Contents

What's new in INCISIVE MD?

This is the annual year-end release for adding the 2012 AMA CPT procedure codes, a new 2-month Medicare contract term, the first quarter (Q1) 2012 National CCI edits, and a new Illinois Workers' Compensation contract term for the 2012 medical inflation adjustment.

Who should read these release notes?

If you are an INCISIVE MD user …

Read this entire document for revised features included in this update.

If you are the clinic technical contact …

No action is required to update the software if users have administrative privileges to update the \Program Files directory. The INCISIVE MD application will auto-detect and install the update when the user attempts to log into the application following the release of the update to your clinic. For clinics using terminal services, please contact INCISIVE Support for instructions on manually updating users' profiles.

Medicare 2012 Contract Term Update

The annual goat rodeo of drastic Medicare cuts postponed at the last minute with great sound and fury by Congress happened again this year. On December 23, the President signed into law the Middle Class Tax Relief and Job Creation Act of 2011 which provided for a zero percent update for 2 months. This resulted in the Centers for Medicare and Medicaid (CMS) updating the conversion factor for services provided from January 1 through February 29, 2012 from $33.9764 to $34.0376, an 0.18% increase. Additionally, CMS has updated the 2012 RVU table for other legislative and regulatory adjustments that also results in a small net increase in payment.

Multiple Imaging Reduction for Professional Component

For 2012, INCISIVE MD implements the new 25% multiple procedure reduction for the professional component (Modifier 26) of imaging services in the same imaging family. The application was already calculating the 50% reduction on the technical component (Modifier TC). In those instances where multiple imaging reductions take place, the application will generate a billing note to remind the user of this Medicare rule.

Illinois Workers' Compensation 2012 Contract Term Update

The annual Illinois Workers' Compensation Commission medical professional services fee schedule update has been included with this release. The fee schedule has been updated for the 2012 medical inflation adjustment of 3.77%. The application also implements the key provisions of Public Act 97-18, effective 1 January 2012:

- The Act requires the collapse of the 29 3-digit GeoZIPs to four county-based regions for the professional fee schedule. All of our Illinois customers perform services in Region 2, which consists of Chicago's western suburbs of DuPage, Kane, Lake, and Will counties.

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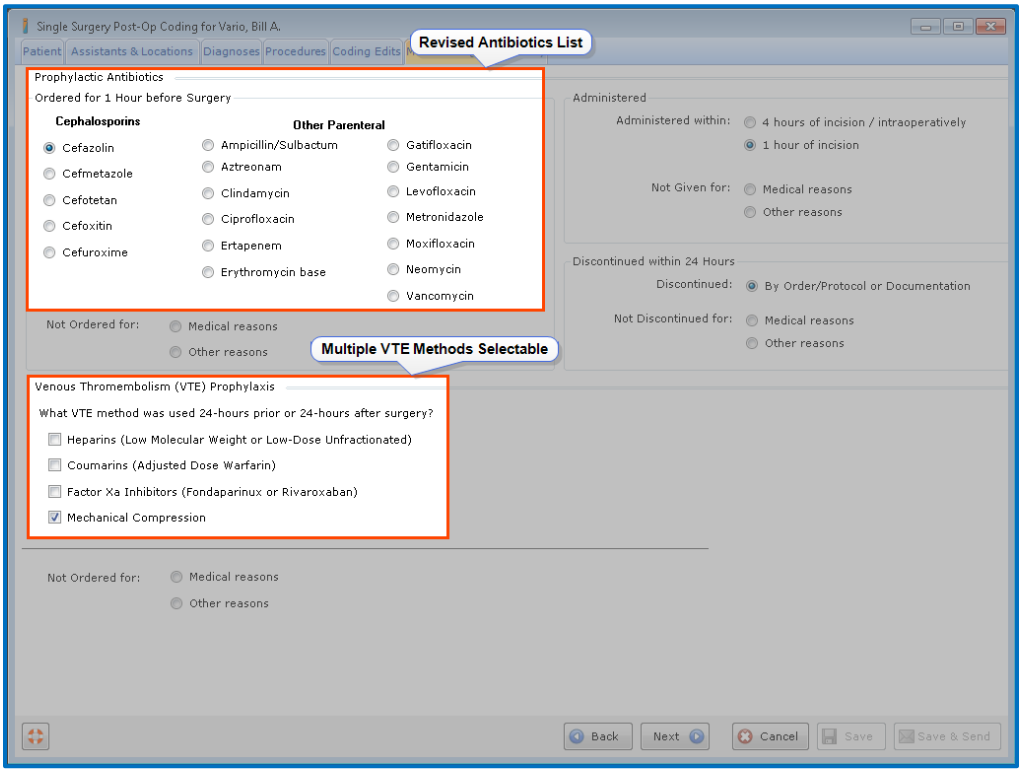
- The Act specifies, “The Commission shall automatically update all codes and associated rules with the version of the codes and rules valid on January 1 of that year”. So effective with this release the application will use the version of the CCI edits current as of the date of service.
- The Commission has removed the *Payment Guide to Global Days, Multiple Procedures, Bilateral Surgeries, Assistant Surgeons, Co-Surgeons, and Team Surgery* spreadsheet from their website. The application will now use the Medicare Payment Policy Indicators (PPI) table unless the Commission specifies a payment guide to use for Modifiers 50, 62, 66, 80, 81, and 82.

The Commission has not yet posted an update to the administrative rules for changes mandated by the Act, we assume revised rules should be posted soon because the Commission is required by the Act to post new rules about submitting workers compensation claims electronically. If any changes are posted that effect the calculation of the contractual expected amount or use of modifiers, we will then revise INCISIVE MD.

Revised Medicare PQRI tab

The Surgery Post-Op Coding **Medicare PQRI** tab has been updated to allow for greater selection of a prophylactic antibiotic listed under PQRI Measures 21 and 22. Users can now select from a defined list of cephalosporin and other parenteral antibiotics based upon the 2011 reporting specification. Only one antibiotic selection can be made from the list. The application will determine the appropriate HCPCS G or F reporting code. For 2012, the reportable HCPCS G or F-codes have not changed.



Additionally, based upon physician feedback, users can now select multiple methods for Venous Thromembolism (VTE) Prophylaxis. We have also changed the available options to clarify the selection, based upon drug class given the recent approval by the

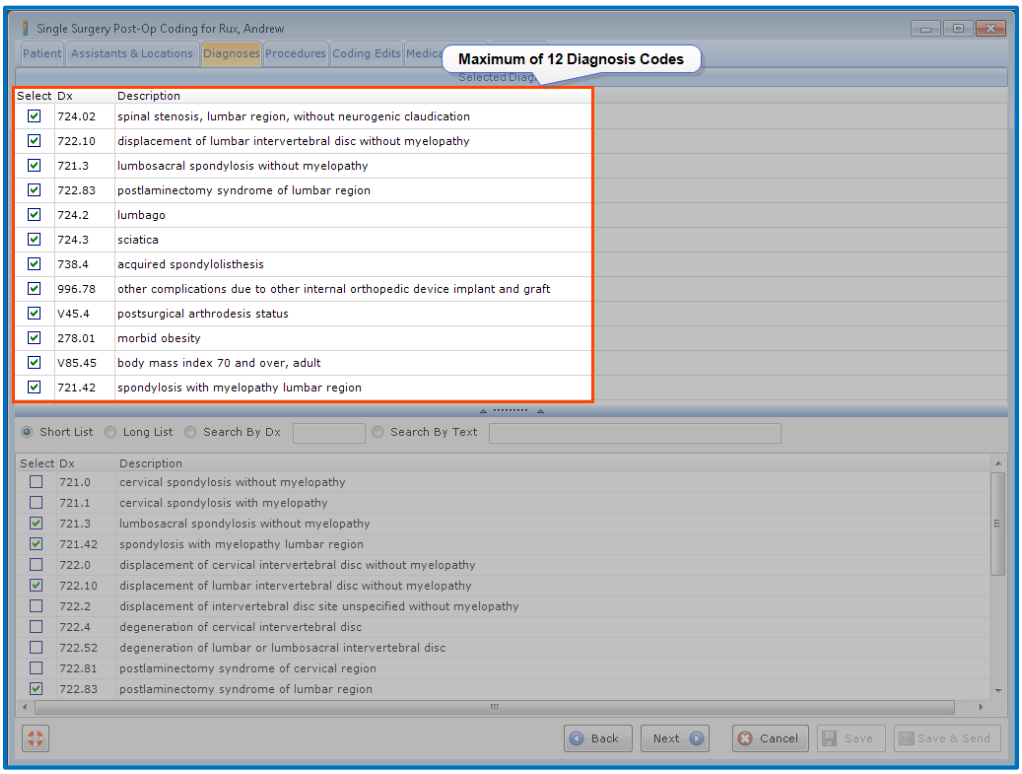
FDA for Rivaroxaban (Brand Xarelto®) for Deep Vain Thrombosis (DVT). The reportable HCPCS F-code for Measure 23 has not changed this year.

Table 1. PQRI VTE Prophylaxis Options

Heparin	For either Low Molecular Weight Heparin (LMWH) or Low-Dose Unfractionated Heparin (LDUH)
Coumarins	For adjusted dose Warfarin
Factor Xa Inhibitors	For Fondaparinux, Rivaroxaban, or other drugs of this class
Mechanical Compression	For Pneumatic Compression, Venous Foot Pumps, or other Devices but does not include Graduated Compression Stockings like TED stockings.

Maximum Diagnosis Codes is now 12

With the implementation of 5010 electronic 837P professional claim standard in 2012, INCISIVE MD now allows users to select up to twelve ICD-9 diagnosis codes per surgery case. However, the application will still restrict the user to choosing only one diagnosis code per procedure in the **Summary** tab **Procedures** grid. We do caution users that the usability of the application will be affected by selecting a large number of diagnoses. User will have to scroll on the Surgery Post-Op Coding **Summary** tab **Procedures** grid to choose the appropriate diagnosis code for each procedure code.



For those customers with integration between INCISIVE MD and their practice management system, INCISIVE MD will send all 12 diagnosis codes in the resulting HL7 DFT financial transaction message. All procedure selected diagnosis codes will be indicated in the HL7 DTF message at the service line level. This should correctly import into the practice management system to list all diagnosis codes that have been

selected in the surgery case and have the proper diagnostic code pointers for each line of service. The primary diagnosis code will be the one related to the Line 1 procedure in the Summary tab Procedures grid.

AMA CPT 2012 Procedure Code Updates

This year's AMA CPT code book changes have a significant impact on spine coding. We have added eleven new treatments and the associated logic to handle changes made to the spine related AMA guidelines. The most significant new treatment is the Combined Posterior Lumbar Fusion (PLF) with Posterior Lumbar Interbody Fusion (PLIF) code (CPT 26633) which is described in detail below. Additionally, a new guideline related to spine instrumentation clarifies when multiple instrumentation codes are reportable. We have also added logic for substituting procedure codes when locations overlap for the following three treatments: New Combined PLF/PLIF with the two corresponding Posterior Fusion codes, Spine Instrumentation Reinsertion with Insertion and Removal, and ACDF with Transpedicular Decompression.

Combined Posterior Lumbar and Interbody Fusion

With the AMA/Specialty Society Relative Value Scale Update Committee (RUC) 5-year review, procedures that are billed 75% together are looked at for combining into single procedure codes. With the 2011 review, the Posterior/Posteroloateral Fusion (CPT 22612) with PLIF (CPT 22630) are combined into a single new procedure code when performed at the same level.

Table 2. Combined PLF/PLIF

Treatment Name	Combined PLF/PLIF Fusion
CPT Codes	22633, 22634
CPT Description	Arthrodesis, combined posterior or posteriolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than decompression), single interspace and segment
Treatment Locations	T12-L1, L1-2, L2-3, L3-4, L4-5, L5-S1
Location Display	Spine > Lumbar | All
Treatment Group	Fusion > Posterior
Supplemental Codes	20930 thru 20937
AMA CPT Bundling Edits	22612, 22630
Supplies & Equipment	None
Summary Text	Combined PLF/PLIF at %LOCATIONS%
Dispute Text	This treatment represents a combined posterior/posteriolateral fusion with an interbody fusion (PLIF) at %LOCATIONS%

Table 3 lists the relevant RVU and Medicare payment information for the poster lumber fusion procedures. With the bundling of the Posterior Fusion with the PLIF, the overall RVUs for these procedures are reduced 41% from 93.00 (CPT 22612 and 22630) to 54.76 (CPT 22630). This translates to a reduction in overall Medicare payment in 2012 of $1,472.30 from the way this would have been paid in 2011. This is a significant impact

to revenue for our spinal and neurosurgeons. If customers desire an analysis of this change using their 2011 INCISIVE MD coding, please contact INCISIVE Support to request this report.

Table 3. Poster Lumbar Fusion Procedure Medicare RVU Information

CPT	Medicare Description	Work RVUs	Total RVUs	Medicare National Price
22612	Lumbar spine fusion	23.53	47.40	$1,623.59
22614	Spine fusion extra segment	6.43	11.63	$395.86
22630	Lumbar spine fusion	22.09	45.60	$1,552.11
22632	Spine fusion extra segment	5.22	9.50	$323.36
22633	Lumbar spine fusion combined	27.75	54.76	$1,863.90
22634	Spine fusion extra segment	8.16	14.77	$502.74

Use Add-On of Other Poster Fusion

The PLF and PLIF procedures are still valid when done individually at different levels. However, only one lumbar fusion procedure can be reported per case, either CPT 22612, 22630, or 22633. The new add-on logic with this set of lumbar fusion procedures is that if additional levels of these procedures are completed, the appropriate add-on for the other primary procedure is to be used. See the Coding Examples below on how coding has changed for this year for posterior lumbar fusions.

CODING EXAMPLES

Case I: A L4-5 Posterior Fusion with an L5-S1 PLIF in 2011 would have been coded as CPT 22630 with 22612-51. In 2012, this same surgery would be coded as CPT 22630 and 22614.

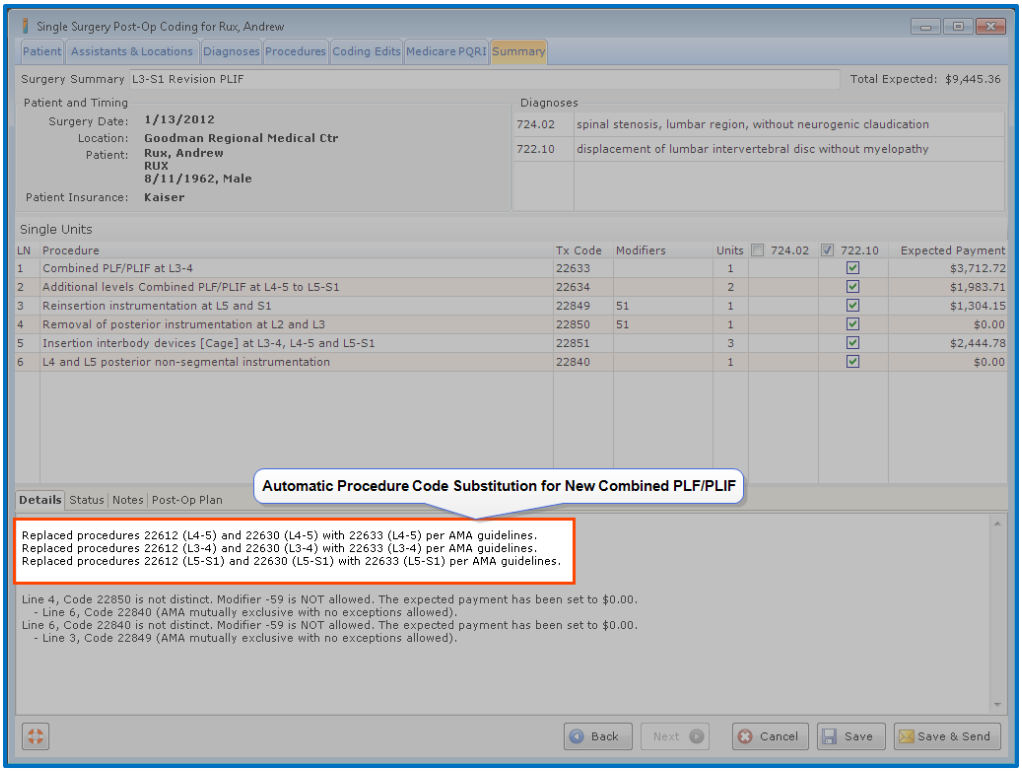
Case II: An L4-S1 two-level PLIF along with T9-T11 two-level posterolateral fusion in 2011 would be coded as CPT 22630, 22632, 22610-51, and 22614. In 2012; however, this would as CPT 22630, 22632, and 22614 (x2)

Case III: A Combined PLF/PLIF at L4-5 and L5-S1 along with an L3-4 Poster Fusion in 2012 would be coded as CPT 22633, 22634, and 22614.

As with the new Combined PLF/PLIF procedure, using the add-on procedure codes for the other fusion levels could have a significant impact to revenue this year. To illustrate using the *Coding Examples – Case I* above, the consequence of this coding change results in a 11.92 Total RVU (69.16 – 57.24) loss and reduces the Medicare payment by $405.73. Therefore, if your spinal or neurosurgeons regularly do multiple spinal level fusions, you can anticipate a noticeable reduction in payer payments this year.

Automatic Substitution for Combined PLF/PLIF

If users select duplicate locations for the Posterior Fusion and PLIF treatments, the application will automatically substitute the new Combined Posterior Fusion/PLIF treatment. The application will remove the duplicate treatments from the Surgical Planning and Coding Summary tab and list a note under the Summary tab Details section indicating the substitution was made.



Posterior Fusion Primary Procedure Selection

If a complex spine fusion case is performed that includes any combination of Posterior/Posterolateral Fusion, PLIF, or Combined PLF/PLIF procedures, the application will determine the best paying primary procedure based upon the selected payer contract for the surgery and use that as the primary procedure code and then use the appropriate add-on procedure codes for the other procedures. To reiterate, you can only report **ONE** of either CPT 22612, 22630, or 22633 per case.

Combined PLF/PLIF Not Reported for PQRI

Medicare did not add CPT 22633 and 22634 to the list of reportable procedures for the Prophylactic Antibiotics Measures 20, 21, and 22. Therefore, this creates a discrepancy between the Posterior/Posterolateral fusion and Posterior Lumbar Interbody Fusion (PLIF) procedures compared to the Combined PLF/PLIF procedure, since the latter two fusion procedures are reportable.

Chondroplasty Conversion to Add-on Procedure

One of the findings from the AMA RUC 5-year review was that chondroplasty is usually performed when other arthroscopic procedures are done on the shoulder; the RUC Committee found this happens 95% of the time. As such, they have converted the chondroplasty procedure (CPT 29826) to add-on status. As such, INCISIVE MD will now restrict the use of this procedure with arthroscopic shoulder procedures (CPT 29806 through 29828) for dates of service beyond 12/31/2011. Additionally, if users search for “chondroplasty” or “29826”, they will only find the primary arthroscopic shoulder procedures associated with this add-on procedure.

Facet Neurotomy

The AMA has made an editorial revision to change the locations for the facet neurotomy from a single nerve to a facet joint since each level has two facet joints. We have updated the locations related to the Facet Neurotomy to allow for unilateral left and right per spine interspace. Additionally, AMA replaced the 2011 set of codes with a new set.

Facet Neurotomy	2011	2012
Cervical & Thoracic	64626	64633
Cervical & Thoracic, add-on	64627	64634
Lumbar	64622	64635
Lumbar, add-on	64623	64636

The treatment within INCISIVE MD will automatically select the correct AMA CPT procedure code based upon the surgery's date of service. Additionally, the AMA has now bundled CPT procedure codes 77003 and 77012 into the facet neurotomy procedures. If a payer contract is set to use the AMA Guidelines edits, INCISIVE MD will set the Expected Payment to $0 for CPT 77003 and 77012 when coded along with the facet neurotomy procedures.

Only One Reportable Spine Instrumentation Procedure Per Approach

The AMA has revised the spine instrumentation guideline to clarify that only one insertion, removal, or reinsertion procedure code is appropriate and reportable per approach. In the past, we have instructed providers to code the case as they have performed it and report all instrumentation codes done at different levels since there was no National CCI edit related to insertion with removal, or insertion with reinsertion. Users of INCISIVE MD may continue to indicate where the insertion, removal, or reinsertion work is performed; the application will determine which of the procedures is best paid by the selected surgery's contract fee structure. A twist to this is that if both anterior and posterior instrumentation are removed, report both procedures.

Additionally, if a contract is set to use the AMA Guidelines, the application will show the other instrumentation procedures with a contractual **Expected Payment** amount of $0 along with an accompanying billing note explaining why the expected amount is zero.

NOTE: A nuance between the AMA Guidelines and the National CCI edits is the CCI edits still allow the placement of a Modifier 59 to indicate distinct work between instrumentation procedures. See the tables below for the differences in edits between the Guidelines and CCI edits. We ***caution*** users that even though removal and reinsertion are done at different levels and a Modifier 59 can be placed on either one of these procedures according to Medicare; AMA Coding Guidelines only allow one of these procedures to be reported. Because CCI edits allow an override with Modifier 59, we deem it inappropriate to remove the non-reportable procedures from the Surgery Post-Op Coding **Summary** tab **Procedures** grid. Users who do not have the permission to see the **Procedures** grid **Expected Payments** column on the **Summary** tab, users may not realize that one of the listed instrumentation codes should not be reported.

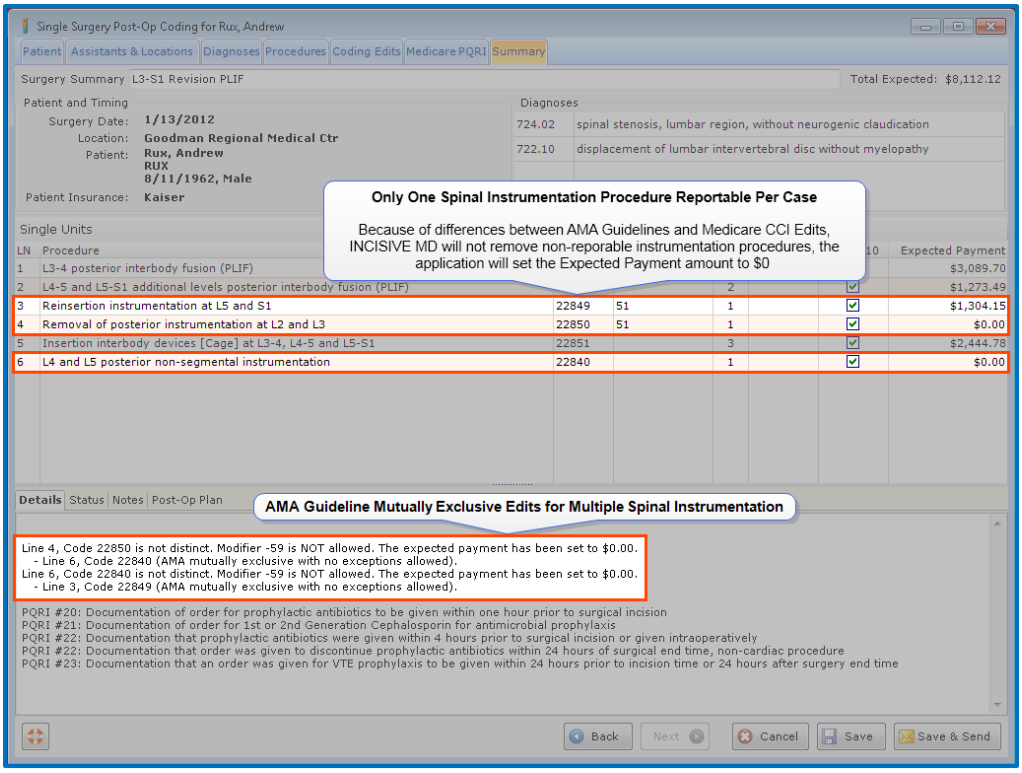


Table 4. CCI Version 18.0 Edits for Spinal Reinsertion (CPT 22849)

Col 1	Col 2	Type	Start	End	Modifier 59 Allowed
22849	22840	Bundled into Primary	20120101	*	1 – Override Allow
22849	22841	Bundled into Primary	20120101	*	0 – No override
22849	22842	Bundled into Primary	20120101	*	1 – Override Allow
22849	22843	Bundled into Primary	20120101	*	1 – Override Allow
22849	22844	Bundled into Primary	20120101	*	1 – Override Allow
22849	22845	Bundled into Primary	20120101	*	1 – Override Allow
22849	22846	Bundled into Primary	20120101	*	1 – Override Allow
22849	22847	Bundled into Primary	20120101	*	1 – Override Allow
22849	22848	Bundled into Primary	20120101	*	1 – Override Allow
22849	22850	Bundled into Primary	20050101	*	1 – Override Allow

Table 5. AMA Guidelines for Spinal Reinsertion (CPT 22849)

Col 1	Col 2	Type	Start	End	Modifier 59 Allowed
22849	22840	Mutually Exclusive	20120101	*	0 – No override
22849	22841	Mutually Exclusive	20120101	*	0 – No override
22849	22842	Mutually Exclusive	20120101	*	0 – No override
22849	22843	Mutually Exclusive	20120101	*	0 – No override
22849	22844	Mutually Exclusive	20120101	*	0 – No override
22849	22845	Mutually Exclusive	20120101	*	0 – No override
22849	22846	Mutually Exclusive	20120101	*	0 – No override

22849	22847	Mutually Exclusive	20120101	*	0 – No override
22849	22848	Mutually Exclusive	20120101	*	0 – No override
22849	22850	Mutually Exclusive	20050101	*	0 – No override

For all payers using an RVU-based system to determine their payment amounts, the reinsertion code will be selected as the best-paid instrumentation procedure. For payers using market-based contracts, the application will perform a pair-wise analysis on the CCI mutually exclusive edits to determine which of the two treatments is lessor paid better and use the will then use the code as the Column 2 code to determine whether a Modifier 59 is appropriate.

Substitution of Insertion and Removal for Reinsertion Procedure

The AMA has revised the spinal instrumentation guideline to clarify the use of the reinsertion procedure (CPT 22849) with other removal and insertion procedures. The new guideline reads, “Code 22849 should not be reported in conjunction with 22850, 22852, and 22855 at the same spinal levels”. To ensure compliance with this guideline, we have implemented AMA Guideline edits that will automatically mark the insertion and removal codes as not distinct if the same level is selected for the reinsertion, removal or insertion treatments. Additionally, if a user selects removal and insertion of instrumentation at the same location and approach (posterior or anterior), the application will automatically substitute the removal and insertion procedures for reinsertion and list a billing note indicating the substitution.

Percutaneous Laminotomy

In a November 2010, an AMA *CPT Assistant* article clarified that when spinal decompression procedures involve an open surgical technique and a combination of open/endoscopic techniques that existing spinal decompression procedure codes, AMA CPT 63030 and 63047, are only for open approaches. AMA indicated in the article that when spinal decompression procedures are done endoscopically, they should be reported using an unlisted procedure code. Many people have been coding a Minimally Invasive Lumbar Decompression (MILD) using these open approach procedure codes when, in fact, they should have been using an unlisted procedure codes if the surgeon completed the entire surgery endoscopically.

For this year, minimally invasive spine decompressions should be reported using the new Percutaneous Laminotomy/Laminectomy Category III procedure codes 0274T (cervical or thoracic) and 0275T (lumbar). See the New 2012 Treatments Added to INCISIVE MD section for information on the Percutaneous Laminotomy/Laminectomy treatment. The AMA additionally made editorial changes to the descriptions of the spinal decompression procedures to clarify that these procedure are for open approaches only. The AMA removed “including open and endoscopically assisted approaches” from the CPT definition for procedure codes 63020 to 63035.

NCCI Edits Version 18.0

This update includes the first quarter 2012 National Correct Coding Initiative (CCI) update, Version 18.0. This version includes 15,530 new edit pairs while eliminating 6,197 edit pairs. There are now more than 750,000 active edit pairs in the CCI tables. The majority of the new edits for this version are related to the new 2012 AMA CPT codes.

Treatments Added At Customer Request

At customers' request, we have added a series of sinus endoscopy treatments to INCISIVE MD.

Treatment Name	CPT Range
Repair of CSF Leak by Sinus Endoscopy	31290, 31291
Frontal Sinus Exploration	31276
Maxillary Antrostomy	31256
Surgical sinus Endoscopy	31292, 31293, and 31294

New 2012 AMA CPT Procedure Codes

At the end of this document are the details about the new 2012 AMA CPT Procedure codes that have been added to INCISIVE MD. The new treatment tables detail each treatment's information and where the treatment can be located on the Procedures tab.

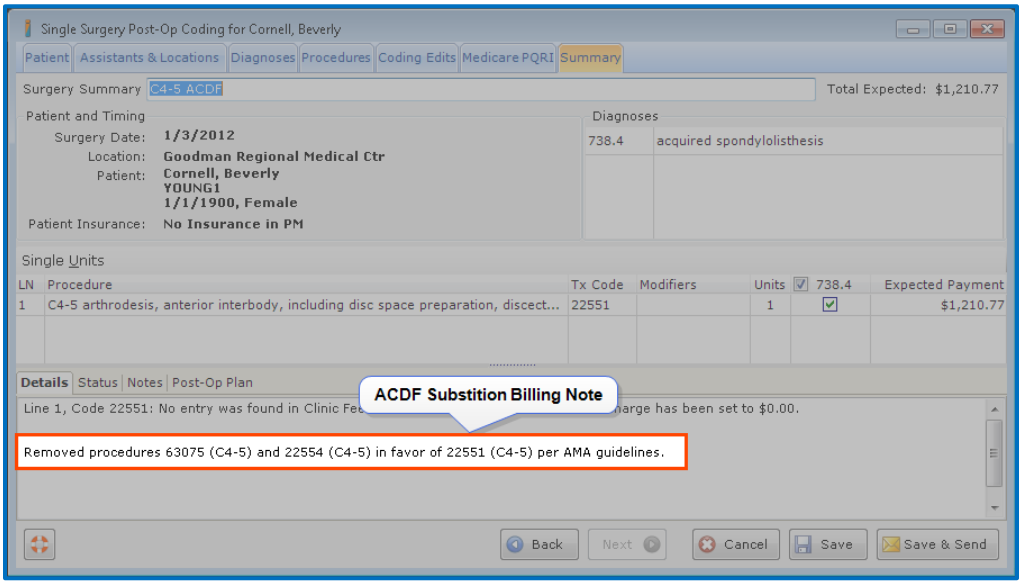
Treatment Name	CPT Range
Collagenase injection	20527
Electronic Analysis of Implanted Pump	62367, 62368, 62369, 62370
Electronic analysis of Peripheral Field Neurostimulator	0285T
Multi-layer compression system application	29581, 29582, 29583, 29584
Percutaneous Laminotomy	0274T, 0275T
Peripheral Field Neurostimulator Implantation	0282T, 0283T
Peripheral Field Neurostimulator Revision Or Removal	0285T
Skin Graft Substitute Application	15271, 15272, 15273, 15274, 15275, 15276, 15277, and 15278
Electrical Pain Modulation (TEMPR)	0278T
Thoracotomy with Exploration	32100
Transcranial magnet stimulation (TMS)	90867, 90868, and 90869

Minor Corrections to INCISIVE MD

The following minor items have been fixed within INCISIVE MD.

2011 Anterior Cervical Decompression and Fusion (ACDF) Treatment

In 2010, as part of the 5-year RUC review, a new Anterior Cervical Discectomy and Fusion (ACDF) procedure (CPT 22551) was added by the AMA to combine the existing anterior interbody fusion procedure (CPT 22554) with the anterior cervical discectomy procedure (CPT 63075). For the 2011 annual update, we did not incorporate into INCISIVE MD a mechanism to substitute the selection of anterior interbody fusion and anterior cervical discectomy procedure at the same level with the new bundled ACDF procedure. Along with the reinsertion and combined posterior/posteriolateral interbody fusion substitutions, the application will now also automatically substitute CPT 22551 for 22554 and 63075 when the procedures are performed at the same level. Regardless of how users select locations for the ACDF, anterior discectomy, or anterior interbody, the application will determine the correct procedure coding. While viewing the **Summary** tab, the user will see the substitution and the other procedures removed from **Summary** tab **Procedures** list. When this occurs, the application will indicate the substitution on the **Summary** tab **Details** section with a billing note like “Removed procedures 63075 (C4-5) and 22554 (C4-5) in favor of 22551 (C4-5) per AMA guidelines”.



Corrected login issues for customers with an apostrophe in their name

We have corrected an issue where users with an apostrophe in their first or last name, such as O’hara, was unable to add patients to INCISIVE MD.

Users are unable to select Stereotactic Computer-Assisted Navigation via Extradural Cranial approach (CPT 61781).

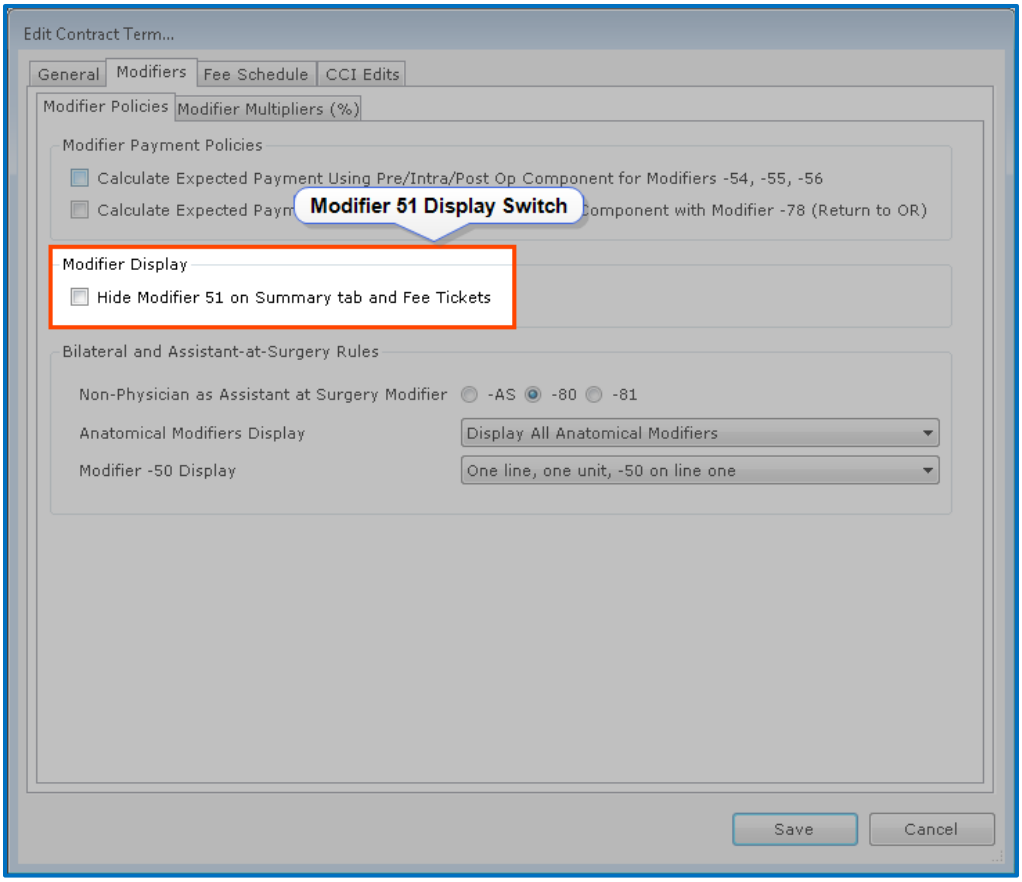
We corrected an issue in which users were unable to select the Stereotactic Computer-Assisted Navigation via Extradural Cranial approach (CPT 61781) as an add-on procedure.

Billing Note Regarding Modifier 50 on Two Lines Corrected

When a contract term is set to display Modifier 50 on two lines, a billing note was generated that incorrectly identified this situation. For example, a Billing Note for a CPT 63042-50 for the second line of service listing the Modifier could read as: "Line 2, Code 63042: The comparable procedure code for 63042 is." This incorrectly identifies that situation where the second line has been converted to acting like an add-procedure. In this release, this same billing note would read as: “Line 2, Code 63042: Primary procedure converted to an add-on.”

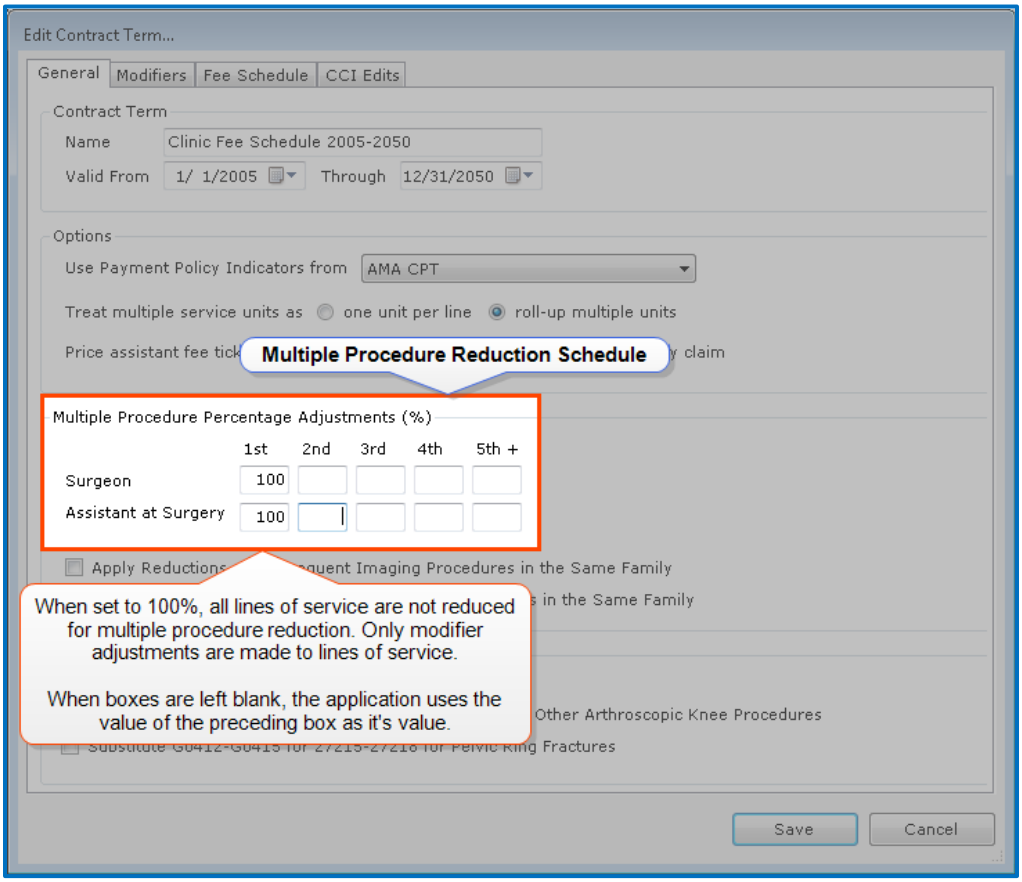
Hide Display of Modifier 51

You can now set INCISIVE MD to hide the display of Modifier 51 on both the **Summary** tab and Fee Tickets. Medicare suggests not reporting Modifier 51 because their payment system will automatically sort the submitted procedures according to their payment rules and apply multiple procedure reduction accordingly. The default setting is to display Modifier 51 on the **Summary** tab and INCISIVE MD documents. Users desiring to follow the Medicare Modifier 51 suggestion will need to check the Medicare contract term > **Modifiers** > **Modifier Display** > **Hide Modifier 51 on Summary tab and Fee Tickets** checkbox.



Users can set this Modifier 51 display property for any contract term. To change this contract term setting, edit the contract term and switch to the **Modifiers** tab and go to the **Modifier Display** > **Hide Modifier 51 on Summary tab and Fee Tickets** checkbox and check it.

Adding this feature also corrected a situation in which if the contract term **General** tab > **Multiple Procedure Percentage Adjustments** settings where for 100% and no additional reduction, the application would not do multiple procedure reduction (MPR) and also not display Modifier 51 on the **Summary** tab or INCISIVE MD documents. This is incorrect coding; now MPR calculation is separated from the display of Modifier 51. If you check the **Modifier Display** > **Hide Modifier 51 on Summary tab and Fee Tickets** checkbox, INCISIVE MD will still calculate the multiple procedure reduction according to the schedule outlined under the contract term's **Multiple Procedure Percentage Adjustments** settings. It will not, however, show Modifier 51 in the **Summary** tab > **Procedures** grid > **Modifiers** column or INCISIVE MD documents.



How do I contact INCISIVE Support?

During normal business hours, 8:00 am to 5:00 pm Pacific Time, you may contact technical support at (503) 546-5323 or by email at support@crosscurrentinc.com. Our INCISIVE MD Support website also offers resources to help answer basic questions about the software

New 2012 Treatments Added to INCISIVE MD

Treatment 1. Collagenase Injections

Treatment Name	Collagenase injection
CPT Codes	20527
CPT Description	Injection, enzyme (eg collagenase), palmar fascial cord (ie Dupuytren's contracture)
Treatment Locations	Upper Extremity > Hand
Location Display	Palmar Fascial Cord
Treatment Group	Injections > Therapeutic/Diagnostic
Supplemental Codes	None
AMA CPT Bundling Edits	None
Supplies & Equipment	J0775 - Clostridium Histolyticum (Xiaflex), 0.01 mg
Summary Text	%LOCATIONS% collagenase injection for Dupuytren's contracture
Dispute Text	This code represents an collagenase enzyme injection for Dupuytren's contracture of the %LOCATIONS%.

Treatment 2. Electronic Analysis of Implanted Pump

Treatment Name	Electronic Analysis of Implanted Pump
CPT Codes	62367, 62368, 62369, 62370
CPT Description	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status);
Treatment Locations	62367 – NO reprogramming or refill 62368 – Reprogramming 62369 – Reprogramming and refill 62370 – reprogramming and refill by a Physician
Location Display	Spine > Cervical | Throacic | Lumosacral | All Spine
Treatment Group	Assistive > Implantables
Supplemental Codes	None
AMA CPT Bundling Edits	Do not report with 95990 and 95991
Supplies & Equipment	None
Summary Text	Electronic Analysis of Implanted Pump at %LOCATIONS%
Dispute Text	This code presents the electronic analysis of a programmable, implanted pump for intrathecal or epidural drug infusion with %LOCATIONS%

Treatment 3. Electronic Analysis of Peripheral Field Neurostimulator

Treatment Name	Electronic analysis of Peripheral Field Neurostimulator
CPT Codes	0285T
CPT Description	Electronic analysis of implanted peripheral subcutaneous field stimulation pulse generator, with reprogramming when performed
Treatment Locations	Assistive > Implantables
Location Display	Assistive > Implantables
Treatment Group	Assistive > Implantables
Supplemental Codes	None
AMA CPT Bundling Edits	Do Not report with 64550 – 64595, 77002, 77003, 95970 95973
Supplies & Equipment	None
Summary Text	Electronic analysis of %LOCATION% Peripheral Field Neurostimulator
Dispute Text	This code presents the electronic analysis of implanted peripheral subcutaneous field stimulation pulse generator, with reprogramming when performed.

Treatment 4. Multi-layer Compression System Application

Treatment Name	Multi-layer compression system application
CPT Codes	29581, 29582, 29583, 29584
CPT Description	Application of multi-layer compression system; 29581 – Leg (below knee), including ankle and foot 29582 – thigh and leg, including ankle and foot when performed 29583 – upper arm and forearm 29584 – upper arm, forearm, hand, and fingers
Treatment Locations	29581 – Lower Leg and Ankle and Foot 29582 – Thigh and Knee 29583 – Upper Arm And Elbow 29584 – Forearm and Wrist and Hand
Location Display	29581 – Lower Leg and Ankle | Foot > Assistive 29582 – Thigh and Knee > Assistive 29583 – Upper Arm And Elbow > Assistive 29584 – Forearm and Wrist | Hand > Assistive
Treatment Group	Assistive > Casting/Splinting
Supplemental Codes	None
AMA CPT Bundling Edits	Do not report: 29581 with 29540, 29580, 36475, 36478, 97140 29582 with 29540, 29580, 36475, 36478, 97140 29583 with 29584, 97140 29584 with 29583, 97140
Supplies & Equipment	None
Summary Text	Multi-layer compression system application of %LOCATION%
Dispute Text	This code represents a %LOCATION% multi-layer compression system application

Treatment 5. Percutaneous Laminotomy

Treatment Name	Percutaneous Laminotomy/Laminectomy
CPT Codes	0274T, 0275T
CPT Description	Percuteanous lamintomy/laminectomy (interlaminar approach) for decompression of neural elements, (with or without ligamentous resection, discectomy, facetectomy and/or foraminotomy), any method, under indirect image guidance (eg fluoroscopic, CT) with or without the use of an endoscope, single or multiple levels, unilateral or bilateral
Treatment Locations	0274T - Spine > Cervical | Thoracic 0275T –Spine> Lumbosacral | All Spine
Location Display	Unilateral Left/Right for Spine Interspaces
Treatment Group	Decompression > Posterior
Supplemental Codes	None
AMA CPT Bundling Edits	None
Supplies & Equipment	None
Summary Text	%LOCATION% Percutaneous Laminotomy by interlaminar approach for decompression of nerve roots
Dispute Text	This code represents a %LOCATION% Percutaneous Laminotomy by interlaminar approach for decompression of neural elements that may include discectomy, facetectomy, or a foraminotomy.

Treatment 6. Peripheral Field Neurostimulator Implantation

Treatment Name	Peripheral Field Neurostimulator implantation
CPT Codes	0282T, 0283T
CPT Description	Percutaneous or open implantation of neurostimulator electrode array(s), subcutaneous (peripheral subcutaneous field stimulation), including imaging guidance, when performed, cervical, thoracic or lumbar
Treatment Locations	Assistive > Implantables
Location Display	0282T – For Trial (including removal after trial) 0282T – Permanent
Treatment Group	Assistive > Implantables
Supplemental Codes	None
AMA CPT Bundling Edits	Do Not report with 64550 – 64595, 77002, 77003, 95970 95973
Supplies & Equipment	None
Summary Text	Percutaneous or open %LOCATION% implantation of peripheral subcutaneous field neurostimulator
Dispute Text	This code presents the %LOCATION% percutaneous or open implantation of peripheral subcutaneous field neurostimulator with imaging guidance

Treatment 7. Peripheral Field Neurostimulator Revision or Removal

Treatment Name	Peripheral Field Neurostimulator revision or removal
CPT Codes	0285T
CPT Description	Revision or removal of pulse generator or electrodes, including imaging guidance, when performed, including addition of new electrodes, when performed
Treatment Locations	Assistive > Implantables
Location Display	Assistive > Implantables
Treatment Group	Assistive > Implantables
Supplemental Codes	None
AMA CPT Bundling Edits	Do Not report with 64550 – 64595, 77002, 77003, 95970 95973
Supplies & Equipment	None
CPT Description	Revision or removal of pulse generator or electrodes, including imaging guidance, when performed, including addition of new electrodes, when performed
Summary Text	Revision or removal of %LOCATION% peripheral subcutaneous field neurostimulator.
Dispute Text	This code presents the revision or removal of a %LOCATION% peripheral subcutaneous field neurostimulator including imaging guidance

Treatment 8. Skin Graft Substitute Application

Treatment Name	Skin graft substitute application
CPT Codes	15271, 15272, 15273, 15274, 15275, 15276, 15277, and 15278
CPT Description	Application of skin substitute graft to trunk, arms, legs, total wound surface area
Treatment Locations	15271, 15272, 15273, 15274 – Torso (Trunk, Back, Pelvis, Hip), Upper Extremity (Shoulder, Upper Arm and Elbow, Forearm and Wrist), Lower Extremity (Thigh and Knee, Lower Leg and Ankle) 15275, 15276, 15277, 15278 – Head and Neck (Head, Eye, Nose, Face, Ear, and Neck), Upper Extremity (Hand, Fingers and Thumb), Lower Extremity (Foot, Toes)
Location Display	Assistive > Grafting
Treatment Group	Assistive > Grafting
Supplemental Codes	None
AMA CPT Bundling Edits	Do not reporting 97602 along with 15271 through 15274
Supplies & Equipment	None
Summary Text	%LOCATION% skin graft substitute application
Dispute Text	This code represents a %LOCATION% skin graft substitute application

Treatment 9. Electrical Pain Modulation (TEMPR)

Treatment Name	Electrical Pain Modulation (TEMPR)
CPT Codes	0278T
CPT Description	Transcutaneous electrical modulation pain reprocessing (eg scrambler therapy), each treatment session (includes placement of electrodes)
Treatment Locations	Whole Body
Location Display	Assistive > Pain Management
Treatment Group	Assistive > Pain Management
Supplemental Codes	None
AMA CPT Bundling Edits	None
Supplies & Equipment	None
Summary Text	%LOCATION% Transcutaneous electrical modulation pain reprocessing therapy (TEMPR)
Dispute Text	The code represents a Transcutaneous electrical modulation pain reprocessing therapy (TEMPR) including “scrambler therapy”.

Treatment 10. Thoracotomy

Treatment Name	Thoracotomy with exploration
CPT Codes	32100
CPT Description	Thoracotomy with exploration
Treatment Locations	Torso > Trunk
Location Display	Unilateral Lung
Treatment Group	Incision > Thoractomy
Supplemental Codes	None
AMA CPT Bundling Edits	Do not report with 19260, 19271, 19272, 32503, 32504
Supplies & Equipment	None
Summary Text	%LOCATION% Thoracotomy with exploration
Dispute Text	This code represents a %LOCATION% Thoracotomy with exploration

Treatment 11. Transcranial magnet stimulation (TMS)

Treatment Name	Transcranial magnet stimulation (TMS)
CPT Codes	90867, 90868, and 90869
CPT Description	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment
Treatment Locations	90867 – Initial cortical mapping and motor threshold determination 90868 – Subsequent delivery & management 90869 – Motor threshold re-determination
Location Display	Brain & Skull > Intercranial
Treatment Group	Functional Neurosurgery
Supplemental Codes	None
AMA CPT Bundling Edits	Do not report 90869 with 90867 or 90868
Supplies & Equipment	None
Summary Text	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; %LOCATIONS%
Dispute Text	This code represents a therapeutic repetitive transcranial magnetic stimulation (TMS) treatment for %QUALIFER%

Treatment 12. Repair of CSF Leak by Sinus Endoscopy

Treatment Name	Repair of Cerebrospinal Fluid (CSF) Leak
CPT Codes	31290, 31291
CPT Description	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak
Treatment Locations	31290 -- Ethmoid region 31291 - Spenoid region
Location Display	Head and Neck > Sinuses
Treatment Group	Repair > Surgical Sinus Endoscopy
Supplemental Codes	None
AMA CPT Bundling Edits	None
Supplies & Equipment	None
Summary Text	Surgical sinus endoscopy with repair of cerebrospinal fluid leak via %LOCATIONS%
Dispute Text	This code represents a surgical sinus endoscopy with repair of cerebrospinal fluid leak via %LOCATIONS%

Treatment 13. Frontal Sinus Exploration

Treatment Name	Frontal sinus exploration
CPT Codes	31276
CPT Description	Nasal/sinus endoscopy, surgical, with frontal sinus exploration, with or without removal of tissue from frontal sinus
Treatment Locations	Bilateral Sinuses
Location Display	Head and Neck > Sinuses
Treatment Group	Repair > Surgical Sinus Endoscopy
Supplemental Codes	None
AMA CPT Bundling Edits	None
Supplies & Equipment	None
Summary Text	%LOCATIONS% surgical sinus endoscopy with frontal sinus exploration
Dispute Text	This code presents a %LOCATIONS% surgical sinus endoscopy with frontal sinus exploration

Treatment 14. Maxillary Antrostromy

Treatment Name	Maxillary antrostomy
CPT Codes	31256
CPT Description	Nasal/sinus endoscopy, surgical, with maxillary antrostomy
Treatment Locations	Bilateral Maxillary Sinus
Location Display	Head and Neck > Sinuses
Treatment Group	Repair > Surgical Sinus Endoscopy
Supplemental Codes	None
AMA CPT Bundling Edits	None
Supplies & Equipment	None
Summary Text	Surgical sinus endoscopy with %LOCATIONS% antrostomy
Dispute Text	This code presents surgical sinus endoscopy with %LOCATIONS% antrostomy

Treatment 15. Surgical Sinus Endoscopy

Treatment Name	Surgical sinus endoscopy
CPT Codes	31292, 91293, and 31294
CPT Description	Nasal/sinus endoscopy, surgical;
Treatment Locations	Bilateral Sinuses 31292 – Medial OR Interior Orbital Decompression 31293 – Medial AND Interior Orbital Wall Decompression 31294 – Optic Nerve Decompression
Location Display	Head and Neck > Sinuses
Treatment Group	Repair > Surgical Sinus Endoscopy
Supplemental Codes	None
AMA CPT Bundling Edits	None
Supplies & Equipment	None
Summary Text	%LOCATIONS% surgical sinus endoscopy with frontal sinus exploration
Dispute Text	This code presents a %LOCATIONS% surgical sinus endoscopy with frontal sinus exploration