What’s New in Spine Coding for 2018?

Code changes for all medical specialties take effect on January 1, 2018 as a result of the CPT Editorial Panel process. The American Medical Association (AMA) is responsible for Current Procedural Terminology (CPT) and has convened the CPT Editorial Panel to develop and maintain the nomenclature healthcare providers use to report medical procedures and services. The CPT Editorial Panel meets three times a year to evaluate code change proposals for new and emerging technology and is responsible for reorganizing and maintaining the code set. After codes are created or modified by the CPT Editorial Panel, they go before the Relative Value Update Committee (RUC), also convened by the AMA, to be valued. For more information on the RUC process and how to efficiently complete a RUC survey if you are randomly selected to do so, this 11-minute video prepared by the AMA is a good resource.

The CPT Editorial Panel and the RUC processes are cyclical; code changes approved by the CPT Editorial Panel at the February 2016 meeting, the May 2016 meeting, and the September/October 2016 meeting take effect on January 1, 2018. The Centers for Medicare and Medicaid Services (CMS) takes the RUC recommendations under consideration when assigning final values to codes and updates its payment policies annually via the Physician Fee Schedule rulemaking. The final rule setting code values and payment rates for 2018 was released by CMS on November 2, 2017.

ISASS joined the AMA’s House of Delegates in June 2014. With a seat in the House of Delegates came the opportunity to participate as advisors to the CPT Editorial Panel and the RUC beginning in calendar year 2015. ISASS strives to represent our membership in all three of these forums and provides this educational coding resource to our membership to prepare for spine coding in 2018 and beyond.

Table of Contents

| Deleted Codes          | 2 |
| New Codes             | 2 |
| Revised Codes         | 3 |
| New Guidelines        | 3 |
| New Codes - Final Values and Surgeon Reimbursement | 4 |
| Quick Reference Tables | 5 |
DELETED CODES

The following code will be deleted effective 01/01/18:

Pre-Sacral Interbody Fusion – Second Level
The CPT Editorial Panel approved deletion of Category III CPT code 0309T at the February 2016 meeting. Category III codes are archived five years from the date of initial publication or extension unless extended.

All CPT code descriptors have been taken from Current Procedural Terminology (CPT®) 2018, American Medical Association. All Rights Reserved. CPT is registered trademark of the American Medical Association.

NEW CODES

The following new code takes effect 01/01/18:

Bone Marrow Aspiration for Spine Surgery
The CPT Editorial Panel approved creation of a new Category I code, CPT code 20939, to report bone marrow aspiration for spine surgery at the September/October 2016 meeting:

20939 - Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (List separately in addition to code for primary procedure)

Use 20939 in conjunction with 22319, 22532, 22533, 22534, 22548, 22551, 22552, 22554, 22556, 22558, 22590, 22595, 22600, 22610, 22612, 22630, 22633, 22634, 22800, 22802, 22804, 22808, 22810, 22812) (For bilateral procedure, use 20939 with modifier 50) (For aspiration of bone marrow for the purpose of bone grafting, other than spine surgery and other therapeutic musculoskeletal applications, use 20999)

All CPT code descriptors have been taken from Current Procedural Terminology (CPT®) 2018, American Medical Association. All Rights Reserved. CPT is registered trademark of the American Medical Association.

REVISED CODES

The following code revision takes effect 01/01/18:

Diagnostic Bone Marrow Aspiration
CPT code 38220 has been revised to report diagnostic bone marrow aspiration only.

38220 – Diagnostic bone marrow aspiration(s)
(Do not report 38220 in conjunction with 38221) (For diagnostic bone marrow biopsy(ies) and aspiration(s) performed at the same session, use 38222)

All CPT code descriptors have been taken from Current Procedural Terminology (CPT®) 2018, American Medical Association. All Rights Reserved. CPT is registered trademark of the American Medical Association.

NEW GUIDELINES

The CPT Editorial Panel approved inclusion of a new definition of partial vertebral corpectomy into the following sections of CPT guideline language at the September/October 2016 meeting:

- Surgery > Nervous System > Spine and Spinal Cord > Excision, Anterior or Anterolateral Approach for Intraspinal Lesion
- Surgery > Nervous System > Spine and Spinal Cord > Lateral Extracavitary Approach for Extradural Exploration/Decompression
- Surgery > Nervous System > Spine and Spinal Cord > Anterior or Anterolateral Approach for Extradural Exploration/Decompression
- Surgery > Nervous System > Spine and Spinal Cord > Excision, Anterior or Anterolateral Approach, Intraspinal Lesion

The following new definition will be incorporated into the guideline language of the CPT sections listed above:

For vertebral corpectomy, the term partial is used to describe removal of a substantial portion of the body of the vertebra. In the cervical spine, the amount of bone removed is defined as at least one-half of the vertebral body. In the thoracic and lumbar spine, the amount of bone removed is defined as at least one-third of the vertebral body.

CPT codes 63090 and 22558 were flagged by the AMA RUC Relativity Assessment Workgroup as reported together more than 75% of the time. The RUC referred the codes to the CPT Editorial Panel to bundle lumbar decompression and arthrodesis into one CPT code. The spine specialty societies participating in CPT and RUC reviewed the CPT coding guidelines for 63090 and believe 63090 may have been inappropriately reported with 22558 because there is no definition for partial vertebral corpectomy in CPT. Rather than moving forward with the bundling of the codes, the societies requested the CPT Editorial Panel approve inclusion of a new definition of partial vertebral corpectomy into CPT guideline language to clarify appropriate reporting of the decompression codes.

All CPT code descriptors have been taken from Current Procedural Terminology (CPT®) 2018, American Medical Association. All Rights Reserved. CPT is registered trademark of the American Medical Association.
NEW CODES – FINAL VALUES AND SURGEON REIMBURSEMENT

To set surgeon payment rates, CMS evaluates three components of medical services/procedures: physician work, practice expense, and malpractice expense. Each component is assigned a value also known as a relative value unit (RVU). The work RVU, practice expense RVU, and malpractice RVU are each multiplied by geographic practice cost indices (GPCI), added together, and then multiplied by a conversion factor that is updated annually. The 2018 final conversion factor is $35.9996. Please note that the reimbursement amounts contained in this document are not calculated using the geographic practice cost indices (GPCI), so your reimbursement will be slightly different than the amounts listed based on the geographic location of your practice. Also note that these are the approximate reimbursement rates to the surgeon (not the facility) for these procedures performed in a facility (not an office) setting.

Reimbursement Formula:

Reimbursement = \((\text{Work RVU} \times \text{GPCI}) + (\text{Practice Expense RVU} \times \text{GPCI}) + (\text{Malpractice RVU} \times \text{GPCI})\) \times \text{Conversion Factor}

ISASS participated in the CPT and RUC processes for this new code and is pleased that CMS followed the RUC recommendations for this code.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>20939</td>
<td>Bone marrow aspiration for bone grafting, spine surgery only, through separate skin or fascial incision (List separately in addition to code for primary procedure)</td>
<td>1.16</td>
<td>0.59</td>
<td>0.39</td>
<td>1.94</td>
<td>$69.84</td>
</tr>
</tbody>
</table>

Spine practices should update their CPT materials annually due to many changes to the guidelines and codes. For a complete listing of code changes, please reference the 2018 CPT codebook.

The coding opinions referenced are those of the ISASS Coding & Reimbursement Task Force based on their coding experience and do not constitute legal advice. Every effort is made to ensure the accuracy of information provided, however, these opinions do not replace information contained in public or private payer policies or any published CPT material. The final decision for coding any procedure must be made by the surgeon, considering regulations of insurance carriers and any local, state or federal laws that apply to the surgeon’s practice. ISASS nor any of its officers, directors, agents, employees, committee members or other representatives shall have any responsibility or liability for any claim, including but not limited to any claims for costs, legal fees, Medicare or insurance fraud, arising from the use of these opinions.