Chapter IV
Musculoskeletal
CPT-4 20000 - 29999

A. Introduction

The general guidelines regarding correct coding apply to the CPT-4 codes in the range of 20000-29999. Specific issues unique to this section of CPT are clarified in the following guidelines.

B. Anesthesia

Anesthesia administered by a physician performing a procedure is included in the procedure. Accordingly, injections of local anesthesia for musculoskeletal procedures (surgical or manipulative) are not to be separately billed. Specifically, the CPT-4 code 20550 (injection tendon, ligament...) is not to be used as an injection code to provide local anesthesia for a surgical, closed, manipulative or other procedure.

C. Biopsy

In accordance with the sequential procedure policy, when a biopsy is performed in conjunction with any excision, destruction, removal, repair or internal fixation procedure, the biopsy procedure is not to be separately coded. If the biopsy is performed at a different site and represents a significant, separately identifiable service, a biopsy service is billed. For example, if a patient presents with an upper extremity fracture and, during an internal fixation procedure, it is determined to be medically reasonable to perform a bone biopsy of the iliac crest while under the same anesthetic, a separate service for a bone biopsy, with the "DS" modifier, could be billed. If, however, through the same incision, a biopsy of the humerus was obtained, this service is not to be separately billed.

Additionally, in accordance with the sequential procedure policy, when an arthroscopic procedure is followed by an open procedure at the same session, only the most comprehensive service performed is billed; generally, this would be the open procedure. If an arthroscopic service is performed at one site and an open procedure is performed at another, the arthroscopic service is billed with a

modifier indicating that these services were performed at different anatomic sites (e.g. "RT" or "LT" modifier, "DS" modifier, etc.)

D. Fractures

1. In general, the application of external immobilization devices (including casts) after a procedure also includes the maintenance and removal services during the post-procedure period. Some CPT-4 codes have been included for removal and modification of external fixation devices by a physician other than the physician who initially applied the device. These codes are not to be billed by the same entity (physician, practice, group, etc.) that performed the initial application service. In general, supplies used in casting are to be separately billed but the application of the cast, splint, strapping is included in the evaluation and management service (when no procedure is performed) or major procedure performed. CPT-4 codes describing modification of casts (e.g., 29700-29750) are not to be billed when these modifications are performed at the same session as the primary (open or closed) procedure. When a primary procedure is not performed, the cast application, maintenance, and removal are included as part of the evaluation and management service, according to CPT-4 definition.

2. Separate codes have been created for removal of internal fixation devices as a separate procedure and modification/removal of these devices in conjunction with other procedures. When a superficial or deep implant (buried wire, pin, rod) requires a surgical procedure to remove (e.g., CPT-4 code 20670), and it is performed as a separate procedure, this service may be billed. On the other hand, when the service is performed in conjunction with another procedure involving the same area, it is not to be billed separately.

3. In accordance with the general policy on most extensive procedures, when a fracture requires closed reduction followed by open reduction at the same patient encounter (e.g., inability to accomplish the closed reduction), only the open reduction service is billed.

4. When interdental wiring (e.g., CPT-4 code 21497) is necessary in the treatment of facial (or other) fractures, as part of a facial reconstructive surgery, or arthroplasty, it is included as part of the service; accordingly, a separate service using the

CPT-4 code 21497 is not billed. If billed with other head and neck procedure codes, it should be coded with the "DS" modifier, indicating a separate distinct service was performed. The medical record should reflect the nature of the separately identifiable service.

5. When it is necessary to perform skeletal/joint manipulation under anesthesia to assess range of motion or accomplish fracture reduction as part of another related procedure, the corresponding manipulation code (e.g., CPT-4 codes 22505, 23700, 27275, 27570, 27860) is not to be separately billed.

6. CPT-4 codes 22840-22855 (spinal instrumentation) are not to be billed with any CPT-4 code outside of the range (CPT-4 codes 22305-22812 for fracture and arthrodesis).

E. General Policy Statements

1. When a tissue transfer procedure (e.g. graft) is described in the principal procedure code, a separate service is not billed for performing the tissue transfer service necessary to complete the procedure.

2. In situations where monitoring of interstitial fluid pressure is routinely performed as part of the post-operative care (e.g. distal lower extremity procedures with risk of anterior compartment compression), a separate code for monitoring of interstitial fluid pressure (e.g., CPT-4 code 20950) is not billed.

3. When electrical stimulation is used to aid bone healing, the appropriate bone stimulation codes (CPT-4 codes 20974-20975) should be billed; the codes for nerve stimulation (CPT-4 codes 64550-64595) are inappropriate for this service. If a neurostimulator is medically necessary for other indications (e.g. pain control), a separate service is billed, however, the "DS" modifier should be attached indicating that this represents treatment of different symptoms; accordingly the medical record should reflect the indication for the nerve stimulator. In addition, CPT-4 codes 97014 & 97118 (physical medicine for electrical stimulation) are not to be billed in conjunction with the above listed codes.

4. Routinely, exploration of the surgical field is performed during a surgical session; codes describing independent exploratory services are not to be billed when a more comprehensive procedure is being performed in the same area. Specifically, an exploration code such as CPT-4 code 22830 (exploration of spinal fusion) is not billed with other procedures involving the spine unless performed at a different site/different incision from the other procedure(s). If, for example, a cervical spine procedure was being performed, and, at the same operative session, a lumbar fusion was explored through a separate incision, the CPT-4 code 22830-DS could be billed assuming the requirement for medical necessity was satisfied.

5. Debridements (CPT-4 codes 11040-11044, and 11700-11711) are included in the surgical procedures conducted on the musculoskeletal system when debridement of tissue is in the immediate surgical field. In open fractures, debridement of tissue due to the fracture should not be separately billed. If, however, tissue debridement is necessary for a more extensive area (e.g., concurrent soft tissue damage due to trauma), the debridement codes can be billed.

6. Grafts, such as CPT-4 codes 20900-20924, are only to be separately billed if the major procedure code description does not include graft in its definition.

7. The CPT-4 code 20926 is a general code for tissue grafting (e.g., paratenon, fat, dermis) to be used when the primary procedure does not include grafting and when another graft code does not more accurately describe the nature of the grafting procedure being performed. Accordingly, it should not be used with codes in which the graft is already listed as a part of the procedure or with other grafting codes (see Chapter III for other graft codes).