ICD-10-CM Code for DBS Battery/Generator Replacement

May 31, 2018

**Question:**
We are using the diagnosis code of T85.190 (Other mechanical complication of implanted electronic neurostimulator of brain electrode (lead), initial encounter) for the replacement of a deep brain stimulator generator (2 leads, 61886) because the battery died. This code requires a 7th digit and we are struggling with the difference between initial encounter (A) and subsequent encounter (D) for this case. It’s not an injury or fracture which makes it more difficult to decide. Can I get your expertise?

**Answer:**
A couple of questions/ comments about this:

1. Why are the leads being replaced? Are they dislodged or out of place? If so, then a T code is appropriate.
2. For routine battery replacements because the battery has reach its end of life (a normal occurrence – not a complication), we’d use the condition code such as Parkinson’s disease (G20) and not a T code.

If you’re using a T code then you have 3 choices for the 7th character: A for initial encounter, D for subsequent encounter, and S for sequela. The service is not being performed for a sequela so you can eliminate the 7th character of S. So now you’re between A and D. Since the patient is receiving active treatment for the “other mechanical complication”, you’ll use the 7th character of A (T85.190A).

*This response is based on the best information available as of 05/31/18.*
Carotid Stenting and Diagnostic Angiograms

May 17, 2018

Question:
I was told that no diagnostic angiogram can be billed with a carotid stent. Is this true?

Answer:
Not exactly! Any carotid angiograms on the ipsilateral (same) side are included in a carotid stent procedure. Medically necessary diagnostic carotid stenting on the contralateral side and vertebral angiography on either side are separately reportable.

*This response is based on the best information available as of 05/17/18.

ICD-10-CM Code for Spinal Stenosis

May 3, 2018
Question:
Should the code set M48.0- be used for both central canal stenosis and foraminal stenosis?

Answer:
There is no distinction made in ICD-10-CM for central canal stenosis vs foraminal stenosis. Therefore, the M48.0- code covers both/all types of spinal stenosis.

*This response is based on the best information available as of 05/03/18.*

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Evacuation of Cervical Epidural Hematoma

April 19, 2018

Question:
How do I code a cervical laminectomy with extradural epidural hematoma evacuation? I was thinking about using 63265 but my co-worker said this code is for a tumor removal and not for a hematoma.

Answer:
Sorry, but your co-worker is incorrect. The code series, 63265-63268, is for laminectomy procedures to remove intraspinal lesions “other than neoplasm” so these codes would never be used for tumor removal.

Examples of extradural non-neoplasm lesions where 63265-63268 are used include a hematoma or abscess.
Removal of Halo

March 29, 2018

Question:
One of my neurosurgeons saw a new patient in the office for evaluation of neck pain after an MVA. The patient had a type III odontoid fracture and another provider, in a different state, placed a halo 2½ months ago. My provider decided to remove the halo. Can he bill for the halo removal and, if so, what code is it?

Answer:
Yes, you can report CPT 20665 (Removal of tongs or halo applied by another physician) in addition to your E/M code assuming you have performed and documented a “significant and separately identifiable” E/M service. So you’d report the following codes: E/M-25 and 20665. However, if your physician or a spine surgeon in your group had originally placed the halo and it was removed in the 90-day global period, then you could not bill for the removal.

*This response is based on the best information available as of 03/29/18.*
Placement of Lumbar Subarachnoid Drain

March 15, 2018

Question:
My neurosurgeon states he placed a subarachnoid drain in the lumbar spine after a craniotomy for CSF leak repair procedure. He thinks the correct code is 62350. Is this accurate?

Answer:
No. You’ll use 62272 (Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter) instead. CPT 62350 is for placement of a catheter for long-term medical administration such as that necessary for a spinal pump; it is not the correct code for a lumbar drain.

*This response is based on the best information available as of 03/15/18.

Injection of Marcaine into Muscle/Skin

March 1, 2018

Question:
My neurosurgeon always injects Marcaine into the muscle and
skin incision prior to closure after spine procedures. Can I bill this with a nerve block or trigger point code?

Answer:
This is a method to help with post-operative pain control and is not separately billable by the surgeon.

*This response is based on the best information available as of 03/01/18.

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**Intradural Neurolysis of Spinal Cord with Laminectomy for Tumor Removal**

February 15, 2018

**Question:**
One of our neurosurgeons did a thoracic laminectomy and removal of intradural, intramedullary tumor. He says he spent a lot of time on intradural neurolysis of thoracic cord to remove the tumor. Is there a CPT code I am not finding for this neurolysis or would we go the route of 63286 with 22 modifier?

**Answer:**
There is not a separate CPT code for the service you describe. This is included in your primary procedure code, 63286, because the procedure code descriptor says “intradural, intramedullary.”

*This response is based on the best information available as
Blood Clot and Tumor Removal – 1 or 2 Codes?

February 1, 2018

Question:
Hemorrhagic tumor – I removed tumor and blood clot surrounding the tumor. Can I use 61510 and 61313?

Answer:
No, use 61510 for the tumor removal which includes removing any associated hematoma. Only one exposure/craniotomy was performed so only one code should be reported.

*This response is based on the best information available as of 02/01/18.

Assistant Surgeon Payments

January 18, 2018

Question:
We are seeing payers ask for payment back when we use Modifier 80 for assistant surgeon. Is there a reason why they would
take the payment back?

Answer:
We are seeing many payers including Medicare and Medicaid ask for payment recovery when the documentation does not explain what role the assistant played in the surgery. It is not enough just to identify that the patient encounter is complex but actual detail of what the assistant did during the surgery can support billing for an assistant surgeon.

*This response is based on the best information available as of 01/18/18.*