Coding Corner: A Look at 2012 CPT Changes

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CPT 2012 introduced several code changes for 2012 affecting orthopaedics. The questions and answers that follow highlight of some of the changes, but do not represent all new codes or code changes.

Biologic Implant Add- On Code

Question:

In reviewing the 2012 CPT codes, our tumor surgeon came across CPT code 15777, Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (eg, breast, trunk) (List separately in addition to code for primary procedure).

Our question is this: In December, 2011 the surgeon resected a large soft tissue tumor and was left with a deep tissue void after the resection. He did not code a CPT code for the placement of the apligraf material because he said he was using the material deep in the wound, not for skin closure. In looking at the new code, he is wondering if this is the correct code in 2012? Can you advise us?

Answer:

Great question! Yes, CPT code 15777 was introduced as a new code to ensure accurate reporting of biologic implants used as soft tissue reinforcement within a wound. CPT code 15777 is an add-on code and is reported in addition to the primary procedure code. The good news with this new add-on code is that it does not have just "one" index or "parent" code for which it can be reported in addition. If the surgeon has a similar procedure in the future, report the primary resection/reconstruction code(s) and then sequence 15777 after the primary code without a modifier 51.

New vs Established Patient Definitions

Question:

We are reading with interest the 2012 new patient definition and reviewing the decision tree in the CPT manual. We have many subspecialists within our orthopaedic practice. Using this "subspecialty" definition, does this mean that if a patient is seen on 12/1/11 as a new patient by the General Orthopaedic Surgeon and on 1/5/12 is seen for the first time by our Joint Reconstructive Surgeon that he can report a new patient visit on 1/5/12?

Answer:

It depends on your private payors' interpretation of specialty and subspecialty.

CPT has not specified the definition of "specialty" vs. "subspecialty" in the new patient definition. We do know that the AMA created taxonomy codes years ago for the purpose of organizational claims submission to identify /differentiate providers.

Medicare defines "specialties' for the purpose of claims submissions and will consider a request for a subspecialty to receive specialty designation. For example, within orthopaedics, the "subspecialty" of Hand Surgery has its own designation as a "Specialty" by Medicare. Once Medicare creates a specialty designation, they will apply the new patient/different specialty rule for claims processing. Medicare has not at this time defined Joint Reconstruction as a "Specialty", thus the subspecialty designation remains.

Survey your private payors to determine if they are using taxonomy codes, Medicare specialty codes or internal specialty codes for the purpose of new patient definition and claims processing. Continue to apply the Medicare approved specialty designations for reporting new and established patients to Medicare.

Chondroplasty and Meniscectomy

Question:

Our surgeon performed a right medial meniscectomy and a tri-compartmental chondroplasty on a 45 year-old-female. Can the surgeon report the chondroplasty and the meniscectomy or only the meniscectomy?

Answer:

Effective 1/1/12, CPT revised the meniscectomy codes (29880 and 29881) to include a chondroplasty performed in the same knee, same session. The correct way to report this case for all payors is to report 29881.

Collagenase Injections

Question:

Our hand surgeon will begin treating Dupuytren's contractures this year using Collagenase to inject the cords. I see there is a new CPT code for the injection and the manipulation and understand the definitions. Is modifier 58, staged procedure, the correct modifier to append to the manipulation at the second visit?

Answer:

Great job on thinking ahead! The good news is that the injection code, 20527 (Injection, enzyme (e.g., collagenase), palmar fascial cord (i.e., Dupuytren's contracture) does not have a global period. The manipulation the next day is reported with CPT code 26341 (Manipulation, palmar fascial cord (i.e., Dupuytren's cord), post enzyme injection (e.g., collagenase), single cord) and no modifier is required.

Posterior Fusions

Question:

Our surgeon is performing a posterolateral fusion at L4-5 and an interbody fusion at the same level. We are trying to precertify this with CPT codes 22612 and 22630 and our payor is telling us the codes are invalid. How can that be accurate?

Answer:

2012 introduced multiple CPT code and Guideline changes related to spine surgery. One change introduced a new code, 22633 to be reported when the surgeon performed both procedures defined in your question at the same level during the same operative session. Instead of reporting 22612 and 22630, you will report 22633, for the first level combined fusion. CPT code 22633 is defined as, "Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment; lumbar".

Arthroscopic Subacromial Decompressions

Question:

I see that 29826 is an add-on code now and can be reported in addition to a list of codes in the arthroscopic section of CPT. Now that it is an add-on code, does it mean that the procedure will be paid at 100%?

Answer:

Yes, that is correct. Add-on codes are valued only for the intra-service work. Since there is no global period and the code cannot stand alone, the reimbursement is 100% of the allowable. Do not append modifier 51 (multiple procedures) when reporting 29826 in addition to other arthroscopic procedures.