2013 CPT Changes – Musculoskeletal /Orthopedics / Spine

Please see all code changes for 2013. However, pay particular attention to the following changes pertinent to Musculoskeletal and Orthopedics.

Evaluation and Management Services:

Eliminating “providers” and “physicians” from Evaluation and Management code descriptors

Previous to the 2013 CPT Changes, Evaluation and Management codes had the following descriptions: “Counseling and/or coordination of care with providers or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.” This has now been changed to “Counseling and/or coordination of care with other physicians, qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.” This provides a more definitive description of what constitutes a “provider” from a CPT standpoint.

The previous verbiage was also followed by a time threshold with the following language, “Physicians typically spend (amount of time) face-to-face with the patient and/or family.” This has now been changed to “Typically (amount of time) are spent face-to-face with the patient and/or family.”

Defining the broad term “Counseling”

Counseling is now defined as: “a discussion with a patient and/or family concerning one or more of the following: Diagnostic results, impressions, and/or recommended diagnostic studies, Prognosis, Risks and benefits of management (treatment) options, Instructions for management (treatment) and/or follow-up, Importance of compliance with chosen management (treatment) option, Risk factor reduction, and Patient and family education”. Again, more definition provided at what may take place in a counseling session. A discussion with a patient in which treatment options, etc and the risks/benefits of those options, would fall under the counseling definition.

Physician Documentation of Face-to-Face visit for Durable Medical Equipment (DME)

G0454 Physician documentation of face-to-face visit for Durable Medical Equipment determination performed by Nurse Practitioner, Physician Assistant or Clinical Nurse Specialist

Musculoskeletal System:

Orthopedic-specific surgical CPT code changes

Guidelines have been revised in the following areas:

The following are guideline changes and/or clarification:

Spine CPT Errata—Changes formalized for 2013. A guideline change has been added to the spine bone grafts (20930–20938), instrumentation (22840–22844, 22848, 22845–22847), and intervertebral device (22851) CPT codes. The change supports a CPT Errata issued in May 2012 that addressed the omission of CPT codes 22633 and 22634 as appropriate primary or index codes for bone graft, instrumentation, and intervertebral device codes. These codes may be appropriately related. This guideline change allows appropriate reporting of the codes which may have been previously mutually exclusive.

Bone marrow aspirate—Clarification has been added following the bone graft codes (20930–20938) related to bone marrow aspiration. CPT code 38220 defines the work associated with the harvest of bone marrow for bone grafting; it should not be used to report bone marrow aspirate for platelet-rich stem cells. Instead, Category III code 0232T should be used when bone marrow aspiration is performed for platelet-rich stem cell.

Cervical Spinal Arthrodesis Guideline—Guidelines were added to CPT codes 22554, 22585, 63075, and 63076; if the work associated with these procedures is performed during the same surgery by the same surgeon or by two separate
surgeons/individuals during the same session, the correct codes are 22551 and 22552. CPT codes 63075 and 22554 may not be unbundled and reported for the same patient, same session.

Cast application—Guideline changes were made in the “Application and Strapping” section addressing the application of the first cast, its removal, coding by the individual who performs the initial service, and restorative management. Refer to the section for specific comments. CPT code 29590 (Denis-Browne bar [splat] with manipulation and casting [eg, for metatarsus adductus, clubfoot]) was deleted.

Hip arthroscopy—Under a new guideline instruction, CPT code 29916 (Arthroscopic labral repair of a torn labrum) is considered inherent to CPT codes 29915, 29862, and 29863. CPT code 29916 should not be reported in addition to CPT codes 29915, 29862, or 29863 because the repair is already included in these codes, whether as a takedown and repair or a repair of an already torn labrum. This guideline is not new information, but a clarification based on inquiries received since the introduction of the new hip arthroscopy codes.

Chemodenervation—A guideline change was introduced for CPT code 64614 (Chemodenervation of muscle(s); extremity and/or trunk muscle(s) [eg, for dystonia, cerebral palsy, multiple sclerosis]). CPT code 64614 may only be reported once per extremity. The parenthetical (s) was removed from extremity. A parenthetical instruction following CPT code 64614 states that modifier 50 should not be appended to this code. Check with your payers to determine specific rules to code submission.

Intraoperative nerve monitoring—Clarification was added in the Intraoperative Neurophysiology section. Intraoperative nerve monitoring by the operating surgeon is included in the primary surgical service and is not separately reportable. This is a clarification—not a new instruction.

22586 Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace

0309T Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft, when performed, lumbar, L4-L5 interspace. This is a category III code and is an add-on code to 22586.

23473 Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component

23474 Revision of total shoulder arthroplasty, including allograft when performed; humeral and glenoid component

24370 Revision of total elbow arthroplasty, including allograft when performed; humeral or ulnar component

24371 Revision of total elbow arthroplasty, including allograft when performed; humeral and ulnar component

The CPT instructions state that the removal of the implant should not be reported in addition to the revision codes.

Extracorporeal Shock Wave: Wound Healing

Two new Category III codes for extracorporeal shock wave for wound healing were introduced:

0299T—Extracorporeal shock wave for integumentary wound healing, high energy, including topical application and dressing care; initial wound

0300T—Each additional wound (List separately in addition to code for primary procedure.)

As a result of the new codes, a guideline change is introduced for CPT code 28890 (Extracorporeal shock wave, high energy, performed by a physician or other qualified healthcare professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia). The guideline states that CPT code 28890 may not be reported with the new codes 0299T and 0300T; a similar guideline with the new codes indicates they may not be reported with CPT code 28890.