Surgery: Musculoskeletal System

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This section contains information to assist providers in billing for surgical procedures related to the musculoskeletal system.

Idiopathic Scoliosis: "When to Bill "By Report"

"By Report" CPT® code 22899 should be used to bill Medi-Cal for correction of idiopathic scoliosis when the listed procedure codes used (22800, 22802, 22804, 22808, 22810, 22812, 22840, 22841, 22842, 22843, 22844, 22848, 22853, 22854, 22859) do not fully describe the procedure because of modifications to the operative approach. Some examples of these cases are Luque wiring or Luque rod and wiring, Wisconsin wiring, foraminotomies and facetectomies. The entire procedure and single charge should be billed on one claim line using CPT code 22899.

Claims must be accompanied by an attached comprehensive summary of the pre-operative description of the deformity and the operative procedure, including size and location of curves, spinal segments wired and arthrodesed, and supplemental rods and cables inserted, whether rods are left in or removed, and description of graft procedure(s).

Note: Obtaining autogenous graft and its application is considered part of the basic operative procedure and is not separately reimbursable.

Electrical Stimulation to Aid Bone Healing

The CPT code book lists the following procedure codes to facilitate the identification and reimbursement of the use of electrical stimulation to aid bone healing.

‹‹**Table of CPT codes for Reimbursable Procedures**››

Code	Description
20974	Electrical stimulation to aid bone healing; non-invasive (non-operative)
20975	Electrical stimulation to aid bone healing; invasive (operative)

Both codes are billed "By Report." Claims for these services must contain sufficient documentation to permit determination of medical necessity and reimbursement levels.

Cast applications may be billed in addition to CPT code 20974.

Arthroscopy

‹‹The following arthroscopic codes involving the shoulder, elbow, wrist or ankle are benefits and do not require authorization when performed as ambulatory surgical procedures.

Table of Codes for Reimbursable Procedures››

Code	Description
29819	Arthroscopy, shoulder, surgical; with removal of loose body or foreign body
29820	Arthroscopy, shoulder, surgical; synovectomy, partial
29821	Arthroscopy, shoulder, surgical; synovectomy, complete
29822	Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])
29823	Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])
29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
29826	Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (List separately in addition to code for primary procedure)
29830	Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)
29834	Arthroscopy, elbow, surgical; with removal of loose body or foreign body
29835	Arthroscopy, elbow, surgical; synovectomy, partial
29836	Arthroscopy, elbow, surgical; synovectomy, complete
29837	Arthroscopy, elbow, surgical; debridement, limited
29838	Arthroscopy, elbow, surgical; debridement, extensive
29840	Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)

‹‹**Table of Codes for Reimbursable Procedures (continued)**››

Code	Description
29843	Arthroscopy, wrist, surgical; for infection, lavage and drainage
29844	Arthroscopy, wrist, surgical; synovectomy, partial
29845	Arthroscopy, wrist, surgical; synovectomy, complete
29846	excision and/or repair of triangular fibrocartilage and/or joint debridement
29847	internal fixation for fracture or instability
29848	Endoscopy, wrist, surgical, with release of transverse carpal ligament
29894	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with removal of loose body or foreign body
29895	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; synovectomy, partial
29897	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, limited
29898	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; debridement, extensive
29899	Arthroscopy, ankle (tibiotalar and fibulotalar joints), surgical; with ankle arthrodesis
29900	Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy
29904	Arthroscopy, subtalar joint, surgical; with removal of loose body or foreign body
29905	Arthroscopy, subtalar joint, surgical; with synovectomy
29906	Arthroscopy, subtalar joint, surgical; with debridement
29907	Arthroscopy, subtalar joint, surgical; with subtalar arthrodesis
‹‹C9781	Arthroscopy, shoulder, surgical; with implantation of subacromial spacer (e.g., balloon), includes debridement (e.g., limited or extensive), subacromial decompression, acromioplasty, and biceps tenodesis when performed››

Arthroscopy: Knee

CPT code 29866 (arthroscopy, knee, surgical; osteochondral autograft[s]) is not separately reimbursable with CPT codes 29870, 29871, 29874, 29875, 29877 and 29884 when performed at the same session. Document in the *Remarks* area/*Additional Claim Information* field (Box 19) of the claim if code 29866 was performed at a different session.

Code 29866 is not separately reimbursable with CPT codes 29879 and 29885 thru 29887 when performed on the same compartment. Document in the *Remarks* area/*Additional Claim Information* field (Box 19) of the claim if code 29866 was performed on a different compartment.

CPT code 29867 (arthroscopy, knee, surgical; osteochondral allograft) is not separately reimbursable with CPT codes 29870, 29871, 29874, 29875, 29884 and 77570 when performed at the same session. Document in the *Remarks* area/*Additional Claim Information* field (Box 19) of the claim if code 29867 was performed at a different session.

Code 29867 is not separately reimbursable with CPT codes 29879 and 29885 thru 29887 when performed on the same compartment. Document in the *Remarks* area/*Additional Claim Information* field (Box 19) of the claim if code 29867 was performed on a different compartment. Code 29867 also is not reimbursable when billed in conjunction with CPT code 27415.

CPT code 29868 (arthroscopy, knee, surgical; meniscal transplantation) is not separately reimbursable with CPT codes 29870, 29871, 29874, 29875, 29880, 29883 and 29884 when performed at the same session. Document in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim form if code 29868 was performed at a different session.

Code 29868 is not separately reimbursable with CPT codes 29881 and 29882 when performed on the same compartment. Document in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim form if code 29868 was performed on a different compartment.

Arthroscopy: “By Report” Billing

CPT codes 29830 (arthroscopy, elbow) and 29894 (arthroscopy, ankle) require “By Report” billing. Claims for these services must include a copy of the operative report and findings to determine the appropriate reimbursement.

Authorization Required

CPT codes 29904 thru 29907 (arthroscopy of subtalar joint) are reimbursable to podiatrists with *Treatment Authorization Request* (TAR) approval.

Assistant Surgeon Services: Non-Benefits

Assistant surgeon services are not reimbursable for arthroscopic codes 29800, 29804, 29819 thru 29823, 29825 thru 29827, 29830, 29834 thru 29838, 29840, 29843 thru 29848, 29894 thru 29895, 29897 thru 29900 and 29904 thru 29907.

Ligament Repair: Reimbursement Restrictions

Reimbursement for CPT codes 29888 and 29889 (arthroscopically aided ligament repair) when billed with modifier 62 (two surgeons/co-surgeons) or 66 (surgical team) is limited to the rate on file for a single surgeon. In addition, codes 29888 and 29889 are not reimbursable if billed in conjunction with CPT codes 27427 thru 27429 (ligamentous reconstruction/augmentation, knee, intra-articular, open or intra-articular, open and extra-articular).

Wrist Arthroscopy: Reimbursement Restrictions

CPT code 29840 (arthroscopy, wrist, diagnostic) is not separately reimbursable to any provider if billed in conjunction with arthrotomy-related CPT code 25040 or 25100 thru 25107 for the same recipient and date of service.

Cast and Splint Materials

When fiberglass is used as a casting or splinting material, providers must bill "By Report" using modifier 59 with CPT codes 29000 thru 29086, 29105 thru 29131, 29305 thru 29450 or 29505 thru 29515. The claim submission must include:

- An invoice listing the actual cost to the billing provider of the fiberglass materials used in the casting/splinting procedure, and
- A detailed explanation in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim form or on an attachment indicating that a fiberglass cast/splint was applied and the number and size of fiberglass rolls used.

Supplies and/or drugs, other than fiberglass materials, should be billed on a separate claim line with the appropriate surgical procedure code and modifier UA or UB.

Note: Reimbursement for fiberglass casting is based on the actual invoice cost to the billing provider. An interdepartmental invoice from the facility is not acceptable.

For routine plaster cast materials, providers should continue to bill the appropriate code (depending on body part and cast size) using CPT codes 29000 thru 29086 or 29305 thru 29450 and modifier UA or UB.

Multiplane External Fixation System

CPT code 20697 (application of multiplane [pins or wires in more than 1 plane]; exchange [ie, removal and replacement] of strut, each) is limited to one unit per single surgical session. Reimbursement of more than one unit requires a copy of the operative report as documentation of medical necessity.

Code 20697 is exempt from the multiple procedures cutback when billed with modifier 51.

Spinal Instrumentation

CPT code 22849 (reinsertion of spinal fixation device) is not reimbursable with codes 22850, 22852 or 22855 unless there is documentation that the procedure was performed at a different spinal level, for the same recipient, same date of service, any provider.

Code 22857 (total disc arthroplasty) will not be reimbursed with codes 22558, 22845 or 49010 unless there is documentation that the procedure was performed at a different spinal level, for the same recipient, same date of service, any provider.

Code 22862 (revision/replacement of total disc arthroplasty) will not be reimbursed with codes 22558, 22845, 22865 or 49010 unless there is documentation that the procedure was performed at a different spinal level, for the same recipient, same date of service, any provider.

Spinal Prosthetic Devices

The following codes are limited to one unit per single surgical session:

Table of CPT codes for Reimbursable Procedures

Code	Description
22856	Total disc arthroplasty (artificial disk), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical
‹‹22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical››
‹‹22860	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar››
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical
22864	Removal of total disc arthroplasty (artificial disk), anterior approach single interspace; cervical

For CPT codes 22861 and 22864, reimbursement of more than one unit requires a copy of the operative report as documentation of medical necessity.

‹‹CPT code 22858 is reimbursable for primary surgeon services with a *Treatment Authorization Request* (TAR). Assistant surgeon services do not require a TAR››.

Note: Providers should use code 22858 in conjunction with code 22856. Code 22856 is only reimbursable for the first level of the procedure. Code 22858 is reimbursable for the second level of the procedure.

Documentation Required for Multiple Tendon/Ligament Injections

Claims submitted for CPT code 20550 (injection[s], single tendon sheath, or ligament, aponeurosis) in quantities greater than one require documentation in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19), or on a claim attachment, that injections were administered at separate sites.

Arthrodesis

The following spinal and lumbar arthrodesis-related CPT codes are Medi-Cal benefits:

Table of CPT codes for Reimbursable Procedures

Code	Description
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace
22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or diskectomy to prepare interspace (other than for decompression), single interspace; lumbar
22633	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; lumbar

Code 22552 requires justification for billing more than one additional level.

Code 22612 is not separately reimbursable with code 22630 or code 22633 unless documentation submitted with the claim indicates the procedure was performed at a different interspace and segment, for the same recipient, same date of service, any provider.

Code 22633 is not separately reimbursable with code 22612 or 22630 unless documentation submitted with the claim indicates the procedure was performed at a different level, for the same recipient, same date of service, any provider.

‹‹Arthrodesis: Hand

HCPCS code C7566 (arthrodesis, interphalangeal joints, with or without internal fixation, with autografts [includes obtaining grafts]) is reimbursable for primary and assistant surgeon services with an approved TAR.››

Percutaneous Vertebroplasty

The following CPT codes are reimbursable for percutaneous vertebroplasty:

‹‹**Table of CPT codes for Reimbursable Procedures**››

Code	Description
22510	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
22511	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral
22512	Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)

Authorization

These services require authorization. *Treatment Authorization Requests* (TARs) for these codes must document all of the following:

- Loss of mobility with severe debilitating pain, caused by an acutely fractured vertebra presently at 50 percent of original height or greater, and
- Etiology of the severe debilitating pain from sources other than the vertebral fracture have been previously worked up and ruled out. (for example, protruded disc at same spinal level), and
- Non-invasive corrective medical treatments, including a two-week trial of opioids and physical therapy with modalities, have been tried and failed, and
- Associated conditions that may have caused the fracture have also been concurrently evaluated and treated, (for example, multiple myeloma, hemangioma, malignant neoplasm or severe osteoporosis)

Reimbursement Restrictions

CPT codes 22510 thru 22512 are not separately reimbursable with the following codes when the surgery is performed at the same spinal level. Document in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim, or on a claim attachment, when the surgery is performed at a different level. A TAR is required for reimbursement to the primary surgeon.

‹‹**Table of CPT codes for Reimbursable Procedures**››

Code	Description
20225	Biopsy, bone, trocar, or needle; deep
22310 thru 22315, 22325, 22327	Treatment of vertebral fractures and/or dislocations

Percutaneous Vertebral Augmentation

The following CPT codes are reimbursable for percutaneous vertebral augmentation:

‹‹**Table of CPT codes for Reimbursable Procedures**››

Code	Description
22513	Percutaneous vertebral augmentation, including cavity creation using mechanical device, one vertebral body, unilateral or bilateral cannulation, **inclusive of all imaging guidance**; thoracic
22514	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar
22515	Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

No more than three of any combination of these codes may be billed on the same date of service, same recipient and same provider.

Reimbursement Restrictions

CPT codes 22513 thru 22515 are not separately reimbursable with codes 20225, 22310, 22315, 22325 or 22327 when performed at the same spinal level. Document in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim, or on a claim attachment, when the surgery is performed at a different level.

A TAR is required for reimbursement to the primary surgeon. Assistant surgeon services do not require a TAR.

Arthroplasty: Shoulder Repair, Revision or Reconstruction

Do not report CPT codes 23334 and 23335 in conjunction with 23473 and 23474 if a prosthesis [ie, humeral and/or glenoid component(s)] is being removed and replaced in the same shoulder. Providers must document when performed on opposite shoulder.

Arthroplasty: Elbow Repair, Revision or Reconstruction

Do not report CPT codes 24370 and 24371 in conjunction with 24160 if a prosthesis [ie, humeral and/or glenoid component(s)] is being removed and replaced in the same elbow. Providers must document when performed on opposite elbow.

‹‹Arthroplasty: Hand Repair, Revision or Reconstruction

The following CPT and HCPCS codes are Medi-Cal benefits:

Table of CPT and HCPCS codes for Reimbursable Procedures

Code	Description
1003T	Arthroplasty, first carpometacarpal joint, with distal trapezial and proximal first metacarpal prosthetic replacement (eg, first carpometacarpal total joint)
C1608	Prosthesis, total, dual mobility, first carpometacarpal joint (implantable)

An approved TAR is required for reimbursement of CPT code 1003T and HCPCS code C1608.››

Arthrocentesis

CPT codes 20604 (arthrocentesis, aspiration and/or injection, small joint or bursa; with ultrasound guidance, with permanent recording and reporting) and 20606 (arthrocentesis, aspiration and/or injection, intermediate joint or bursa; with ultrasound guidance, with permanent recording and reporting) are reimbursable to podiatrists with an approved TAR. Assistant surgeon services are not reimbursable.

Thoracic Fracture and/or Dislocation

The following CPT codes are reimbursable for both primary and assistant surgeon services.

Table of CPT codes for Reimbursable Procedures

Code	Description
21811	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1 thru 3 ribs
21812	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4 thru 6 ribs
21813 *	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs

Arthrodesis Sacroiliac Joint

CPT code 27279 (arthrodesis, sacroiliac joint, percutaneous or minimally invasive, with image guidance, includes obtaining bone graft when performed, and placement of transfixing device) is reimbursable for both primary and assistant surgeon services with TAR. Providers must bill with modifier 50 for bilateral procedures.

Indications

Recipients may be eligible for minimally invasive sacroiliac joint (SIJ) fusion if all of the following criteria are met:

- Significant SIJ pain (pain rating of at least 5 on the 0 thru 10 numeric rating scale, where a 0 represents no pain and 10 represents worst imaginable pain) or significant limitations in activities of daily living
- SIJ pain confirmed with at least three physical examination maneuvers that stress the SIJ and cause the patient's typical pain
- Confirmation of the SIJ as a pain generator with at least 75 percent acute decrease in in pain
- Failure to respond to at least six months of non-surgical treatment consisting of non-steroidal anti-inflammatory drugs and/or opioids (if not contraindicated) and one or more of the following: rest, physical therapy and/or steroid injection. Failure to respond means continued pain that interferes with activities of daily living and/or results in functional disability
- Additional or alternative diagnoses that could be responsible for the recipient's ongoing pain or disability have been ruled out

Minimally invasive SIJ fusion is not indicated for recipients with the following:

- Less than 6 months of back pain
- Failure to pursue conservative treatment of the SIJ (unless contraindicated)
- Pain not confirmed with a diagnostic SIJ block
- Existence of other pathology that could explain the recipient's pain

Authorization

For recipients undergoing minimally invasive SIJ fusion, the following must be documented in the recipient's medical record and available on request. TARs must also include the following documentation in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim, or on a claim attachment:

- A complete history and physical documenting the likely existence of SIJ pain
- Performance of a fluoroscopically guided intra-articular SIJ block using local anesthetic on the affected side (or both sides) which shows at least a 75 percent acute reduction in pain
- A course of conservative treatment that includes use of non-steroidal anti-inflammatory drugs and/or opioids (unless contraindicated) and one of the following:
  - An adequate period of rest, or
  - An adequate course of physical therapy wherein the physical therapist specifically documents a lack of response to treatment, or
  - SIJ steroid injections into the affected joint with inadequate response or a return of pain in the weeks to months following the injections, or
  - Radiofrequency ablation of the affected SIJ with either inadequate response or a return of pain in the weeks to months following the procedure
- SIJ pain has continued for a minimum of six months
- All other diagnoses that could be causing the recipient's pain have been ruled out
- Within one month after surgery, pain level and/or functional disability is continuing, and it is the surgeon's opinion SIJ fusion is the only treatment option that will provide long term relief

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.
*	For external rib fixation, bill with CPT code 21899 (unlisted procedure, neck or thorax).