Placement of Pedicle Screws/Rods Only

Question:

What code to use for placing pedicle screws only? No other procedure performed so there is no primary procedure to use. Patient has a failed fusion and soon after (during the global period) the neurosurgeon surgeon said she reinforced the fusion by placing pedicle screws/rods only...nothing more. I’ve heard you say, at AANS courses, to use an unlisted code for this (22899). I did that but the payor denied both 22899 saying it was an “appropriate parent” code for 22840. Now what?

Answer:

Actually, I think there is some confusion. When we recommend using 22899 that means you report only 22899. It is not accurate to report both 22899 and 22840. The unlisted code, 22899, would represent your entire procedure.

Sacroplasty

Question:

The doctor did a vertebroplasty of the S1 segment of the sacrum. I used code 0200T for this procedure and Medicare denied stating “procedure/treatment has not been deemed proven effective by payer”. Is there another code I should have used or is there a way to get some type of reimbursement for this procedure from Medicare?
Yes, 0200T is the correct code for a percutaneous sacroplasty. Unfortunately, Medicare does not have a standard payment policy for this code but leaves it up to each local carrier to determine whether they will pay. Wish I had better news for you.

---

**RVUs**

**Question:**

What is the difference between a facility versus non-facility on Medicare’s fee schedule?

**Answer:**

The difference refers to the place of service where the activity/CPT code was performed. Medicare’s physician fee schedule reimburses differently for a CPT code performed in a facility (e.g., hospital) differently than it does a non-facility (physician office). Generally, the reimbursement is higher in the non-facility setting because the physician incurs the practice expense for providing the service.

---

**Fluoroscopy**

**Question:**

Can I bill a fluoroscopy code such as 77002-26 when I do a transsphenoidal pituitary tumor removal? Or, how about billing
77003-26 when I do a discectomy?

Answer:

Actually, use of fluoroscopy for localization or to help you perform a surgical procedure is included in the global surgical package for that surgical CPT code (e.g., 61548, 63030) and not separately billable by the surgeon.

---

**Pituitary Surgery**

**Question:**

My neurosurgeon and an ENT doctor do pituitary surgeries together and the ENT wants to bill 62165 and 61548 together. Is it ok to bill both codes?

**Answer:**

No, it is not appropriate to report both codes together. Choose the single code that best describes what was done and each physician will append modifier 62 (two surgeons, or co-surgery) to that single code.

---

**Intraoperative Steroid Injection With Discectomy**

**Question:**

My neurosurgeon does an intraoperative injection of a steroid
before he closes. Can I bill 63211 with 63030? I looked at the CCI edits and it seems like I’d need to use modifier 59 on 62311 to get it paid.

**Answer:**

We would not expect to see this code combination for procedures performed at the same spinal level. Intraoperative pain management by the operating surgeon is included in the postoperative global surgical package. Also, a “smaller” procedure (62311) performed at the same spinal level is included in the larger code (63030).

It is not appropriate to report 62311 with 63030 together (even with modifier 59 on 62311) if 62311 is at the same level/incision.

---

**Reprogramming of a Shunt**

**Question:**

For the life of me, I cannot get paid on 62252 when we reprogram a VP shunt in the global period. What can I do to get these paid?

**Answer:**

It is appropriate to append modifier 58 to the reprogramming code, 62252, in this case as the patient’s condition may warrant reprogramming during the postoperative period. Hopefully that will get you paid!
**Gamma Knife**

**Question:**

Do the stereotactic radiosurgery codes 61796-61799 include the planning? I’m being told that I can also bill 77295 along with the stereotactic radiosurgery codes. This doesn’t seem right to me.

**Answer:**

You are correct to question this advice. The surgical stereotactic radiosurgery codes that a neurosurgeon reports, 61796-61799, do indeed include your planning as well as being present with the patient at the time the service is provided. A neurosurgeon should not also report 77295.

---

**Minimally Invasive Laminectomies and Foraminotomies**

**Question:**

My neurosurgeon did a minimally invasive approach with bilateral paramedian incisions and bilateral L4-5 and L5-S1 laminectomies with foraminotomies for neural decompression and stenosis. Can I bill 63047, 63047-50, 63048 and 63048-50 for this because he made two incisions? He said told me the procedure was more difficult since he’s just learning this technique.

**Answer:**
Actually, CPT 63047 says “unilateral or bilateral” so it is not appropriate to report 63047 or 63048 with modifier 50. The number of incisions does not dictate the number of CPT codes.

---

**Modifier 80 vs. 62**

**Question:**

I have a question concerning modifier 80. According to Medicare this modifier should be used when 2 different specialties are performing surgery on the same patient but not doing the same procedure. Modifier 62 can be used for 2 different specialties when performing the same procedure but also for the same specialty. Am I explaining this correctly?

**Answer:**

Modifier 80 is appended to the assistant surgeon’s codes, which are usually the same codes as the primary surgeon’s, when that surgeon is assisting the other. Typically the assistant is of the same specialty but sometimes other specialty physicians (e.g., general surgeon, family practice) may assist the primary surgeon. The primary surgeon is doing all the activities described by the CPT code(s) billed – the assistant surgeon is just helping out. The assistant surgeon does not dictate an operative report. Example: partner neurosurgeon assists on a discectomy (primary surgeon bills 63030, assistant bills 63030-80).

Modifier 62 represents co-surgery between two surgeons (Medicare says they must be of different specialties even though CPT does not) when the two surgeons share the activities described by a single CPT code. Two surgeons are necessary usually when neither surgeon performs the single CPT
code on his/her own. Both surgeons dictate an operative report and both have pre and postop responsibilities. Example: ENT and neurosurgeon do a trans-sphenoidal/transnasal approach to excision of a pituitary tumor (both ENT and NS bill 61548-62).