CPT Musculoskeletal Codes

Format of the Musculoskeletal Subsection of the CPT Manual

The musculoskeletal system subsection of the CPT manual contains codes for surgical procedures on bones and muscle, as you might expect from the name. It also covers a variety of surgeries on soft tissues.

The subsection is organized into 16 subheadings. There are 13 subheadings organized by anatomical site. As you see, they start at the top of the body and move down, from the head to the foot and toes. There are three subheadings that are not part of this anatomical conceptualization. It is always helpful to use the CPT Manual index to find the precise codes.

1. General
2. Head
3. Neck (soft tissues) and Thorax
4. Back and Flank
5. Spine (Vertebral Column)
6. Abdomen
7. Shoulder
8. Humerus (upper arm) and Elbow
9. Forearm and Wrist
10. Hand and Fingers
11. Pelvis and Hip Joint
12. Femur and Knee Joint
13. Leg (Tibia and Fibula) and Ankle Joint
14. Foot and Toes
15. Application of Casts and Strapping
16. Endoscopy/Arthroscopy

Each anatomical subheading is further divided by procedure type, more specific anatomic site, condition, and description.
Types of Procedures in the Musculoskeletal System Codes

Most of the anatomical subsections have the same groups of procedures:

- Incision
- Excision
- Repair, Revision and/or Reconstruction
- Fracture and/or Dislocation
- Arthrodesis
- Amputation

Key Questions for Coding Musculoskeletal System Procedures

The key to coding these procedures correctly is a close reading of the medical record. Ask yourself these questions about the event:

1. What kind of tissue is involved—soft tissue or bone? Many of these codes are for procedures to remove tumors, and reporting the tumor excision correctly means identifying the type of tissue from which the tumor was removed.

2. Was the treatment for an acute injury or a chronic problem? Treatments for traumatic injuries are in the acute category; medical conditions are chronic. The ICD diagnosis codes need to match the CPT treatment codes indicating acute or chronic. If the condition is from a traumatic injury, you will also assign an ICD external cause or E code.

3. Where, precisely, was the treatment? If in the spine, which group of vertebrae, cervical, thoracic or lumbar?

4. Does the code include grafting or fixation? If it does not, and it was one of the procedures you are billing, you can report it as an additional procedure.

5. Does the code describe a procedure on a single site? If the physician(s) did the same procedure on multiple sites, you show the number of units, or list the code multiple times with modifiers. HCPCS has codes to specify which finger in procedures done to more than one finger.

6. Do you understand the medical terms? Keep a medical dictionary, or your favorite medical terminology website, at your desk so that you can check.
Tumor Excision: A Special Case

When you code in the Musculoskeletal System subsection, your priority is to identify the reason for treatment. If you are coding a tumor excision, you need to know where in the body the tumor was.

Codes for excising tumors from specific organs are found in the subsection for the body system to which those organs belong, but codes for excising tumors in a region of the body are in this subsection. If the surgeon removes a tumor from the stomach, the code is in the Digestive System subsection, but if she removes it from the soft tissue of the abdominal wall, the code is in the Musculoskeletal System subsection (22900.)

Because this subsection contains codes for excision in both soft tissue and bone, you as the coder need to know both the kind of tissue where the tumor was found and what instruments the surgeon used. Reading all the similar codes in the section will help you to narrow down to the correct code.