

# NEUROSURGERY CODING ALERT

The practical adviser for ethically optimizing coding, reimbursement, and efficiency for neurosurgery practices

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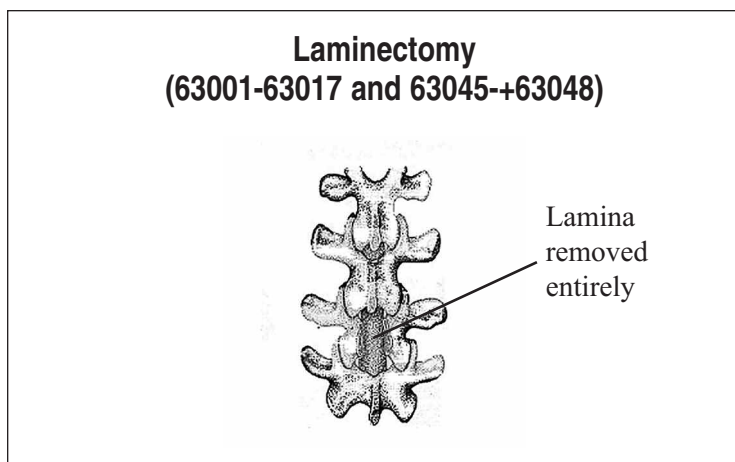
## Look for These Terms to Keep Laminotomy Straight From Laminectomy

▶ **These 'occasional' modifiers let you report both  
procedures at the same level.**

You can stop struggling to differentiate 63001-63017 from 63020-+63044 if you equate "partial" with laminotomy and "complete/total" with laminectomy. Similarities in laminectomy and laminotomy procedures, and terminology, can make your job challenging. These expert tips will help you zoom in on the differences.

### Complete Removal = Laminectomy

A laminectomy is traditionally the removal of the entire lamina from a vertebral segment, says **Nancy L. Reading RN, BS, CPC**, of Cedar Edge Medical Coding and Reimbursement in Centerfield, Utah. Neurosurgeons often perform laminectomies to treat spinal stenosis, says **Marvel J. Hammer, RN, CPC, CHCO**, owner of MJH Consulting, a healthcare reimbursement consulting firm in Denver. The surgery relieves pressure on the spinal cord and/or nerve roots by removing the lamina of the vertebra to widen the spinal canal and create more space for the spinal cord and nerves.



**Tip:** When the neurosurgeon performs a laminectomy simply to relieve compression of the spinal cord without lateral nerve decompression, report codes 63001-63017 as appropriate, depending on the number and location of levels, says

**Robert Komanetsky, CPC**, physician coder at Olive Surgical Group in St. Louis.

When your neurosurgeon performs a laminectomy with nerve decompression by facetectomy (i.e., at the lateral recess where the nerve exits the spinal column), the coding depends on the location of the affected vertebra(e). You'll choose from the following codes for this type of procedure:

- 63045 — *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [e.g., spinal or lateral recess stenosis]), single vertebral segment; cervical*
- 63046 — ... *thoracic*
- 63047 — ... *lumbar*.

As the code descriptors indicate, these procedures may be unilateral or bilateral. Therefore, you'll use the same code, with no modifiers appended, whether the surgeon removes the left or right vertebra, or both vertebra's laminae. If the neurosurgeon removes a lamina from more than one vertebra, report each additional level using +63048 (... *each additional segment, cervical, thoracic, or lumbar [list separately in addition to code for primary procedure]*).

**Best bet:** Work with your surgeon to get accurate, complete documentation. The operative report should clarify the post-op diagnosis, and the wording should

indicate clearly the lamina removed, whether any facets were removed, and if the foramen was widened, Komanetsky says. The surgeon should specify what was done at each vertebral segment so the coder can identify the appropriate levels to report.

## Partial Removal = Laminotomy

When your physician documents an opening in the lamina at any point, you should turn to your laminotomy codes. CPT offers four primary and three add-on codes to describe laminotomy:

- 63020 — *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, including open and endoscopically-assisted approaches; 1 interspace, cervical*
- 63030 — ... *one interspace, lumbar*
- +63035 — ... *each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)*
- 63040 — *Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; cervical*
- 63042 — ... *lumbar*

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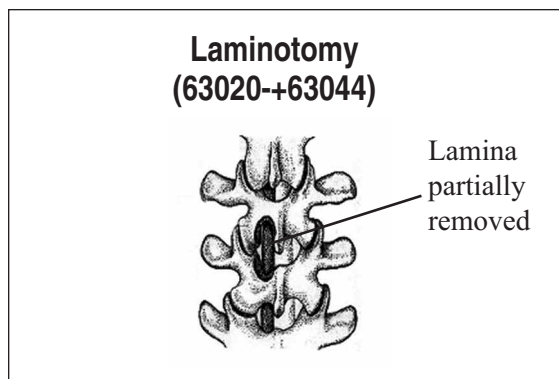
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- +63043 — ... each additional cervical interspace (List separately in addition to code for primary procedure)
- +63044 — ... each additional lumbar interspace (List separately in addition to code for primary procedure).

Typically, the laminotomy codes (63020-+63044) are at the level of the vertebral interspace and used for decompression of the disk space, whereas the laminectomies (63001-63017 and 63045-+63048) are at the level of the vertebral segment and are used to gain further access to deeper lateral structures for decompression.

“Surgeons typically perform a laminotomy to allow improved visibility of/access to the lateral spinal cord and/or nerves for decompression of neural structures. The advantage of a laminotomy is that the natural support of the lamina is left in place, which increases postoperative stability,” Hammer says.



When the neurosurgeon removes a portion of the lamina above and below the disk in question, consider that a one-level procedure and use codes 63020-63035, which are reported per interspace, Komanetsky says.

Traditionally, neurosurgery practices have used 63030 when there is a diagnosis of herniated nucleus pulposus (HNP), disk bulge or herniation, Komanetsky adds.

The laminotomy codes are inherently unilateral, so if your neurosurgeon performs the laminotomy on both the right and left side of an interspace, you should report the procedure code with modifier 50 (*Bilateral procedure*) appended, Reading says.

## Take 2 Actions to Tell Sets Apart

“I am a big fan of color coding your CPT book. Highlight laminotomy codes one color and laminectomy codes another,” Reading says.

If the neurosurgeon does not clearly label in the procedure header which procedure he’s performing, look in the procedure detail for terms such as “partial” or “complete/total” removal of the lamina to help you determine which code to use, Hammer says.

## Check Out Exceptions to Same Level Bundle

Also keep in mind that you should not code a laminectomy and laminotomy at the same level in the same operative setting, because these codes are bundled by the Correct Coding Initiative (CCI). Even though the procedures are often done together, CCI feels that extending the laminectomy to remove part of the adjacent lamina and enter the disk space doesn’t add enough effort to justify separate billing. You can append modifier 59 (*Distinct procedural service*), however, if the neurosurgeon performs the laminotomy at a different level or side than the laminectomy. You can even add modifier 22 (*Increased procedural services*) to 63047 at the same level/side if the physician documents sufficient additional work. □

## You Be the Coder

### Abbott Allograft Bone for ACDF

**Question:** *Our neurosurgeon used “Abbott” allograft bone for an anterior cervical discectomy and fusion (ACDF). I would code it as +20931 (Allograft for spine surgery only; structural ...), but he believes we should use +22851 (Application of intervertebral biomechanical device[s] [e.g., synthetic cage(s), threaded bone dowel(s), methylmethacrylate] to vertebral defect or interspace ...). He explains: “It is two separate pieces that the physician separately mills and contours. Afterward, the doctor glues them together to form a combination cortical/cancellous device. This device has a consistent size and strength rather than a piece of tricortical bone from a cadaver, which has inconsistent size and strength. A factory does this. The physician does the piece of tricortical iliac crest at the time of surgery. Thus, the milled biomechanical device comes that way.” Who is correct?*

Washington Subscriber

**Answer:** See page 15 for the answer. □

## **CCI 15.0 Update:**

# **Include New Radiosurgery Code as Part of 20 Neuro Procedures**

► **Tip: Adhere to new arthroplasty bundles by following CPT guidelines.**

Don't panic when you see the new year's voluminous Correct Coding Initiative (CCI) version 15.0. You can easily keep track of new arthrodesis, stereotactic cranial radiosurgery, and injection edits affecting your neurosurgery practice. All you need to do is follow CPT 2009's guidelines.

## **Apply Deleted Codes' Edits to Replacement Codes**

"Almost all the deleted CCI edits represent deleted CPT codes and not a change in policy," says **Melanie Witt, RN, COBGC, MA**, an ob-gyn coding expert based in Guadalupita, N.M.

**Example:** CPT 2009 deleted codes 0090T (*Total disc arthroplasty [artificial disc], anterior approach, including discectomy to prepare interspace [other than for decompression] cervical; single interspace*), 0093T (*Removal of total disc arthroplasty, anterior approach cervical; single interspace*), and 0096T (*Revision of total disc arthroplasty, anterior approach cervical; single interspace*).

Therefore, CCI 15.0 deletes bundles, such as the nonmutually exclusive edit that bundled 0090T with 22554 (*Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace [other than for decompression]; cervical below C2*), +22845 (*Anterior instrumentation; 2 to 3 vertebral segments ...*), and +22851 (*Application of intervertebral biomechanical device[s] [e.g., synthetic cage(s), threaded bone dowel(s), methylmethacrylate] to vertebral defect or interspace ...*).

**Additions:** CPT 2009 replaced these deleted Category III codes with 22856 (*Total disc arthroplasty [artificial disc], anterior approach, including discectomy with end plate preparation [includes osteophylectomy for nerve root or spinal cord decompression and microdissection], single interspace, cervical*), 22861 (*Revision including replacement of total disc arthroplasty [artificial disc], anterior approach, single interspace; cervical*), and 22864 (*Removal of total disc arthroplasty [artificial disc], anterior approach, single interspace; cervical*). CCI 15.0 applies identical edits to new codes that follow CPT

guidelines. For instance, you should not report 22856 with 22554, +22845, and +22851.

These edits, however, have a modifier indicator of "1," meaning you can bypass this edit with a modifier (such as 59, *Distinct procedural service*). Remember, these procedures must be distinct from one another (for instance, if they occur in separate anatomic locations).

## **Attach Radiosurgery Codes to 20 Neuro Services**

CCI 15.0 bundles new stereotactic cranial radiosurgery codes 61796 (*Stereotactic radiosurgery [particle beam, gamma ray, or linear accelerator] 1 simple cranial lesion*) and 61798 (*... 1 complex cranial lesion*) into over 20 other neurosurgery codes, such as 61312-61315 (*Craniectomy or craniotomy for evacuation of hematoma ...*). All of these edits carry a modifier indicator of "1."

This shouldn't be too much of a surprise. "Your physician won't usually perform radiosurgery with any of the craniotomy codes," says **Gregory Przybylski, MD**, director of neurosurgery at the New Jersey Neuroscience Institute, JFK Medical Center in Edison.

**Remember:** According to CPT guidelines, a "simple" cranial lesion is less than 3.5 cm in maximum dimension. Any lesion 3.5 cm in maximum dimension or larger is considered "complex." In addition, a lesion is classified as complex if it is adjacent (5 mm or less) to the optic nerve, optic chiasm, or optic tract or if the lesion is within the brainstem.

## **Shift Old Edits to Renumbered Infusion/Injection Codes**

CPT 2009 brought renumbered infusion and injection codes (96360, 96365, 96372, 96374, and +96375), and CCI 15.0 responds by bundling these codes into all observation, hospital, emergency department, inpatient consultation, and critical care E/M services.

"These are not new edits per se, as the old codes representing these services were bundled in previous CCI versions," Witt says. They carry an indicator of "1," which means the bundle can be bypassed with the appropriate modifier if the criteria for using than modifier are met (such as modifier 59). □

### **Newsletter Question or Comment?**



If you have a question or comment about the contents of this publication, please contact the editor, Suzanne Leder, MPhil, CPC, at [suzannel@eliresearch.com](mailto:suzannel@eliresearch.com).

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## **News You Can Use:**

# **Medicare Lowers Conversion Factor to \$36.0666 for 2009**

► ***But you won't feel as much of a crunch, thanks to a budget neutrality adjustment.***

CMS has released the Medicare Physician Fee Schedule for next year. Despite a lower conversion factor, the news isn't all bleak. In fact, your neurosurgery practice won't see a change in reimbursement next year. Here's what you need to know now.

## **Some Specialties Fare Better Than Others**

Don't lose heart when you see CMS's 2009 conversion factor of \$36.0666 — a drop from this year's \$38.0870. CMS attempts to make up for the lower conversion factor by boosting the budget neutrality adjustment by 1.1 percent. Therefore, despite the lower conversion factor, the relative value units (RVUs) for some procedures have gone up.

**What it means to you:** While some specialties won't fare as well, neurosurgeons will see a 0 percent scheduled change to their reimbursement. Some specialties will see increases, but others will see decreases of 3 and 4 percent, so consider yourself lucky to have no change at all.

**Where to find it:** The specialty information, which comes from Table 48 in the Fee Schedule Final Rule, shows how the new RVU changes will affect each specialty. You can check other specialties online at <http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf>.

"There is a 6.5 percent, five-year practice expense reduction that has been in the works for the past five years, so without the 1.1 percent increase, we would be seeing a 6.5 percent overall decrease in reimbursement," says **Barbara J. Cobuzzi, MBA, CPC-OTO, CPC-H, CPC-P, CPC-I, CHCC**, president of CRN Healthcare Solutions. "Instead, we are now seeing a 5.4 percent decrease."

## **99213 Gets Boost**

CMS reassigned RVU values for many procedures for 2009. While the RVUs for several procedures went down, your reimbursement for the most commonly reported code, 99213 (*Office or other outpatient visit ...*), rose. Whereas you currently collect \$58.90 for 99213 (not including geographic adjustment), you'll bring in \$61.31

for this service in 2009. Similarly, payments for 99214 (*Office or other outpatient visit ...*) will rise from the current rate of \$89.89 to \$92.33 next year.

## **Look at Ways to Boost Your Income**

Your practice may garner an additional 2 percent bonus if you participate successfully in the PQRI program. Another incentive next year will be that your physicians are eligible to earn 2 percent of their total Medicare allowed charges if they adopt e-prescribing systems. "E-prescribing can greatly reduce the number of medication errors that jeopardize the health and safety of Medicare patients and waste precious healthcare dollars treating conditions that never should have happened," said CMS Acting Administrator **Kerry Weems** in an Oct. 30 statement.

**Take note:** You do not have to have an electronic medical record (EMR) system to perform e-prescribing, Cobuzzi says. "There are many systems that are being made available that are stand-alone e-prescription systems that are substantially less costly than a full-blown EMR." The physician will have to register to be considered for the 2-percent bonus from e-prescribing, and then report e-prescription activity on 50 percent of the Medicare patients he sees.

Reporting includes three G codes, which indicate one of three conditions: 1) that the physician used an e-prescription, 2) that the physician did not write a prescription, or 3) that the physician wrote or phoned in some or all prescriptions due to patient request, to comply with state or federal law, because the pharmacy's system could not receive the data electronically, or because the prescription was for a narcotic or other controlled substance.

## **Watch for Credentialing Changes, Too**

The fee schedule final rule dramatically changes how you can bill when you're waiting for your physician to acquire Medicare credentialing status.

Currently, you can retroactively bill Medicare for services that a physician rendered up to 27 months prior to the physician being enrolled to participate in the Medicare program. But in the future, that 27-month period shrinks down to a 30-day window, according to the final rule.

To review the fee schedule, visit the *Federal Register* Web site at [www.http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf](http://www.http://edocket.access.gpo.gov/2008/pdf/E8-26213.pdf). □

## READER QUESTIONS

### Count Fluoro As Part of the Major Procedure

**Question:** *When our surgeon performs spinal fusions, he often dictates the use of fluoroscopic guidance (and sometimes biplane fluoroscopic guidance) for accurate positioning of instrumentation. After researching the CPT book, I didn't see anything specific to fluoroscopic guidance for this purpose. Is 76000 the most correct code?*

California Subscriber

**Answer:** Although you have found the most correct code (76000, *Fluoroscopy [separate procedure], up to 1 hour physician time, other than 71203 or 71034 [e.g., cardiac fluoroscopy]*), you should not report this along with the screw placement.

The Correct Coding Initiative (CCI) bundles the fluoroscopic or plain radiographic imaging for screw placement into the instrumentation codes (+22840-22855). You'll find that CCI bundles intraoperative imaging required for placement of spinal instrumentation into the instrumentation codes. Therefore, you should not separately report it.

### Use Unlisted for Stabbing in the Back

**Question:** *We have a patient who was stabbed in the back, and my doctor removed the knife, which was lodged within the body of S1. Should I report an unlisted procedure code?*

Maryland Subscriber

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**Answer:** Because CPT contains no code for foreign body removal from the spine, you should report unlisted procedure code 22899 (*Unlisted procedure, spine*).

**Helpful hint:** When reporting an unlisted-procedure code, include a full description of the procedure so the payer can determine the correct payment. As always when using unlisted-procedure codes, you should include the report to identify the specific effort involved, for example, using 63268 (*Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral*) as a comparison if the physician used a posterior laminectomy with extradural approach.

### Define 'Mutually Exclusive' and 'Bundled'

**Question:** *Would you explain what the differences are between mutually exclusive and "column 1/column 2" edits that come from the Correct Coding Initiative (CCI)?*

Florida Subscriber

**Answer:** Mutually exclusive edits pair procedures or services that the physician could not reasonably perform at the same session on the same beneficiary.

For example, CCI lists 61312 (*Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural*) as mutually exclusive of 61313 (*intracerebral*). The payer would not expect that the neurosurgeon would perform both types of craniectomy on the same date for the same patient because they describe different, exclusive procedures.

**Bottom line:** If you were to report two mutually exclusive codes for the same patient during the same session, Medicare would reimburse only for the lesser-valued of the two procedures (in the case of 61312 and 61313, the payer would reimburse only 61312).

Column 1/column 2 edits describe "bundled" procedures. That is, CMS considers the procedure code listed in column 2 as the "lesser" service, which is included as a component of the more extensive, column 1 procedure code.

**Example:** The CCI contains an edit bundling 61535 (*Craniotomy with elevation of bone flap; for removal of epidural or subdural electrode array, without excision of cerebral tissue [separate procedure]*) with 61320 (*Craniectomy or craniotomy, drainage of intracranial abscess; supratentorial*).

In this case, 61320 is the more extensive procedure, which includes the "lesser" procedure 61535. In theory,

removing the electrode array is not significant enough to warrant separate payment when it's done at the same time as the abscess drainage.

**Bottom line:** If you were to report bundled (column 1/column 2) procedures for the same patient during the same session, Medicare would reimburse only for the higher-valued of the two procedures (in the case of 61320 and 61535, the payer would reimburse only 61320).



## Draw the Line Between Segmental, Nonsegmental

**Question:** How can I determine segmental from nonsegmental spinal instrumentation?

North Dakota Subscriber

**Answer:** For posterior instrumentation to determine if the device is segmental (+22842-+22844) or nonsegmental (+22840, *Posterior non-segmental instrumentation [e.g., Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublamina wiring at C1, facet screw fixation ...]*), count the number of fixation points:

- If the surgeon attaches the instrumentation to the spine at only **two** points, the device is **nonsegmental** (regardless of the number of vertebrae spanned).
- If the surgeon attaches the device to at least **three** points (on three different segments), the instrumentation is **segmental**.

In some cases, the surgeon will place a metal cage or other prosthetic device for stabilization in an area where he has removed a large portion of the vertebra. This represents a third type of instrumentation, which you should report using +22851 (*Application of intervertebral biomechanical device[s] [e.g., synthetic cage(s), threaded bone dowel(s), methylmethacrylate] to vertebral defect or interspace ...*).

**Be careful:** Report only a single unit of +22851, regardless of how many devices the surgeon places at one level. If the surgeon places devices on multiple spinal levels, however, you may report multiple units of +22851.

**Example:** The surgeon places two cages at level T6. Report +22851 x 1.

Alternatively, the surgeon places two cages at level T6 and a third cage at level T8. Report +22851 x 2. Some payers may require you to append modifier 59 (*Distinct procedural service*) to the "additional" units of +22851 to distinguish them as occurring at a separate anatomic location(s).



## Post-Op Care Includes Halo Adjustments

**Question:** How can we code for adjusting a cervical halo without using anesthesia?

Indiana Subscriber

**Answer:** You can't report halo adjustments separately. Depending on how the surgeon accomplished the original procedure, you probably reported either 20661 (*Application of halo, including removal; cranial*) or 20664 (*Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology [e.g., pediatric patients, hydrocephalus, osteogenesis imperfecta], requiring general anesthesia*).

Each procedure has a 90-day global period. Periodic adjustments in the office are a component of halo care and are included in the global period.

When the global period ends, you should factor halo adjustments when deciding on an appropriate E/M level (99211-99215 for established outpatients).



## You Be the Coder

### Abbott Allograft Bone for ACDF

**Answer:** You are. According to the American Association of Neurological Surgeons (AANS), all allograft bone other than a threaded allograft bone dowel is coded as +20931. You should use +22851 when your physician uses a synthetic device.

**Keep in mind:** If your physician uses a synthetic device or threaded bone dowel, you can report +22851 once for each level. Even if the neurosurgeon places more than one threaded bone dowel at a particular level, you should still report the code just once for that interspace. For instance, if the surgeon places two cages or two bone dowels at interspace L4/L5, you should report a single unit of +22851.

You may report additional units of +22851 for additional interspaces the neurosurgeon treats. For example, if the surgeon places two cages at L4/L5 and a third cage at L5/S1, you should report +22851 x 2.

**Tip:** For some payers, you may have to append modifier 59 (*Distinct procedural service*) to the second unit of +22851 to indicate that it represents instrumentation placed at a separate anatomic location. □

## Turn to Twist Drill/Burr Hole for Monitor Placement

**Question:** *What is the correct code for placement of right frontal Camino intracranial pressure monitor?*

Arizona Subscriber

**Answer:** The answer depends on the method the surgeon used to place the pressure monitor.

If the surgeon uses a twist drill (a handheld device), report 61107 (*Twist drill hole[s] for subdural, intracerebral, or ventricular puncture; for implanting ventricular catheter, pressure recording device, or other intracerebral monitoring device*). If the surgeon uses a power burr or similar instrument to create the hole(s), instead report 61210 (*Burr hole[s]; for implanting ventricular catheter, reservoir, EEG electrode[s], pressure recording device, or other cerebral monitoring device [separate procedure]*).

— *Technical and coding guidance for You Be the Coder and Reader Questions provided by Gregory Przybylski, MD, director of neurosurgery at the New Jersey Neuroscience Institute, JFK Medical Center in Edison.* □

### Have a neurosurgery coding question? Get help from our experts!

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