

# NEUROSURGERY CODING ALERT

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

2010, Vol. 11, No. 4 (Pages 25-32)

## What's Inside

4 Steps Simplify Cranial Stereotactic Radiosurgery Coding. . . . . 27

► *Descriptor details and correct counting keep you away from traps.*

You Be the Coder . . . . . 28  
• Resection Hinges on Tumor Location

Clarify Anatomic Details When Counting and Coding Interspaces. . . . . 28

► *Learning your surgeon's punctuation preferences offers valuable clues.*

## Reader Questions

Check Choices for Multiple Hemilaminectomies . . . . . 29

Count +22851 by Interspace . . . . . 29

61760 Includes Stereotactic Electrode Removal . . . . . 30

Reporting 63012 Infers Spondylolisthesis . . . . . 30

Reason Dictates Separate Facetectomy Code. . . . . 30

Medication Wash Is Part of Procedure Code. . . . . 31

Submit 63663 for Each Revised Electrode Array. . . 31

Define These 'Mutually Exclusive' and 'Bundled' Terms. . . . . 31

## CCI 16.1 Targets Arthrodesis, Arthroplasty With Both Mutually and NME Neurosurgery Edits

► **Pay attention to the edits that carry modifier indicator "0."**

The Correct Coding Initiative (CCI) Version 16.1 went into effect April 1, with almost 40 percent of 112 new mutually exclusive pairs applying to neurosurgeons. Non-mutually exclusive edits include 67 pairs listing head, spine, or nervous system procedures as the comprehensive component.

As a whole, CCI 16.1 includes 2,054 new edit pairs, with 1,947 modifier indicator changes, says **Frank Cohen, MBB, MPA**, of MIT Solutions Inc. in Clearwater, Fla.

### Watch Exclusive Arthrodesis, Arthroplasty Pairs

Mutually exclusive edits affecting neurosurgeons are split almost equally between arthrodesis and total disc arthroplasty procedures. *Remember:* Mutually exclusive edits mean the code pair "represents procedures or services that could not reasonably be performed at the same session by the same provider on the same beneficiary," according to CMS. Medicare will only reimburse you for the *lesser*-valued of the two procedures.

Codes for posterior and anterior arthrodesis for spinal deformity (22800-22812) and kyphectomy (22818-22819) are mutually exclusive with three disc arthroplasty procedures:

- 22861 — *Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical*
- 22864 — *Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical*
- 22865 — *... lumbar.*

Edits also list 22630 (*Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace [other than for decompression], single interspace; lumbar*) as mutually exclusive with Category III code 0195T (*Arthrodesis, pre-sacral interbody technique, including instrumentation, imaging [when performed], and discectomy to prepare interspace, lumbar; single interspace*).

**No impact:** "One would never do an arthroplasty and fusion at the same level, so those edits should have no impact," says **Gregory Przybylski, MD**, director of neurosurgery at the New Jersey Neuroscience Institute, JFK Medical Center in Edison. The same applies to the edit involving 22630 and 0195T. "You can't do a 22630 at the

same location as 0195T because it was already done with the pre-sacral fusion,” Przybylski adds. “This edit should also have no impact.”

The remaining mutually exclusive edits pertain to total disc arthroplasty procedures 22856-22865. Edits bundle each code with procedures ranging from 22600 (*Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment*) or 22554 (*Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace [other than for decompression]; cervical below C2*) to 22800 (*Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments*).

**Breakage applies:** CCI assigns a modifier indicator of “1” to most of these edit pairs, meaning you can override the edit by reporting the appropriate modifier (such as modifier 59, *Distinct procedural service*). You might see this situation if the surgeon performs a single level arthroplasty at one level and an arthrodesis at a different anatomical level, Przybylski says.

**Exception:** The unbundling exception lies in pairings of 62360-62362 (*Implantation or replacement of device for intrathecal or epidural drug infusion ...*) with 62365 (*Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion*). Those pairs carry a “0” modifier indicator, so you cannot report

the procedures together under any circumstances. Previous edits for 62365 with 62360-62362 allowed you to report both procedures because of the “1” modifier indicator. CCI 16.1 deletes the edits with the “1” modifier in favor of the new edits with a “0.”

## NME Edits Roll Fluoro Into More Procedures

Previous editions of CCI categorized fluoroscopic guidance as a component of common spine or nervous system procedures, and the non-mutually exclusive (NME) edits of CCI 16.1 are no exception. *Remember:* Non-mutually exclusive edits pair codes for two services that physicians often perform during the same session. CCI lists one code as the comprehensive procedure — meaning it’s considered the larger procedure — and the second code as the component, which is a piece of the comprehensive.

**Nervous system news:** Guidance code 77002 (*Fluoroscopic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device]*) is a component of procedures such as 62267 (*Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes*) and 63610 (*Stereotactic stimulation of spinal cord, percutaneous, separate procedure not followed by other surgery*). Similar pairings mark 77003 (*Fluoroscopic guidance*

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*Neurosurgery Coding Alert* (USPS 019-399) (ISSN 1529-6091 print, 1947-6914 online) is published by The Coding Institute, a subsidiary of Eli Research, 2222 Sedwick Road, Durham, NC 27713. © 2010 The Coding Institute.

Subscription price is \$447. Periodicals postage is paid at Durham, NC, 27705 and additional entry offices.

POSTMASTER: Send address changes to *Neurosurgery Coding Alert* PO Box 413006, Naples, FL 34101-3006.

**Web:** www.codinginstitute.com **Customer Service:** service@medville.com **Discussion Group:** www.coding911.com

Rates: USA: 1 yr. \$447; 2 yrs. \$874 (\$20 savings); 3 yrs \$1291 (\$50 savings). Bulk prices available upon request.  
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and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures [epidural, transforaminal epidural, subarachnoid, or sacroiliac joint], including neurolytic agent destruction) as a component of the same procedures.

**Spine watch:** Several spine-related edits involve 22864 (*Removal of total disc arthroplasty [artificial, disc], anterior approach, single interspace; cervical*). CCI 16.1 classifies 22864 as the comprehensive procedure that overrides components such as 22505 (*Manipulation of spine requiring anesthesia, any region*) and 62291 (*Injection procedure for discography, each level; cervical or thoracic*).

All non-mutually exclusive edits for neurosurgery carry a “1” indicator, so you might be able to report both procedures of a pair in certain circumstances, typically when the procedures are performed at different anatomical levels. □

## 4 Steps Simplify Cranial Stereotactic Radiosurgery Coding

► **Descriptor details and correct counting keep you away from traps.**

You know how coding guidelines restrict your ability to report multiple codes during operative sessions? That isn’t the case for cranial stereotactic radiosurgery, but you still need to know what codes to report and when. Use these four steps to ensure correct code selection every time.

### Step 1: Differentiate ‘Simple’ From ‘Complex’

CPT 2009 introduced a new code family for stereotactic radiosurgery. The number and type of lesions treated differentiate the codes:

- 61796 — *Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion*
- +61797 — ... *each additional cranial lesion, simple (List separately in addition to code for primary procedure)*
- 61798 — ... *1 complex cranial lesion*
- +61799 — ... *each additional cranial lesion, complex (List separately in addition to code for primary procedure).*

Your surgeon’s documentation will point you toward “simple” or “complex.” Complex lesions include those that are adjacent (5 mm or less) to the optic nerve/optic chiasm/optic tract or within the brain stem. Certain types of lesions are automatically considered complex (such as schwannomas, arterio-venous malformations, pituitary tumors, glomus tumors, pineal region tumors, and cavernous sinus/parasellar/petroclival tumors).

Simple cranial lesions are less than 3.5 cm in maximum dimension that do not meet CPT’s definition of a complex lesion.

**Tip:** The surgeon might choose to treat the same lesion during more than one session over the course of care, but that doesn’t mean you automatically report everything multiple times. CPT directs you to only submit 61796 or 61798 once per course of treatment, regardless of how many sessions the surgeons require to treat the lesion.

### Step 2: Count the Lesions

Once the surgeon treats multiple lesions, you’ll add either +61797 or +61799 to your claim, based on whether

*(Continued on next page)*

#### Terminology Check: Draw the Line Between Radiosurgery Tactics

Neurosurgeons use a variety of modalities to perform stereotactic radiosurgery, depending on the equipment available. Although codes 61796-+61799 apply to any of the techniques, knowing the differences helps you better understand the procedures.

**Deborah Messinger, CPC**, a coding specialist with Massachusetts General Physicians Organization in Charlestown, says radiosurgery can be performed with any type of beam of ionizing radiation:

- Gamma ray radiosurgery is Cobalt-60 based radiation (Gamma Knife)
- Linear accelerator based radiation is X-ray radiosurgery (Linac, CyberKnife, Novalis TX, Tomo Therapy)
- Proton beam radiosurgery uses proton particle beams from a cyclotron.

Your surgeon’s approach can also hinge on the case complexity. “We generally use Linac for simple treatments that won’t take a long time and that don’t require as much sophistication in performing the treatment,” Messinger says. “Usually this is a patient with one or two small brain metastases.” □

the lesions are simple or complex. You can include either of these add-on codes for a maximum of five lesions treated during the session.

**Over the limit:** How do you report the service if the surgeon treats more than five lesions? You don't, according to AMA instructions. Even if your physician treats more than five lesions on a date of service, you stop at reporting one primary code (61796 or 61798) and four units of the appropriate add-on code.

"Don't report +61797 or +61799 more than four times for an entire course of treatment, regardless of the numbers of lesions your neurosurgeon treats," explains **Marianne Schipper, CPC**, a spine, brain, and endovascular coding specialist at Barrow Neurosurgical Associates in Phoenix, Ariz.

### Step 3: Add On for Frames

Linear accelerator based radiation is frameless. Many other treatment systems, however, are frame-based — which means you'll add another code to your claim.

If the surgeon uses a frame-based system, be sure to include +61800 (*Application of stereotactic headframe for stereotactic radiosurgery [List separately in addition to code for primary procedure]*) on your claim, Schipper says.

**Heads up:** Sometimes the neurosurgeon applies the frame but doesn't participate in the rest of the radiosurgery procedure, says **Deborah Messinger, CPC**, a coding specialist with Massachusetts General Physicians Organization in Charlestown. In that case, you report 20660 (*Application of cranial tongs, caliper, or stereo-*

*tactic frame, including removal [separate procedure]*) instead of +61800.

### Step 4: Double Check CCI Edits

Several editions of the national Correct Coding Initiative (CCI) edits during the past year included restrictions pertaining to stereotactic radiosurgery.

For example, 61796 and 61798 include injections normally reported with +96376 (*Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; each additional sequential intravenous push or the same substance/drug provided in a facility [List separately in addition to code for primary procedure]*).

For the latest CCI edits and explanations, check out the coding toolkit at [www.supercoder.com](http://www.supercoder.com). □

## Clarify Anatomic Details When Counting and Coding Interspaces

► **Learning your surgeon's punctuation preferences offers valuable clues.**

Navigating the anatomy and terminology of spinal procedures is a tricky path to tread on many fronts. If counting and calculating interspaces and segments has you mystified, read on for advice that will help your spinal claims stand tall.

### Verify Vertebral Terms

Learning the difference between vertebral segments and interspaces stymies many coders. Follow this guide from the North American Spine Society "Common Coding Scenarios for Comprehensive Spine Care":

- Vertebral segment describes the basic constituent part into which the spine may be divided. It represents a single complete vertebral bone with its associated articular processes and laminae.
- Vertebral interspace describes the non-bony compartment between two adjacent bodies which contains the intervertebral disc and includes the nucleus pulposus, annulus fibrosus, and two cartilagenous end plates.

**Another clue:** Anatomically, a single spinal nerve exists in the vertebral space between two vertebrae. For

## You Be the Coder

### Resection Hinges on Tumor Location

**Question:** *Our neurosurgeon and an otolaryngologist performed co-surgery for a case described as "resection of the midline skull base extradural tumor extension, endoscopy." Then used a transsphenoidal endoscopic approach to the lesion. They resected the lesion, extending the posterior wall of the sphenoid sinus through that space, then abutting the dura. How should we code this case?*

Alabama Subscriber

**Answer:** Turn to page 31. □

example, the L5 spinal nerve passes across the L4 and L5 vertebrae at the L4-L5 interspace.

## Clarify the Documented Anatomy

“Coders need to clarify with their providers as to their use of anatomic nomenclature when they’re describing the spinal nerve or the vertebral interspace,” advises **Marvel Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO**, owner of MJH Consulting in Denver, Co. For example:

- A dash used between two vertebra (L4-L5) typically indicates a single interspace.
- A comma between two vertebra (L4, L5) could be interpreted a couple of different ways. The comma might designate two vertebrae that the surgeon treated, or might indicate two spinal nerves that exit between two vertebral interspaces. Because of the different possibilities, ask specifics about your surgeon’s documentation. Knowing his documentation preferences will help you interpret his notes more accurately and guide your coding.

With those tips in mind, consider this scenario from coder **Michelle Benz** and decide your best coding approach.

**The case:** Your neurosurgeon performs L4-L5 microdiscectomy. Would you report only 63047 (*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; lumbar*)? Would you assign 63047 with +63048 (... *each additional segment, cervical, thoracic or lumbar [List separately in addition to code for primary procedure]*)? Or is another code your most accurate choice?

**Solution:** “From what I’ve seen, providers don’t typically remove the full lamina when performing microdiscectomy,” Hammer says. If that’s the case in the surgery you’re coding, you’ll actually report 63030 (*Laminotomy [hemilaminectomy], with decompression of nerve root[s], including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar*). The dash in your surgeon’s notes indicates a single interspace between L4 and L5, so you won’t include +63035 (... *each additional interspace, cervical or lumbar [List separately in addition to code for primary procedure]*). The same would hold true if you were coding a full laminectomy represented by 63047. □

## READER QUESTIONS

### Check Choices for Multiple Hemilaminectomies

**Question:** *Our surgeon performed left C7-T1 hemilaminectomies, extradural opening for debulking of the left C7 nerve root tumor; and nerve root exploration. He used C7 and T1 pedicle screw fixation and bone decortication for fusion. How do we code all these procedures?*

Tennessee Subscriber

**Answer:** Start with 63280 (*Laminectomy for biopsy/excision of intraspinal neoplasm; intradural extramedullary, cervical*).

Your arthrodesis code will be either 22610 (*Arthrodesis, posterior or posterolateral technique, single level; thoracic [with or without lateral transverse technique]*) or 22600 (*Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment*).

Lastly, include +22840 (*Posterior non-segmental instrumentation [e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation]* [*List separately in addition to code for primary procedure*]) for the screw fixation.

Assuming the bone removed in the laminectomy is used to stimulate fusion, you can also use 20936 (*Autograft for spine surgery only [includes harvesting the graft]; local [e.g., ribs, spinous process, or laminar fragments] obtained from the same incision [List separately in addition to code for primary procedure]*).

### Count +22851 by Interspace

**Question:** *I’ve always been of the understanding that you should bill +22851 per interspace. One of our payers rejected a claim with multiple units of +22851, stating it was a duplicate charge. Have there been changes we need to know?*

Connecticut Subscriber

**Answer:** You are correct in reporting +22851 (*Application of intervertebral biomechanical device[s] [e.g., synthetic cage{s}, threaded bone dowel{s}, methylmethacrylate] to vertebral defect or interspace [List separately in addition to code for primary procedure]*) for each interspace treated.

(Continued on next page)

For example, if the surgeon treats L3-L4 and L4-L5, you'll report one unit of +22851 for L3-L4 and one unit +22851 with modifier 59 (*Distinct procedural service*) for L4-L5. Ensure that your surgeon documents that he places cages or other prosthetic devices in each interspace.

## 61760 Includes Stereotactic Electrode Removal

**Question:** *The surgeon placed stereotactic depth electrodes for long-term seizure monitoring. The patient tugged at the wires until they loosened and became improperly placed. He was taken back to the operating room the next day so the surgeon could remove the electrodes and patch the burr holes. How should we code the procedures?*

Nebraska Subscriber

**Answer:** Report 61760 (*Stereotactic implantation of depth electrodes into the cerebrum for long-term seizure monitoring*) for the original electrode placement. CPT doesn't include a code specifically for removal of this type of electrode because 61760 includes their eventual removal. Therefore, removal the following

day is considered part of the original procedure and not separately coded.

## Reporting 63012 Infers Spondylolisthesis

**Question:** *A few of our physicians document "instability" or "instability with caudal root compression" instead of clearly noting that they're performing a Gill procedure for spondylolisthesis. Does their documentation need to be more specific before we can report 63012?*

Utah Subscriber

**Answer:** No, their notes do not need to specify "spondylolisthesis" before you submit 63012 (*Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar [Gill type procedure]*). The descriptor for 63012 does not use the verbiage as "e.g.," but does state that it is performed for "spondylolisthesis." Using the ICD-9 diagnostic code for spondylolisthesis (738.4 or 756.12) should be sufficient.

## Reason Dictates Separate Facetectomy Code

**Question:** *Our neurosurgeon performed a facetectomy at C7 and T1 to allow for arthrodesis. Would this step be considered "access," or can we report 63045 in addition to the arthrodesis?*

California Subscriber

**Answer:** The correct answer depends on whether your physician completed facetectomy simply for access to accommodate the arthrodesis. If the answer is yes, you cannot separately report the facetectomy because the surgeon didn't perform the associated decompression.

If, however, the surgeon did not use the facetectomy for access but rather for nerve root decompression, you can submit 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*). You'll also report the applicable arthrodesis code, such as 22600 (*Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment*).

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## Medication Wash is Part of Procedure Code

**Question:** *When our neurosurgeon performs a lumbar disc excision he always pours over the nerve root the same medication that a pain management specialist administers for a steroid injection. We submit 63030 for the main procedure. Is there a CPT code for the medication wash, and can we bill for it?*

New Jersey Subscriber

**Answer:** No, you cannot code separately for the medication wash you describe.

**Explanation:** National Correct Coding Initiative (CCI) edits bundle similar pain management procedures with 63030 (*Laminotomy [hemilaminectomy], with decompression of nerve root[s], including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches; 1 interspace, lumbar*). For example, CCI prevents you from reporting 64483 (*Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level*) or other injection procedures with 63030. It also does not allow you to break the pairing with a modifier. Therefore, payers who follow CCI edits will consider pouring medication into a surgical wound to be part of the procedure and not separately billable.

**Compare:** In contrast, the insertion of a separate and distinct needle into the vertebral foramen is different physician work and malpractice risk as compared to “pouring” the medication into the surgical wound. Even though the end result is the same (the physician places the drug at the anatomic site), the physician work and risk are quite different, so they garner different reimbursement.

---

## Submit 63663 for Each Revised Electrode Array

**Question:** *The physician replaced two sets of spinal cord stimulator leads with eight contacts each. He suggested we bill the code twice, but I think you can only report 63663 once with one unit because the descriptor states “array(s).” What’s the correct coding approach?*

Wyoming Subscriber

**Answer:** You report 63663 (*Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array[s], including fluoroscopy, when performed*) per “array” or “lead,” so you can submit

63663 multiple times if your physician revises more than one array. Notice that the descriptor includes revision and replacement of new arrays, so you don’t need to also report 63650 (*Percutaneous implantation of neurostimulator electrode array, epidural*). The relative value unit (RVU) calculation allows for the additional service associated with 63663 (total facility RVU 12.79 for 63663 versus 10.91 total facility RVU for 63650).

If he places or revises the arrays in the same anatomic site, append modifier 51 (*Multiple procedures*) to 63663. If he revises arrays in different anatomic sites, append modifier 59 (*Distinct procedural service*) instead.

**Remember:** Calculate your code selection based on the number of arrays, not the number of electrode contacts on each catheter, plate, or paddle array placed.

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## Define These ‘Mutually Exclusive’ and ‘Bundled’ Terms

**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  
(Continued on next page)

## You Be the Coder

(Question on page 28)

### Resection Hinges on Tumor Location

**Answer:** If the tumor was a pituitary neoplasm, the most accurate CPT code is 62165 (*Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or transsphenoidal approach*). If the surgeon resected a non-pituitary extradural neoplasm, submit 64999 (*Unlisted procedure, nervous system*) instead. For either scenario, append modifier 62 (*Two surgeons*) since multiple surgeons participated in the case.

**Comparison:** You could report similar procedures with 61607 (*Resection or excision of neoplastic, vascular, or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; extradural*). 61607, however, describes the definitive skull base procedure of resecting a midline extradural skull base tumor and represents an open procedure rather than endoscopy. Because you’re coding an endoscopic approach, 62165 or 64999 are more accurate choices. □

**Answer:** Mutually exclusive edits pair procedures that are 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).

— *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.* □

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