THE BUSINESS OF SPINE

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CODING CHANGES: CPT 2012

The following is a long version of the changes relative to AMA CPT coding for spine and appreciate your taking the time to read through the changes to ensure that you are familiar with the coding adaptations to take place for spine services in 2012.
You have already received some CPT coding changes that will take place for fusion codes for submission in 2012. But here it is again in an expanded version.

ARTHRODESIS CODING

- Arthrodesis codes 22612 and 22630 – CPT changes have identified the bundling of these codes when performed together at the same level/interspace. Code 22633 and code 22634 currently identify primary and additional level codes involving interbody and lateral infusions performed at the same level. In addition, codes 22614 or 22632 applies as an interbody or a lateral fusion (not a combination of both),when performed at any levels in addition to the primary combination codes 22633, as opposed to utilizing the primary procedure codes 22612 or 22630. This is a *significant shift in CPT policy* in that you may not use a primary procedure code when a different procedure is performed at a subsequent or different level. If a case allows for an interbody lateral fusion performed at one level, then code 22633 would apply and for subsequent procedures including interbody fusion, the additional level code would be 22632. If the additional level involved a lateral fusion, the representative code to use would be 22614. This is very confusing and the uncertainty exists as to how this change would fly with private carriers.

- We need to take a closer look at the changes in the language for codes 22610, 22612 or 22614 for lateral fusions. The previous descriptor for these codes included language updates for arthrodesis, posterior, posterolateral technique, single level, thoracic or a lumbar (with or without the lateral transverse technique). The descriptor states that these codes represent arthrodesis, posterior, posterolateral technique, single level, thoracic or lumbar *with lateral transverse technique if performed*, contrary to the *current descriptor which indicates that a lateral transverse technique must be performed* in order to bill for the lateral fusion. It appears that the facet fusion has been removed from this procedure code.

DECOMPRESSION CODING

- Moving on, we know that there are other significant language changes relative to codes 63020, 63030 and 63035 which represents decompression involving laminotomy. It appears that several CPT descriptor changes were made in order to differentiate between open, percutaneous and endoscopic approaches versus a decompressive procedures via indirect image guidance for laminotomy/ laminectomy (intralaminar approach) currently described in code 0274T, a new technology code. This is for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy) any method under indirect image guidance (eg, fluoroscopic, CT), with or without the use of an endoscope, single or multiple levels, unilateral or bilateral; cervical or thoracic and lumbar procedure is represented by code 0275T.

  Additional notes in this series of coding scenarios direct us to codes 63020, 63030 and 63035 for a laminotomy (hemilaminectomy) performed using *an open and endoscopic assisted approach.* Further clarification is described for percutaneous decompression of the nucleous pulposus of intervertebral disc, utilizing a *needle based technique allowing for code 62287.* Code 62267 which is a percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes. Adding to more confusion CPT has language that is directly under code 62287 for decompression procedure percutaneous, there is a comment indicating that this includes an endoscopic approach. Adding to all of this is more direction in coding a non-needle based technique for percutaneous decompression of nucleus pulposus of intervertebral disc suggests that we should look to code 0276T and 0277T which absolutely makes no sense as this is for " Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial thermoplasty, 1 lobe or 2 lobes or more." I do believe that it is a CPT typo.

VERTEBROPLASTY CODING

- We continue with our coding changes for spine to find the vertebroplasty codes 22520, 22521 and 22522 now include the bone biopsy once performed at the same level as the vertebroplasty.

PAIN MANAGEMENT

- There are changes in pain management injection codes; 64633, 64634, 64635 and 64636 are added to describe destruction by neurolytic agent, paravertebral facet joint nerve(s) with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint, cervical or thoracic, single facet joint, lumbar or sacral, single facet joint and lumbar and sacral each additional facet joint. Imaging is now included in these codes and not billable separately. All of these codes replace codes 64622 through 64627 which I believe have just been revised in recent CPT history

  We see the continuation of changes in injection codes, even though we've had the pleasure of significant changes last year. Code 27096 is for an injection procedure for sacroiliac joint, it now includes with image guidance (fluoroscopy or CT) including arthrography when performed. Therefore, there would not be separate billing for imaging.

  Additional changes include codes 62310 and 62311 for injection(s), of diagnostic or therapeutic substance(s) that include needle or catheter placement and also includes contrast for localization when performed, includes anesthetic, antispasmodic, opioid, steroid, other solution, but does not include neurolytic substances.

  Codes 62318 and 62319 also show changes to the injections (including indwelling catheter placement, continuous infusion or intermittent bolus of diagnostic or therapeutic substance(s) including anesthetic, antispasmodic, opioid, steroid, and other solution), but does not include neurolytic substances and includes contrast for localization when performed, epidural or subarachnoid.

  For those surgeons that are doing Intrathecal or Epidural Drug Infusion Pump work, there are changes to codes in that area. Code 62367 has been changed to represent electronic analysis of programmable, implanted pump without reprogramming or refill.

  Additional codes 62369 and 62370 have been added for electronical analysis of programmable implantable pump for interest legal and epidural drug infusion with reprogramming and refill represented by code 62369 or reprogramming and refill (requiring the skill of a physician) to code 62370. Main change is reprogramming for those codes.

RADIOLOGY CHANGES

More changes for X-ray to further lighten your load in your cash receipts.

- Code 72114 and 72120 are main stays in any spine practice. These codes have been changed to add additional views. Code 72114 is a radiologic exam spine lumbarsacral complete, including bending views with a minimum of 6 views. Code 72120 is radiologic exam spine, lumbosacral, bending only; 2 or 3 views.

At this point in time I cannot provide you with the relative value units because they have not been presented, but will do so as soon as possible.

In the meantime, we have attached coding sheets for the documented changes. If you have any questions, please do not hesitate to contact us. We will, of course, be implementing these codes as we are required and follow carriers with specific guidelines.