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CHAPTER IV
SURGERY: MUSCULOSKELETAL SYSTEM
CPT CODES 20000-29999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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Chapter IV
Surgery: Musculoskeletal System
CPT Codes 20000 - 29999

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, or ZZZ. The global concept does not apply to XXX procedures. The global period for YYY procedures is defined by the Carrier (A/B MAC processing practitioner service claims). 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.

Since NCCI 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 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 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 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. NCCI does not contain edits based on this rule because Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits.

If a procedure has a global period of 000 or 010 days, it is defined as a minor surgical 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. NCCI does contain some edits based on these principles, but the Medicare Carriers (A/B MACs processing practitioner service claims) have separate edits. Neither the NCCI nor Carriers (A/B MACs processing practitioner service claims) have all possible edits based on these principles.

Example: If a physician determines that a new patient with head trauma requires sutures, confirms the allergy and immunization status, obtains informed consent, and performs the repair, an E&M service is not separately reportable. However, if the physician also performs a medically reasonable and necessary full neurological examination, an E&M service may be separately reportable.

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 never 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 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. Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an “XXX” procedure is correct coding.

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 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 96360-96376) 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 allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*

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 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-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 or modifier 59.

If the biopsy is performed on the same lesion on which a more extensive procedure is performed, it is separately reportable only if the biopsy is utilized for immediate pathologic diagnosis prior to the more extensive procedure, and the decision to proceed with the more extensive procedure is based on the diagnosis established by the pathologic examination. The biopsy is not separately reportable if the pathologic examination at the time of surgery is for the purpose of assessing margins of resection or verifying resectability. When separately reportable modifier 58 may be reported to indicate that the biopsy and the more extensive procedure were planned or staged procedures.

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. Arthroscopic Procedure Converted to Open Procedure

If an arthroscopic procedure fails and is converted to an open procedure, only the open procedure is reportable. Thus, arthroscopic procedures are bundled into open procedures. If an arthroscopic procedure and open procedure are performed on

different joints, the two procedures may be separately reportable with anatomic modifiers or modifier 59.

F. Fractures and/or Dislocations

1. The application of external immobilization devices (casts, splints, strapping) at the time of a procedure includes the subsequent removal of the device when performed by the same entity (e.g., physician, practice, group, employees, etc.). Providers should not report removal or repair CPT codes 29700-29750 for those services. These removal or repair CPT codes may only be reported if the initial application of the cast, splint, or strapping was performed by a different entity.

2. Casting/splinting/strapping should not be reported separately if a restorative treatment or procedure to stabilize or protect a fracture, injury, or dislocation and/or afford comfort to the patient is also performed. Additionally casting/splinting/strapping CPT codes should not be reported for application of a dressing after a therapeutic procedure. For example, if a provider injects an anesthetic agent into a peripheral nerve or branch (CPT code 64450), the provider should not report CPT codes such as 29515, 29540, 29580, or 29590. Similarly, a provider should not report a casting/splinting/strapping CPT code for the same site as an injection or aspiration (e.g., CPT codes 20526-20615).

3. CPT codes for closed or open treatment of fractures or dislocations include the application of casts, splints, or strapping. CPT codes for casting/splinting/strapping should not be reported separately.

4. If a physician treats a fracture, dislocation, or injury with an initial cast, strap, or splint and also assumes the follow-up care, the physician cannot report the casting/splinting/strapping CPT codes since these services are included in the fracture and/or dislocation CPT codes.

5. If a physician treats a fracture, dislocation, or injury with a cast, splint, or strap as an initial service without any other definitive procedure or treatment and only expects to perform the initial care, the physician may report an evaluation and management (E&M) service, a casting/splinting/strapping CPT code, and a cast/splint/strap supply code (Q4001-Q4051).

For OPPS if a hospital treats a fracture, dislocation, or injury with a cast, splint, or strap as an initial service without any other definitive procedure or treatment, the hospital should report the appropriate casting/splinting/strapping CPT code. Payment for the cast/splint/strap supplies is included in the payment for the procedure reported.

6. An evaluation and management (E&M) service may be reported with a casting/splinting/strapping CPT code if the E&M service is significant and separately identifiable.

7. There are CPT codes (20670 and 20680) for removal of internal fixation devices (e.g., pin, rod). These codes are not separately reportable if the removal is performed as a necessary integral component of another procedure. For example, if revision of an open fracture repair for nonunion or malunion of bone requires removal of a previously inserted pin, CPT code 20670 or 20680 is not separately reportable.

Similarly, if a superficial or deep implant (e.g., buried wire, pin, rod) requires surgical removal (CPT codes 20670 and 20680), it is not separately reportable if it is performed as an integral part of another procedure.

8. CPT code 20670 or 20680 (removal of implant) should not be reported for the removal of wire sutures during cardiac reoperation procedures or sternal procedures (e.g., debridement, resection, closure of median sternotomy separation).

9. If a closed reduction procedure fails and is converted to an open reduction procedure at the same patient encounter, only the more extensive open reduction procedure is reportable. Similarly, if a closed fracture treatment procedure fails and is converted to an open fracture treatment procedure at the same patient encounter, only the more extensive open fracture treatment procedure is reportable.

10. If interdental wiring (e.g., CPT code 21497) is necessary for the treatment of a facial or other fracture, arthroplasty, facial reconstructive surgery, or other facial/head procedure, the interdental wiring is not separately reportable. However, if interdental wiring is performed unrelated to another facial/head procedure, the interdental wiring may be separately reportable with modifier 59.

11. When it is necessary to perform skeletal/joint manipulation under anesthesia to assess range of motion, reduce a fracture or for any other purpose during another procedure in an anatomically related area, the corresponding manipulation code (e.g., CPT codes 22505, 23700, 27275, 27570, 27860) is not separately reportable.

G. Medically Unlikely Edits (MUEs)

1. MUEs are described in Chapter I, Section V.

2. Providers/suppliers should be cautious about reporting services on multiple lines of a claim utilizing modifiers to bypass MUEs. MUEs were set so that such occurrences should be uncommon. If a provider/supplier does this frequently for any HCPCS/CPT code, the provider/supplier may be coding units of service incorrectly. The provider/supplier should consider contacting his/her national healthcare organization or the national medical/surgical society whose members commonly perform the procedure to clarify the correct reporting of units of service. A national healthcare organization, provider/supplier, or other interested third party may request a reconsideration of the MUE value of a HCPCS/CPT code by CMS by writing the MUE contractor, Correct Coding Solutions, LLC, at the address indicated in Chapter I, Section V.

3. The code descriptors for CPT codes 20670 (removal of implant; superficial...) and 20680 (removal of implant; deep...) do not define the unit of service. CMS allows one unit of service for all implants removed from an anatomic site. This single unit of service includes the removal of all screws, rods, plates, wires, etc. from an anatomic site whether through one or more surgical incisions. An additional unit of service may be reported only if implant(s) are removed from a distinct and separate anatomic site.

H. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the

Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual.*

3. With few exceptions the payment for a surgical procedure includes payment for dressings, supplies, and local anesthesia. These items are not separately reportable under their own HCPCS/CPT codes. Wound closures utilizing adhesive strips or tape alone are not separately reportable. In the absence of an operative procedure, these types of wound closures are included in an E&M service. Under limited circumstances wound closure utilizing tissue adhesive may be reported separately. If a practitioner utilizes a tissue adhesive alone for a wound closure, it may be reported separately with HCPCS code G0168 (wound closure utilizing tissue adhesive(s) only). If a practitioner utilizes tissue adhesive in addition to staples or sutures to close a wound, HCPCS code G0168 is not separately reportable but is included in the tissue repair. Under OPPS HCPCS code G0168 is not recognized and paid. Facilities may report wound closure utilizing sutures, staples, or tissue adhesives, either singly or in combination with each other, with the appropriate CPT code in the “Repair (Closure)” section of the *CPT Manual*.

4. If a tissue transfer procedure such as a graft (e.g., CPT codes 20900-20926) is included in the code descriptor of a primary procedure, the tissue transfer procedure is not separately reportable.

5. CPT code 20926 describes a graft of “other” tissues such as paratenon, fat, or dermis. Similar to other graft codes, this code may not be reported with another code where the code descriptor includes procurement of the graft. Additionally, CPT code 20926 may be reported only if another graft HCPCS/CPT code does not more precisely describe the nature of the graft.

6. Some procedures routinely utilize monitoring of interstitial fluid pressure during the postoperative period (e.g., distal lower extremity procedures with risk of anterior compartment compression). CPT code 20950 (monitoring of interstitial fluid pressure) should not be reported separately for this monitoring.

7. If electrical stimulation is used to aid bone healing, bone stimulation codes (CPT codes 20974-20975) may be reported. CPT codes 64550-64595 describe procedures for neurostimulators which are utilized to control pain and should not be reported for electrical stimulation to aid bone healing. Similarly the physical medicine electrical stimulation codes (CPT codes 97014 and 97032) should not be reported for electrical stimulation to aid bone healing.

8. 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.

9. Debridement of tissue related to an open repair of a fracture or dislocation may be separately reportable with CPT codes 11010-11012. However, debridement of tissue in the surgical field integral to the completion of another musculoskeletal procedure is not separately reportable. For example, debridement of muscle and/or bone (CPT codes 11043-11044) associated with excision of a tumor of bone is not separately reportable. Similarly, debridement of tissue superficial (CPT codes 11040-11042, 11720-11721) to, but in the surgical field, of a musculoskeletal procedure is not separately reportable.

10. 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). 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.

11. The NCCI has an edit with column one CPT code of 24305 (tendon lengthening, upper arm and elbow, each tendon) and column two CPT code of 64718 (neuroplasty and/or transposition; ulnar nerve at elbow). When performing the tendon lengthening described by CPT code 24305, a neuroplasty of the ulnar nerve is not separately reportable, but a transposition of the ulnar nerve at the elbow is separately reportable. If a provider performs the tendon lengthening described by CPT code 24305 and performs an ulnar nerve transposition at the elbow, the NCCI edit may be bypassed by reporting CPT code 64718 appending modifier 59.

12. Some procedures (e.g., spine) frequently utilize intraoperative neurophysiology testing. Intraoperative neurophysiology testing (CPT code 95920) 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 90000 neurophysiology testing codes for intraoperative neurophysiology testing (e.g., CPT codes 92585, 95822, 95860, 95861, 95867, 95868, 95870, 95900, 95904, 95925-95937) since they are also included in the global package.

13. Spinal arthrodesis, exploration, and instrumentation procedures (CPT codes 22532-22865) 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.

14. Fluoroscopy reported as CPT codes 76000 or 76001 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.

15. CPT codes 28288, 28306, 28307, 28310, and 28315 should not be reported with bunionectomy CPT codes 28290-28299 for procedures performed on the ipsilateral first toe or metatarsal. CPT codes 28306, 28307, and 28310 (osteotomy procedures) should not be reported with a bunionectomy code because there are bunionectomy codes that include osteotomy of the first metatarsal or proximal phalanx of the first toe. CPT code 28288 (ostectomy ...) should not be reported with a bunionectomy code because it is a misuse of this code to report ostectomy of the median eminence of the metatarsal bone which is integral to the bunionectomy procedure. Additionally, some bunionectomy procedures include excision of the head of the first metatarsal. CPT code 28315 (sesamoidectomy, first toe (separate procedure)) includes the “separate procedure” designation in its code descriptor. CMS payment policy does not allow separate payment for a procedure designated as a “separate procedure” when performed along with another procedure in the same anatomic area.

16. CPT codes 28008, 28060, 28062, 28250 and 29893 describe procedures that may be performed on plantar fascia. No two codes from this group should be reported for treatment of plantar fascia of the ipsilateral foot at the same patient encounter.

17. Fluoroscopy (CPT codes 76000 and 76001) is an integral component of arthroscopic procedures when performed. CPT codes 76000 and/or 76001 should not be reported separately with an arthroscopic procedure.

18. Under Medicare Global Surgery Rules, drug administration services (CPT codes 96360-96376) are not separately reportable by the physician performing a procedure for drug administration services related to the procedure.

Under the OPPS drug administration services related to operative procedures are included in the associated procedural HCPCS/CPT codes. Examples of such drug administration services include, but are not limited to, anesthesia (local or other), hydration, and medications such as anxiolytics or antibiotics. Providers should not report CPT codes 96360-96376 for these services.

Medicare Global Surgery Rules prevent separate payment for postoperative pain management when provided by the physician performing an operative procedure. CPT codes 36000, 36410, 37202, 62310-62319, 64400-64484, and 96360-96376 describe some

services that may be utilized for postoperative pain management. The services described by these codes may be reported by the physician performing the operative procedure only if provided for purposes unrelated to the postoperative pain management, the operative procedure, or anesthesia for the procedure.

If a physician performing an operative procedure provides a drug administration service (CPT codes 96360-96375) for a purpose unrelated to anesthesia, intra-operative care, or post-procedure pain management, the drug administration service (CPT codes 96360-96375) may be reported with an NCCI-associated modifier if performed in a non-facility site of service.

19. The Medicare global surgery package includes insertion of urinary catheters. CPT codes 51701-51703 (insertion of bladder catheters) should not be reported with a procedure with a global period of 000, 010, or 090 days.

20. Repair of a surgical incision (CPT codes 12001-13153) is generally included in the global surgical package. These codes should not be reported separately to describe closure of such surgical incisions. However, there are a few types of procedures defined by the *CPT Manual* where repair codes are separately reportable. NCCI edits do not bundle CPT codes 12001-13153 into all surgical procedures where closure of the incision is included in the global surgical package, but only into those surgical procedures with identified problems. Physicians must code correctly even in the absence of NCCI edits.

21. Control of bleeding during an operative procedure is an integral component of a surgical procedure and is not separately reportable. Postoperative control of bleeding not requiring return to the operating room is included in the global surgical package and is not separately reportable. However, control of bleeding requiring return to the operating room in the postoperative period is separately reportable utilizing modifier 78.

22. Fine needle aspiration (FNA) (CPT codes 10021, 10022) should not be reported with another biopsy procedure code for the same lesion unless one specimen is inadequate for diagnosis. For example, an FNA specimen is usually examined for adequacy when the specimen is aspirated. If the specimen is adequate for diagnosis, it is not necessary to obtain an additional biopsy specimen. However, if the specimen is not adequate and another

type of biopsy (e.g., needle, open) is subsequently performed at the same patient encounter, the other biopsy procedure code may also be reported with an NCCI-associated modifier.

23. If the code descriptor of a HCPCS/CPT code includes the phrase, “separate procedure”, the procedure is subject to NCCI edits based on this designation. CMS does not allow separate reporting of a procedure designated as a “separate procedure” when it is performed at the same patient encounter as another procedure in an anatomically related area through the same skin incision, orifice, or surgical approach.

24. Most NCCI edits for codes describing procedures that may be performed on bilateral organs or structures (e.g., arms, eyes, kidneys, lungs) allow use of NCCI-associated modifiers (modifier indicator of “1”) because the two codes of the code pair edit may be reported if the two procedures are performed on contralateral organs or structures. Most of these code pairs should not be reported with NCCI-associated modifiers when the corresponding procedures are performed on the ipsilateral organ or structure unless there is a specific coding rationale to bypass the edit. The existence of the NCCI edit indicates that the two codes generally should not be reported together unless the two corresponding procedures are performed at two separate patient encounters or two separate anatomic sites. However, if the corresponding procedures are performed at the same patient encounter and in contiguous structures, NCCI-associated modifiers should generally not be utilized.