Pain Management Coding Alert

CPT® 2015: Prepare Now for New Vertebroplasty and Kyphoplasty Code Choices in 2015

Plus: Don't miss these spinal myelography updates.

Some of your spinal coding will change quite a bit in January once CPT® 2015 goes into effect. Here's your scoop on what to expect from updates to joint injections, vertebroplasty, kyphoplasty, and more.

Watch for Kyphoplasty, Vertebroplasty Code Overhaul

You'll be reporting kyphoplasty and percutaneous vertebroplasty services differently in 2015, thanks to six new codes that will represent the services based on the number of vertebral bodies treated and the spinal area. Note that each code will continue to represent both unilateral and bilateral injections:

- 22510 – Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic
- 22511 – ... lumbosacral
- +22512 – ... each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)
- 22513 – Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (e.g., kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic
- 22514 – ... lumbar
- +22515 – ... each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure).

"It's important to see that the new vertebroplasty code, 22510, also includes the cervical spine region," says **Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO**, of MJH Consulting in Denver, Co. "If a provider performs a cervical vertebroplasty in 2014, you can only report it with 22899 (Unlisted procedure, spine). It will be good that pain management providers will be able to report the cervical procedure with the new 22510 code."

These codes will replace your current options, 22520-22525. The biggest change is the addition of "inclusive of all imaging guidance" to the descriptors. Each of the new codes also includes the "bulls-eye" symbol designation, which means the associated RVUs and service include moderate sedation. This is new for kyphoplasty in 2015. The 2014 codes (22523-22525) did not include moderate sedation, so you could bill it separately.

Because of the updated descriptors, the associated radiology codes for guidance will be deleted. You'll no longer be able to report the following codes as part of your vertebroplasty or kyphoplasty claim:

- 72291 – Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance
- 72292 – ... under CT guidance.

Pay Attention to Region for Spinal Myelography

Spinal myelography codes also undergo changes that will help you code procedures in more detail. Existing code 62284 (Injection procedure for myelography and/or computed tomography, spinal [other than C1-C2 and posterior fossa]) will be revised to represent the lumbar area rather than its current, wider range "spinal" designation. The new descriptor will

read, "Injection procedure for myelography and/or computed tomography, lumbar (other than C1-C2 and posterior fossa)."

You'll also have four new code choices for myelography via lumbar injection:

- 62302 – Myelography via lumbar injection, including radiological supervision and interpretation; cervical
- 62303 – ... thoracic
- 62304 – ... lumbosacral
- 62305 – ... 2 or more regions (e.g., lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical).

Note that three of the codes specify spinal region (cervical, thoracic, or lumbar) and the fourth represents the procedure in two or more regions (lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical).

Also: You'll report the new codes 62302-62305 if the same physician performs both the myelogram injection and the interpretation of the diagnostic study. If two different physicians perform the different components, however, you'll submit 62284 for the injection. The physician completing the radiologic supervision and interpretation of the report will choose from 72240-72270.

Focus on Guidance for Joint Injections

Changes to joint injection codes will specify whether the physician used ultrasound guidance during the procedure. The current codes (20600, 20605, and 20610) will be revised to specify "without ultrasound guidance," and you'll have three new codes for the same injections using US guidance. The new codes are:

- 20604 – Arthrocentesis, aspiration and/or injection, small joint or bursa (e.g., fingers, toes); with ultrasound guidance, with permanent recording and reporting
- 20606 – Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting
- 20611 – Arthrocentesis, aspiration and/or injection, major joint or bursa (e.g., shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting.

Check When Chronic Care Management Might Apply

CPT® 2013 introduced three new codes for complex chronic care coordination services (99487, 99488, and +99489). CPT® 2015 expands on this concept by adding two codes for chronic care management services:

- 99490 – Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
    - o multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
    - o chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline,
    - o comprehensive care plan established, implemented, revised, or monitored.
- +99498 – ... each additional 30 minutes (List separately in addition to code for primary procedure).

"Without having additional information on what would be required to report these services, it's hard to determine the differences between the revised codes and new codes," Hammer says. "The primary difference that I initially see is the term 'complex' in the revised codes whereas the new codes are just chronic care management. It will be interesting to see what additional information coders will get to help differentiate between the two groups of codes."