

Introducing the 2009 CPT code updates

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Reading the new *Current Procedure Terminology (CPT®) 2009* can be a daunting challenge, but is necessary to ensure that you and your staff are aware of new and revised CPT codes and Guideline instructional changes. This article focuses on new CPT and HCPCS codes applicable to ortho-paedics (exclusive of changes to the evaluation and management codes); you should review the entire *CPT 2009* for changes that may affect your individual practice.

Fractures and "G" codes

Good news for trauma surgeons—CPT 2009 includes a guideline change for codes 27215, 27216, 27217, and 27218 identifying these four pelvic bone fracture patterns (with or without pelvic ring disruption) as unilateral procedures.

But Medicare does not agree with the unilaterality of this anatomic structure and will no longer recognize codes 27215, 27216, 27217, or 27218 for unilateral or bilateral fracture treatments. Instead Medicare created new G codes to define the treatment of these fractures ([Table 1](#)). These codes are for Medicare patients only.

According to the American Medical Association CPT instructions, the correct codes are Category I codes and may be reported as bilateral procedures. Continue to report codes 27215, 27216, 27217, and 27218 to private payors.

General musculoskeletal CPT codes

Two new codes describe the application of external fixation using stereotactic computer-assisted adjustment. The computer-assisted external fixation allows the surgeon to perform simultaneous correction of multiple axes of a fracture or deformity as the fixation is dynamic with multiple fixator struts.

- 20696—Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)—new code related to external fixation
- 20697—Application of multiplane (pins or wires in more than one plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (i.e., removal and replacement) of strut, each—new code related to a

single strut change in an external fixator, usually of the spatial frame type

The instrumentation codes (22840–22851) were revised to support changes in codes where the instrumentation may be reported. Add-on codes were deleted because they may not be reported alone and must be reported with the code for the base procedure code.

In addition, the following changes were made:

- 20550—Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar “fascia”)—Guideline change to see the new CPT code(s) 64455 and 64632 for injection of Morton’s neuroma
- 20930, 20936, 20937—Guideline changes instructing the physician that these three bone graft codes may be reported in addition to the new category III codes (0195T and 0196T)
- 20985—Guideline change referencing the reinstatement of the Category III codes for 0054T and 0055T and the simultaneous deletion of codes 20986 and 20987. Medicare did not assign relative value units (RVUs) to 20986 and 20987 in 2008 and did not reimburse these procedures. Check with your local Medicare carrier to determine reimbursement because some states consider this a “not medically necessary” procedure.
- 23585—Revised to reflect the changes in 2009 related to fractures, open reduction/internal fixation (ORIF) and external fixation. CPT code 23585 now reads “Open treatment of scapular fracture (body, glenoid or acromion) includes internal fixation, when performed.”
- 27396 (single tendon) and 27397 (multiple tendons)—Revised to reflect any transplant or transfer of muscles, including re-direction or re-routing of muscles to any part of the thigh, and not just the hamstring to patella. You can use these codes to report any transplant of any muscles in the thigh.
- 28446—Now includes a new reference to use CPT code 28899 for open osteochondral allograft or repairs using industrial grafts
- 69990—Revised as inclusive to the new disk arthroplasty codes
- 72275—Guideline changes related to injection procedures

Anesthetic agents

New codes were added for the treatment of Morton’s neuroma. These services may be reported as bilateral injections but when multiple injections are done at the same site, the CPT code is reported only once.

- 64455—Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton’s neuroma)
- 64632—Destruction by neurolytic agent; plantar common digital nerve

Cervical disk arthroplasty code additions and revisions

Three 2008 Category III codes have been converted to Category I codes in 2009. Because cervical disk arthroplasty includes the use of the operating microscope and fluoroscopic guidance, these two services are not reportable separately. Additionally, interspace preparation (22554), anterior instrumentation (22845), cages (22851), and discectomy with decompression

and osteophytectomy (63075) are all included and are not reportable separately. Category III codes continue to exist for the additional cervical interspace (0195T, 0196T).

- 22856—A new code for "Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection), single interspace, cervical"
- 22857—Revised to correct a grammatical change, "single interspace, lumbar"
- 22861—A new code for "Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical"
- 22862—Guideline revised to apply only for lumbar revision
- 22864—A new code for "Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical"
- 22865—Guideline revised to apply for removal of lumbar disk only

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