HOT TOPICS
CLARIFICATION ON CODING ISSUES

Cyst vs. Tumor Excision

Integumentary System or Musculoskeletal System Coding
• 11403 - $122.48 (Excision benign lesion 2.1 to 3cm)
• 11603 - $175.09 (Excision malignant lesion 2.1cm to 3cm)
• 21931- $917.17 (Excision soft tissue tumor, back 3cm or >)

Integumentary System Code
• Describes excision of cutaneous lesions, as well as superficial subcutaneous lesions such as cysts and scars

Musculoskeletal System Code
• Musculoskeletal lesion excision codes pertain to subcutaneous, and superficial or deep soft tissues

Cyst vs. Tumor Excision

• Epidermal cyst (Epidermoid, Epidermal Inclusion, Infundibular)
• An infiltration of epidermal cells into the dermis, exude an odorous, cheese like material if ruptured

Describes excision of cutaneous lesions, as well as superficial subcutaneous lesions such as cysts and scars
Cyst vs. Tumor Excision

- Tumors are formed by an abnormal growth of neoplastic cells that enlarged in size

**Lipoma**
- Lump or mass that is made up of fat cells (adipocytes)
- Common, benign, slow-growing tumor
- Develop in the subcutaneous tissue, located beneath the skin and above the muscle
- Lipomas can grow large in size and multiple growths can develop, most commonly in the back, neck, shoulders or arms

Intermediate Repair

- **Simple repair:** used when the wound is superficial, eg, involving primarily epidermis, dermis, and subcutaneous tissue and no deeper structures. The wound closure involves closing one layer, and includes local anesthesia, and chemical or electrocauterization of unclosed wounds.
- **Intermediate repair:** requires layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (nonmuscle) fascia.
- Single-layer closure of heavily contaminated wounds, which required extensive cleaning or removal of particulate matter also constitutes as intermediate repair.

Complex Repair

- The flap was then elevated superiorly and inferiorly. Once the flaps were developed, this allowed for closure of the defect. The flaps were then advanced and closed
- Undermining alone of adjacent tissues to achieve closure, without additional incisions does not constitute adjacent tissue transfer; see complex repair codes 13100-13160
Advancement Flap

Question: Please explain an advancement flap and how it is reported.

Answer: An advancement flap involves making an incision and elevating a flap to move it over to cover a defect. An advancement flap is reported with codes 14000-14350. Undermining tissues does not constitute an advancement flap. Undermining is reported with the complex repair code series (13100-13160).

Muscle Flaps

Random pattern flap a myocutaneous flap with a random pattern of arteries, as opposed to an axial pattern flap.

Axial pattern flap a myocutaneous flap containing an artery in its long axis.

Arthroscopic Complete Shoulder Synovectomy

- The AAOS Coding, Coverage and Reimbursement Committee recognizes three "areas" or "regions" of the shoulder: the glenohumeral joint, the acromioclavicular joint and the subacromial bursal space."

April 2006 Bulletin

- A partial synovectomy (29820) or limited debridement (29822) would consist of work done in just a portion of the shoulder, such as the front or the back of the shoulder. To support a complete synovectomy (29821) or extensive debridement (29823), the documentation should support work in BOTH the front and back of the shoulder.

April 2004 Bulletin
Complete Synovectomy 29821

**Question:**
- CPT code 29821 describes a complete synovectomy of the shoulder performed arthroscopically. In order to be considered a complete synovectomy, does the entire intra-articular synovium need to be removed?

**Answer:**
- Yes. Code 29821, Arthroscopy, shoulder, surgical; synovectomy, complete, is reported for a complete synovectomy for a synovitic disease, such as rheumatoid arthritis or pigmented villonodular synovitis, with removal of the entire intra-articular synovium.
- If a partial synovectomy is performed, then code 29820, Arthroscopy, shoulder, surgical; synovectomy, partial, is reported. If only a diagnostic arthroscopy is performed, and some synovium is resected for visualization, only a diagnostic arthroscopy can be reported.

**Topaz of Rotator Cuff**

- TOPAZ MicroDebrider is a tool which utilizes Coblation® technology to perform a small incision in the fascia and is considered an alternative to the use of standard surgical instruments such as scalpels, low frequency electrocautery, etc.
- Because the TOPAZ MicroDebrider is a tool and not a procedure, code selection will depend on the service performed, and the specific anatomy involved as described in the code descriptor.

**NCCI Edit Guideline Changes for 2013**

22. CMS considers the shoulder joint to be a single anatomic structure. An NCCI procedure to procedure edit code pair consisting of two codes describing two shoulder joint procedures should never be bypassed with an NCCI-associated modifier when performed on the ipsilateral shoulder joint. This type of edit may be bypassed only if the two procedures are performed on contralateral joints.
NCCI Edit Guideline
Changes for 2013

Example
Arthroscopic rotator cuff repair (29827) and debridement of labrum (29822)

“Manos” Carpal Tunnel Release

Question
- What is the correct CPT code to report for percutaneous carpal tunnel release using the Manos carpal tunnel release (CTR) system?

Answer
- It would be appropriate to report code 64999, Unlisted procedure, nervous system for percutaneous carpal tunnel release using the Manos carpal tunnel release (CTR) system. The Manos system is a percutaneous procedure performed without visualization and without the use of an endoscope. Because it is not an open surgical procedure, it is not appropriate to report code 64721, Neuroplasty and/or transposition; median nerve at carpal tunnel.
DeNovo NT (Natural Tissue)
DeNovo ET (Engineered Tissue)

We were able to visualize the medial femoral condyle with retraction. At this point we used a #15 blade and a cautery to remove the cartilage to get to the underlying subchondral bone. We then created a template using paper and then proceeded to apply the (Vericarte) cartilage with fibrin glue. Once this had hardened we placed an additional few drops of Arthrosurface UniCap equipment was brought onto the field.

Arthrosurface/HemiCap

Central reamer was now performed down to the drill stop

Trial placed (used to determine curvature of the radius)

Central stud screw inserted to proper depth

Excess fibrin was trimmed off. Once we had completed this we had complete stability of the defect. After the glue had hardened we put the knee through a range of motion which showed the knee was stable. We irrigated the knee.
Coding

AMA Query - July 12, 2013

- There is no specific CPT code that describes the HemiCAP implants surgical procedure performed on the knee.
- It would be appropriate to report code 27599, Unlisted procedure femur or knee.
- The knee arthroplasty services codes (27437-27447) would not be additionally reported.

MAKOplasty

MAKOplasty
0054T, Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images

- Code 0055T, Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image guidance based on CT/MRI images

- When CT and MRI are both performed, 0055T would be reported only once.

- Code 20985, Computer-assisted surgical navigational procedure for musculoskeletal procedures, imageless

- Code 0055T is reported when no images are generated.

Medial Patellofemoral Ligament Reconstruction (MPFL)

What would be the appropriate coding for MPFL (Medial Patellofemoral Ligament) reconstruction using a gracilis allograft?

OP NOTE: An incision was made just medial to the patella and a split was made in the VMO attachment just exposing the medial edge of the patella at the insertion of the medial patellofemoral ligament. Dissecting down we located the anatomic origin of the MPFL and a guide pin was then drilled here. This guidepin was then carried across the femur heading in an anterior proximal direction. This was then overreamed with the Endobutton drill and measured 70 mm. A semitendinosus allograft was then wrapped around an Arthrex TightRope and the proximal 25 mm were looped together and sutured. The distal ends had #2 FiberWire suture placed in a whip stitch fashion. The 6 mm reamer was then used to ream over the guidepin to a depth of 25 mm and the sutures from the TightRope were then tied and passed through the eye of the guidepin and the TightRope was brought through the femur and then tightened to secure the graft. A plane was then made beneath the vastus medialis but extraarticular and then utilizing suture passers, the graft was passed deep to the vastus medialis. We then passed the 2 limbs of the gracilis graft into each hole and then tied the sutures over a bone bridge anterolaterally.

Based upon comments received from our physician advisors representing the American Academy of Orthopaedic Surgeons and the American Orthopaedic Association, the correct code to report is 27422, Reconstruction of dislocating patella; with extensor realignment and/or muscle advancement or release (eg, Campbell, Goldwaite type procedure).

FAST Procedure

Focused Aspiration of Scar Tissue

Ultrasound guidance used to identify pathologic tissue and guide the TX1 MicroTip™ during tissue removal.

Tendon treatment

- The TX1 MicroTip simultaneously debrides, cuts, and aspirates diseased tendon or other soft tissue in various musculoskeletal structures. This image demonstrates the removal of pathologic tissue in the lateral epicondyle of the elbow.

Do not report a percutaneous tenotomy.
FAST Procedure Coding

- **OP NOTE**: The area was anesthetized with lidocaine. Following this, #11 blade was introduced to create a track down to the tendon. A TX1 handpiece was introduced and 35 seconds of ultrasound frequency was used to debride the tissue. After adequate removal of tissue, significant change was seen on ultrasound. The TX1 handpiece was removed.

- **CPT code 24999, Unlisted procedure, humerus or elbow, should be reported to describe the “ultrasound frequency” for the treatment of lateral epicondylitis using the “FAST [Focused Aspiration of Scar Tissue] ultrasound technique/system.” To further clarify, if performing the “FAST [Focused Aspiration of Scar Tissue] ultrasound technique/system” procedure in the foot or ankle region, if the FAST procedure were performed on an Achilles or plantar fascia it would be reported using an unlisted procedure (e.g., 27899, Unlisted procedure, leg or ankle, 28899, Unlisted procedure, foot or toes).

Ankle Ligaments

- **If the surgeon performs a “primary” repair it does not matter when it was done. Primary refers to the fact that you join the two ends of the ligament together. If the surgeon performs a direct repair, regardless of timing it is a primary repair. Report 27695 or 27696**

- **If its a secondary repair, that means it is a reconstruction (27698), regardless of when it was done in relation to the time of the initial injury. Secondary means you bring in some other tissue to do the repair because it is too late to do a primary repair.**

- **Primary and secondary refer to the way it was repaired, not when it was repaired. In general primary repairs are done early and secondary repairs are done later when you can no longer do a primary repair.**
Primary Repair (Brostom)

- 27695 – Repair, primary, disrupted ligament, ankle; collateral
- 27696 – both collateral ligaments (Medial and Lateral side of ankle)

Per AAOS, transfer or mobilization of adjacent retinaculum is an inclusive component of these codes

Secondary Repair

CPT Manual Definition

- 27698 – Repair, secondary, disrupted ligament, ankle, collateral (eg. Watson-Jones procedure)

Coder’s Desk Reference

- There are several techniques, including Watson-Jones, Evan, and Chrisman-Snook.

Secondary Repair

Evan Chrisman-Snook

Peroneus Brevis Tendon Peroneus Brevis Tendon
Secondary Repair

Watson-Jones

Syndesmosis Disruption

CPT Assistant March 09

- Syndesmosis repair is inclusive to distal fibular (lateral malleolus) fracture treatment when a screw is put through the fracture plate into the tibia

AAOS

- A "bimalleolar equivalent" fracture means that in addition to one of the malleoli being fractured, the ligaments on the inside (medial) side of the ankle are injured. Usually, this means that the fibula is broken along with injury to the medial ligaments, making the ankle unstable.

Haglund’s Deformity

If a Haglund’s deformity of the heel and retrocalcaneal bursa were removed, then code 28118, Osteotomy, calcaneus, should be reported.

If additional work other than for exposure was performed on the Achilles tendon, then that service would be reported as 28200, Repair, tendon, flexor, foot; primary or secondary, with-out free graft, each tendon.

If there is a spur on the bottom of the foot and a plantar fascial release is performed, then code 28119, Osteotomy, calcaneus; for spur, with or without plantar fascial release, would be reported instead of/in addition to 28118.
Arthroereisis

There currently is no CPT code that specifically and accurately describes a subtalar arthroereisis procedure. This procedure typically involves making an incision over the sinus tarsi and inserting an implant to reposition and stabilize the rearfoot, resulting in a decrease in pronatory forces to the foot. The most appropriate CPT code to report a subtalar arthroereisis procedure is code 28899, Unlisted procedure, foot or toes.

Recently, some surgeons advocated coding the subtalar arthroereisis procedure as a treatment of a dislocation. This would be a misrepresentation of the dislocation treatment codes, as there is no anatomical evidence of a joint dislocation (ie, complete disruption of a joint) present at the subtalar joint when using this type of implant.

Turbinate Reduction

Radiofrequency – creating 3 intramural lesions per turbinate, using 30 seconds of radiofrequency per lesion used for inferior turbinate reduction

The described procedure indicates three lesions were created to each inferior turbinate (bilateral) where the soft tissue is ablated by radiofrequency without the removal of bone, therefore code 30802 is appropriate.

Radiofrequency ablation – mucosa is destroyed underlying bone is preserved
Turbinate Reduction

INCORRECT CODING

PROCEDURE: Endoscopic left inferior turbinate and maxillary antrostomy, septum with removal of flatus, egopharingeal endoscopic resection of sinusoidal cyst, unilateral

REMARKS: Coblation was then used on both inferior turbinate with power setting of 4, 30802

12 per turbinate, 1 pass per turbinate. The turbinate were nearly performed.


“Redo” Endoscopic Sinus Surgery

• CPT code 31297 should be used to bill post-operative endoscopic debridement

• Following intranasal procedures performed endoscopically, there can be accumulation of clots and crusts which are felt to contribute to postoperative synechia (scar) formation and delay return of function to the native ciliated mucosa.

• Presence of such material along with retained blood and secretions likely contributes to postoperative residual or recurrent infection. Debridement is usually performed at least once in the postoperative period.

• Although the exact number of postoperative debridements depends on the surgeon’s judgment, most patients require four or fewer. If performed outside of the global surgical period, code 31237 should be reported, without modifier, each time a debridement is performed.

Endoscopic Sinus Stents

Answer

• There is no specific CPT code to describe endoscopic stent placement at the time of endoscopic sinus surgery. Therefore, code 31299. Unlisted procedure, accessory sinuses, should be reported irrespective of the type of stent inserted (ie, drug-eluting or non-drug eluting).

• Code 31299 may be reported in addition to the appropriate endoscopic sinus procedure codes.
Pterygium

June 09 CPT Assistant

• In some surgical procedures, amniotic membrane is used after the removal of a conjunctival growth known as pterygium graft. In those situations, the correct code to report is:
• 65426 – Excision or transposition of pterygium; with graft

Medicare CCI Edit Guidelines

• CPT codes 65420 and 65426 describe excision of pterygium without and with graft respectively. Graft codes and the ocular surface reconstruction CPT codes 65780-65782 should not be reported separately with either of these codes for the ipsilateral eye.

(For placement of amniotic membrane using tissue glue, use 66999)

Aqueous Shunt

• 66180 - Aqueous shunt to extraocular reservoir

• To prevent the drainage tube from eroding through the conjunctiva, the surgeon may place a piece of processed, dehydrated human pericardial allograft over the drainage tube before closing the conjunctival flap. The allograft is cut to size and secured in place with nylon sutures, anchoring its edges to the sclera. (Application of the allograft is not coded separately.)

CPT Assistant Sep. 03

Question:

• May codes 66180 and 67255 be reported for placement of the “Ahmed Glaucoma Valve” with scleral reinforcement?

Answer:

• Yes. It is appropriate to report code 66180, Aqueous shunt to extraocular reservoir (eg, Molteno, Schmed, Denver-Krupin), for placement of the “Ahmed Glaucoma Valve” in addition, code 67255 - Scleral reinforcement with graft, should also be reported to describe the scleral graft procedure.

• As code 67255 is designated as a "separate procedure," it is recommended that the modifier 59, Distinct Procedural Service, be appended to indicate a distinctly separate procedure was performed in addition to that represented by code 66180.
Microstent

- 0191T – Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the trabecular meshwork
- 0192T – external approach
- 0253T – internal approach, into the suprachoroidal space

Microstent with Trabeculectomy

Question
- May CPT codes 66170 and 66172 trabeculectomy ab externo be reported in addition to 0191T and 0192T for insertion of anterior segment aqueous drainage device without extraocular reservoir?

Answer
- No. It would not be appropriate to report either Category I code 66170 or 66172 (trabeculectomy codes) in addition to either Category III code 0191T or 0192T (insertion of anterior segment aqueous drainage device, without extraocular reservoir).

Canaloplasty

- 66174 – Transluminal dilation of aqueous outflow canal; without retention of device or stent
- 66175 – with retention of device or stent
HOT TOPICS

CLARIFICATION ON CODING ISSUES