to assess the surgical field or extent of disease, it is not separately reportable. If the findings of a diagnostic arthroscopy lead to the decision to perform an open procedure, the diagnostic arthroscopy may be separately reportable. Modifier 58 may be reported to indicate that the diagnostic arthroscopy and non-arthroscopic therapeutic procedures were staged or planned procedures. The medical record must indicate the medical necessity for the diagnostic arthroscopy.
3. If an arthroscopic procedure is converted to an open procedure, only the open procedure may be reported. Neither a surgical arthroscopy nor a diagnostic arthroscopy code should be reported with the open procedure code when a surgical arthroscopic procedure is converted to an open procedure.
4. With three exceptions (which are described in Chapter IV, Section E (Arthroscopy), Subsection #7), an NCCI PTP edit code pair consisting of two codes describing two shoulder arthroscopy procedures shall not be bypassed with an NCCI PTP-associated modifier when the two procedures are performed on the ipsilateral shoulder. This type of edit may be bypassed with an NCCI PTP-associated modifier only if the two procedures are performed on contralateral shoulders.
5. With the exception of the knee and shoulder, arthroscopic debridement should not be reported separately with a surgical arthroscopy procedure when performed on the same joint at the same patient encounter. For knee arthroscopic debridement see the following subsection. For shoulder arthroscopic debridement, see Subsection 7 below.

6. CPT codes 29874 (Surgical knee arthroscopy for removal of loose body or foreign body) and 29877 (Surgical knee arthroscopy for debridement/shaving of articular cartilage) should not be reported with other knee arthroscopy codes (29866- 29889). With two exceptions, HCPCS code G0289 (Surgical knee arthroscopy for removal of loose body, foreign body, debridement/shaving of articular cartilage at the time of other surgical knee arthroscopy in a different compartment of the same knee) may be reported with other knee arthroscopy codes. Since CPT codes 29880 (Arthroscopy, knee, surgical; with meniscectomy (medial AND lateral, including any meniscal shaving) including debridement/ shaving of articular cartilage (chondroplasty) same or separate compartment(s), when performed) and 29881 (Surgical knee arthroscopy with meniscectomy (medial OR lateral, including debridement/shaving of articular cartilage of same or separate compartment(s)) include debridement/shaving of articular cartilage of any compartment, HCPCS code G0289 may be reported with CPT codes 29880 or 29881 only if reported for removal of a loose body or foreign body from a different compartment of the same knee. HCPCS code G0289 should not be reported for removal of a loose body or foreign body or debridement/shaving of articular cartilage from the same compartment as another knee arthroscopic procedure.
7. Shoulder arthroscopy procedures include limited debridement (e.g., CPT code 29822) even if the limited debridement is performed in a different area of the same shoulder than the other procedure. With three exceptions, shoulder arthroscopy procedures include extensive debridement (e.g., CPT code 29823) even if the extensive debridement is performed in a different area of the same shoulder than the other procedure. CPT codes 29824 (Arthroscopic claviculectomy including distal articular surface), 29827 (Arthroscopic rotator cuff repair), and 29828 (Biceps tenodesis) may be reported separately with CPT code 29823 if the extensive debridement is performed in a different area of the same shoulder.
8. Arthroscopic synovectomy of the knee may be reported with CPT codes 29875 (Limited synovectomy, "separate procedure") or 29876 (Major synovectomy of two or three compartments). A synovectomy to "clean up" a joint on which another more extensive procedure is performed is not separately reportable. CPT code 29875 should **not** be reported with another arthroscopic knee procedure on the ipsilateral knee. CPT code 29876 may be reported for a medically reasonable and necessary synovectomy with another arthroscopic knee procedure on the ipsilateral knee if the synovectomy is performed in two compartments on which another arthroscopic procedure is not performed. For example, CPT code 29876 should **not** be reported for a major synovectomy with CPT code 29880 (Knee arthroscopy, medial AND lateral meniscectomy) on the ipsilateral knee, since knee arthroscopic procedures other than synovectomy are performed in two of the three knee compartments.

F. Spine (Vertebral Column)

1. Exploration of the surgical field is a standard surgical practice. Physicians should not report a HCPCS/CPT code describing exploration of a surgical field with another HCPCS/CPT code describing a procedure in that surgical field. For example, CPT code 22830 describes exploration of a spinal fusion. CPT code 22830 should not be reported with another procedure of the spine in the same anatomic area. However, if the spinal fusion exploration is performed in a different anatomic area than another spinal procedure, CPT code 22830 may be reported separately with modifier 59 or XS.

2. Some procedures (e.g., spine) frequently use intraoperative neurophysiology testing. Intraoperative neurophysiology testing (HCPCS/CPT codes 95940, 95941/G0453) should not be reported by the physician performing an operative procedure since it is included in the global package. However, when performed by a different physician during the procedure, it is separately reportable by the second physician. The physician performing an operative procedure should not bill other 9XXXX neurophysiology testing codes for intraoperative neurophysiology testing (e.g., CPT codes 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95907-95913, 95925-95937) since they are also included in the global package.
3. Spinal arthrodesis, exploration, and instrumentation procedures (CPT codes 22532-22865) and other spinal procedures include manipulation of the spine as an integral component of the procedures. CPT code 22505 (Manipulation of spine requiring anesthesia, any region) should not be reported separately.
4. Many spinal procedures are grouped into families of codes where there are separate primary procedure codes describing the procedure at a single vertebral level in the cervical, thoracic, or lumbar region of the spine. Within some families of codes, there is an AOC for reporting the same procedure at each additional level without specification of the spinal region for the AOC. When multiple procedures from one of these families of codes are performed at contiguous vertebral levels, a physician should report only one primary code within the family of codes for one level and should report additional contiguous levels using the AOC(s) in the family of codes. The reported primary code should be the one corresponding to the spinal region of the first procedure. If multiple procedures from one of these families of codes are performed through separate skin incisions at multiple vertebral levels that are not contiguous and in different regions of the spine, the physician may report one primary code for each non-contiguous region.

For example, the family of CPT codes 22532-22534 describes arthrodesis by lateral extracavitary technique. CPT code 22532 describes the procedure for a single thoracic vertebral segment. CPT code 22533 describes the procedure for a single lumbar vertebral segment. CPT code 22534 is an AOC describing the procedure for each additional thoracic or lumbar vertebral segment. If a physician performs arthrodesis by lateral extracavitary technique on contiguous vertebral segments such as T12 and L1, only one primary procedure code (i.e., the one for the first procedure) may be reported. The procedure on the second vertebral body may be reported with CPT code 22534. If a physician performs the procedure at T10 and L4 through separate skin incisions, the physician may report CPT codes 22532 and 22533.

CPT codes 22510-22512 represent a family of codes describing percutaneous vertebroplasty, and CPT codes 22513-22515 represent a family of codes describing percutaneous vertebral augmentation. Within each of these families of codes, the physician may report only one primary procedure code and the add-on procedure code for each additional level(s) whether the additional level(s) are contiguous or not.

5. CPT codes 22600-22614 describe arthrodesis by posterior or posterolateral technique. CPT codes 22630-22632 describe arthrodesis by posterior interbody technique. CPT codes 22633-22634 describe arthrodesis by combined posterior or posterolateral technique with posterior interbody technique. These codes are reported per level or interspace. CPT code 22614 is an AOC code that may be reported with primary CPT codes 22600, 22610, 22612, 22630, or 22633. CPT code 22632 is an AOC that may be reported with primary CPT

codes 22612, 22630, or 22633. CPT code 22634 is an AOC that may be reported with primary CPT code 22633.

If a physician performs arthrodesis across multiple interspaces using the same technique in the same spinal region, the physician should report a primary code for the first interspace and an AOC for each additional interspace. If the interspaces span two different spinal regions through the same skin incision, the physician should report a primary code for the first interspace and an AOC for each additional interspace. If the interspaces span two different spinal regions through different skin incisions, the physician may report a primary code for the first interspace through each skin incision and an AOC for each additional interspace through the same skin incision.

If a physician performs arthrodesis across multiple contiguous interspaces through the same skin incision using different techniques, the physician should report one primary code for the first interspace and AOCs for each additional interspace.

If a physician performs arthrodesis across multiple non-contiguous interspaces through the same skin incision using different techniques, the physician should report one primary code for the first interspace and AOCs for each additional interspace.

If a physician performs arthrodesis across multiple non-contiguous interspaces through different skin incisions using different techniques, the physician may report one primary code for the first interspace through each skin incision and AOCs for each additional interspace through the same skin incision.

6. Fluoroscopy reported as CPT code 76000 should not be reported with spinal procedures, unless there is a specific “CPT Manual” instruction indicating that it is separately reportable. For some spinal procedures, there are specific radiologic guidance codes to report in lieu of these fluoroscopy codes. For other spinal procedures, fluoroscopy is used in lieu of a more traditional intraoperative radiologic examination which is included in the operative procedure. For other spinal procedure codes, fluoroscopy is integral to the procedure. (CPT code 76001 was deleted January 1, 2019.)
7. CPT code 38220 describes diagnostic bone marrow aspiration(s). It shall not be reported separately with musculoskeletal procedures (e.g., spinal osteotomy, vertebral fracture repair, spinal arthrodesis, spinal fusion, laminectomy, spinal decompression, vertebral corpectomy), for bone marrow aspiration for platelet rich stem cell injection or other therapeutic musculoskeletal applications.
8. CPT codes 38230 (Bone marrow harvesting for transplantation; allogeneic) and 38232 (Bone marrow harvesting for transplantation; autologous) should not be reported separately with a spinal osteotomy, vertebral fracture repair, spinal arthrodesis, spinal fusion, spinal laminectomy, spinal decompression, or vertebral corpectomy CPT code for procurement of bone marrow aspirate. CPT codes 38230 and 38232 are used to report the procurement of bone marrow for future bone marrow transplantation.
9. CMS payment policy does not allow separate payment for CPT codes 63042 (Laminotomy...; lumbar) or 63047 (Laminectomy...; lumbar) with CPT codes 22630 or 22633 (Arthrodesis; lumbar) when performed at the same interspace. If the two procedures are performed at different interspaces, the two codes of an edit pair may be reported with modifier 59 or XS.

