Spinal Arthrodesis Group Exercises

1. Two surgeons work together to perform an arthrodesis. Dr. Bonet, a general surgeon, makes the anterior incision to gain access to the spine for the arthrodesis procedure. Dr. Carpenter, the neurosurgeon, takes over and performs the anterior interbody arthrodesis on level T9-T10 utilizing a structural allograft. To stabilize the fusion site, the same physician also applied anterior instrumentation to T9-T10. Dr. Bonet comes back to perform the closure after the arthrodesis on this patient. Each physician documents his portion of the same procedure in separate operative reports. How should the professional services be reported?

Dr. Bonet:

22556-62
Rationale: Dr. Bonet is a general surgeon and performed the incision and closure to gain access to the spine. All CPT’s include incision and closure unless otherwise stated. When two surgeons work together as primary surgeons performing distinct part(s) of a single reportable procedure, each surgeon should report his/her procedure(s) with a modifier -62. If one of the surgeon’s acts as an assistant surgeon on other procedures performed during the same operative session, those services are then reported and modifier -80, -81, or -82 is added as appropriate

Dr. Carpenter:

22556-62, 20931, 22845

2. A single physician performed posterior arthrodesis on levels T1-T8 for a patient with severe kyphosis utilizing an autograft from the patient’s rib (obtained through the
same incision). To stabilize the fusion site, the same physician also applied posterior segmental instrumentation to T1-T8. How should the professional services be reported?

22802, 20936, 22843
Musculoskeletal System Individual Exercises

1. A physician performs an exploration of a penetrating wound of the neck. During the same surgical session, he also performs an exploration of a penetrating wound on the leg. How would these services be reported?

   20100, 20103-59

2. What is the correct code used to report a reconstruction of the zygomatic arch and glenoid fossa with bone and cartilage using an autograft?

   21255 The zygomatic bones are the cheekbones. The obtaining of the autograft is bundled into the reconstruction procedure per the note included in the code description.

3. A physician partially excises the posterior vertebral component of two thoracic vertebral segments. This procedure is performed for intrinsic bony lesions. How would these services be reported?

   22101, 22103 Note that the procedure involved a posterior vertebral “component.” Codes 22112 and 22116 are for a vertebral “body” not “component” therefore would not be appropriate. Also Codes 63300 et seq are for the “resection of a vertebral body for an intraspinal lesion” and would also not be appropriate because the bony lesions were of the vertebral component not intraspinal (i.e. within the spine) in this question.

4. A surgeon performed an osteotomy (including diskectomy) of the L2 spine by anterior approach. During the same surgical session, the surgeon also performed arthrodesis of the L3-L4 lumbar interspace using the anterior interbody technique. How would these services be reported?

   22224, 22558-59 The -59 modifier is used because the procedures were performed on two separate levels of the lumbar spine.
5. A patient has been diagnosed with scoliosis. The surgeon performs anterior arthrodesis, with an application of a Risser jacket body cast (not including the head), on five thoracic vertebral segments. How would these services be reported?

22810 The code range is 22800 - 22812 is used for reporting arthrodesis for scoliosis and other spinal deformities in lieu of the more general arthrodesis codes. Application of the body jacket is included in the surgical procedure, per the casting guidelines in the CPT manual.

6. A physician performs arthrodesis on the C5-C7 vertebral segments using a posterior technique. She also performs posterior segmental instrumentation on the C5-C7 vertebral segments. Dual rods with multiple intermediate hooks are used along with bone grafts obtained from the patient’s rib (through the same incision). How would these services be reported?

22600, 22614, 22842, 20936

7. A physician biopsied a soft tissue mass of the upper arm involving muscle fascia. The physician documented that the mass was superficial. How would these services be reported?

24065 Although some biopsies are reported using integumentary codes, in this case, the procedure involved the muscle fascia and would therefore be reported using a musculoskeletal code. Note that the muscle fascia is the covering over the muscle. 24066 is only reported if the procedure was documented as deep or documented as involving subfascial or intramuscular tissue.

8. A patient has fractured his ulnar shaft. The physician performs a closed treatment of the ulnar shaft with manipulation. After manipulating the fracture site, the physician then applied a long arm cast. How would these services be reported?

25535 The code 24675 would not be correct because there is no indication that the fracture was at the proximal end. The application of the long arm cast (29065) would be bundled into the fracture care code, per the guidelines.

9. Same as above questions except two months later (but still during the global period), the physician unexpectedly has to repeat the same procedure. Prior to the re-manipulation, the physician has to remove the previously placed long arm cast. The
physician re-manipulates the ulnar shaft fracture and has to apply another long arm cast. How would these additional services be reported?

25535-76 The -76 modifier is reported because this is a repeat procedure by the same physician. See Musculoskeletal Guidelines. There was no documentation that the re-manipulation was due to a complication of the primary procedure, consequently –78 would not be appropriate. Note that -76 does not specify any particular time frame (e.g., same day, postoperative period, etc.) during which the procedure must have been repeated. Modifier –58 would not be appropriate because it was not planned prospectively at the time of the original procedure nor was it more extensive than the original procedure. The removal of a cast by the same physician who applied it is not separately reportable (29705). The application of the new cast is bundled into the fracture care code (25535); therefore would not be separately reported.

10. A surgeon injects a steroid into the sacroiliac joint under fluoroscopic guidance. No other physician was involved in the procedure. The procedure was performed in the local hospital, so the physician did not own the equipment. No formal arthrography was performed. How would the physician’s services be reported?

27096, 77003-26. Code 27096 is the correct reporting because code 27096 specifically refers to the sacroiliac joint while code 20610 uses more general language (i.e., hip joint).

11. A surgeon removes a deep foreign body from a patient’s knee area. How would these services be reported?

27372

12. A patient has been diagnosed with deep tumors on her legs the one on the right calf was 3cm and the one on her left thigh was 2cm. Both tumors involved muscle tissue. A surgeon excised both tumors. How would these services be reported?

27619 [-RT], 27328-59 [-LT]. Neither code should be reported twice or as a bilateral procedure because there are two separate procedure codes for the surgical services provided. Anatomically, the thigh is the femur and the calf is in the lower leg. Many payors do not identify the –RT and –LT modifiers making –59 the preferred modifier in most cases.
13. A patient has been diagnosed with severe peripheral vascular disease and has gangrene on his left leg. A general surgeon amputates the leg below the knee through the tibia and fibula. The patient is told that if the gangrene has spread, an above the knee amputation will be needed. How would the initial amputation be reported?

27880[-LT]

14. A month later (but still during the global period), the patient in the above question returns to the surgeon’s office because there is gangrene present on the stump of the left leg. The surgeon performs an above the knee amputation at the hospital, which the surgeon reports using 27590. Assuming 27590 was the correct code, what modifier would be appended to the code?

Modifier -58  This procedure was related to the original surgery and was planned.

15. A physician performs a diagnostic left knee arthroscopy with harvesting of three chondral bone grafts obtained from the patient. During the same session, the same physician also performs an arthroscopic graft placement of cartilage into the patient’s left knee. How would these services be reported?

29866 [-LT] Look up, “Arthroscopy, surgical, knee, cartilage autograft”. Since the graft was harvested from the patient’s own body it is considered an “autograft”. The harvesting of the autografts is an inherent part of the procedure per the code description. This code is reported only once per procedure regardless of the number of autografts obtained and inserted. The diagnostic knee arthroscopy (CPT code 29870) is not separately reported. See parenthetical note under CPT code 29866.
Musculoskeletal Operative Report
Total Knee Replacement

Preoperative Diagnosis: Degenerative arthritis, left knee.

Postoperative Diagnosis: Same.

Procedure: Left total knee replacement.

Anesthesia: Spinal

Indications:

This is a 47 year old woman with progressive history of knee pain with radiographic evidence of valgus deformity and degenerative joint disease.

Procedure:

The patient was taken to the operating room, given a spinal anesthetic, prepped and draped in the usual fashion. After exsanguinating the leg the tourniquet was inflated. An anterior incision was made followed by a medial arthrotomy. The patella was everted. The patella was in excellent condition with no evidence of chondromalacia. There was extensive degenerative changes in the medial and lateral femoral condyles with particularly bone loss on the posterior aspect of the lateral femoral condyle. An intramedullary guide was placed into the tibia followed by a 7 degree distal valgus cut. A sizer was placed and measured 60 so a 60 millimeter AP cutting guide was performed. The external medullary guide was applied on the tibia and 8 millimeters was taken from the medial aspect of the joint. A spacer was the placed and showed good flexion and extension gaps. A notch cutter was then placed and the appropriate cut was made. A 71 millimeter template was applied to the tibia localized over the medial third of the tibial tubercle. The appropriate punch was used. Trial components were then placed. I had excellent stability and range of motion with a 10. Since the patella was then pristine looking it was decided that given her young age that it should be resurfaced. The rotation of the tibia and femur was again checked confirming the tibia was on the medial third of the tibial tubercle and the distal femur was in about 3 degrees of external rotation to the femur. It should be noted that given the deficiency of the posterior aspect of the lateral femoral condyle a Freer was placed between the external rotation jig and the bone to maintain an appropriate amount of external rotation. The knee was then thoroughly irrigated with normal saline solution. The cement was then applied to the respective prostheses. The tibia and femur were impacted in the usual position. It was then compressed with a 12. Warm saline was placed in the joint to help solidify the cement. The knee was then disarticulated. Excess cement was extruded and a 10 spacer was pinned into place.
There was excellent motion, stability, and tracking of the patella. After further irrigation the arthrotomy was closed with #1 Tycron sutures and 0 Vicryl suture, the subcutaneous tissues were closed with interrupted 0 and 2-0 Vicryl sutures, and the skin was closed with clips. Xeroform and a sterile dressing were applied. The patient tolerated the procedure well and was stable on transfer to the recovery room.

How should the surgeon’s professional services be reported?

**Procedure Code:**

27447[-L.T]  The physician documented a total knee replacement which includes both the medial and lateral compartments. The resurfacing of the patella is inclusive in the code description of 27447. Although, the physician stated that “the knee was disarticulated” it would be inappropriate to report code 27598. To “disarticulate” means to separate or amputate at the joint. In order to place the prosthesis the surgeon must separate the joint. Closure is generally not separately reported in the absence of specific CPT guidelines to the contrary.