Exploration of Fusion (22830) – Two Questions Answered

April 13, 2017

Question:
Can we bill 22830 with modifier 50 because we explored both sides?

Question:
Can we bill 22830 for each level explored?

Answer:
No and no. CPT 22830, for exploration of spinal fusion, is used once regardless of the number of levels explored. It is assumed that you explore “both sides” of the spine which is typically considered a central structure from a coding standpoint.

*This response is based on the best information available as of 04/13/17.

Endoscopic Transnasal Pituitary Tumor Removal

March 30, 2017

Question:
I’m confused. Should I use 61548 vs 61580 & 61600 to bill an endoscopic transnasal approach to remove a pituitary tumor?
Or is this an unlisted code (64999)?

**Answer:**

Good question – there are actually 3 CPT codes that specifically address removal of a pituitary tumor none of which are the skull base surgery codes you asked about (61580 & 61600). They are listed in the table below:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Descriptor</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>61546</td>
<td>Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach</td>
<td>Craniotomy, open</td>
</tr>
<tr>
<td>61548</td>
<td>Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic</td>
<td>Transnasal or transseptal using a microscope</td>
</tr>
<tr>
<td>62165</td>
<td>Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach</td>
<td>Transnasal or trans-sphenoidal using an endoscope</td>
</tr>
</tbody>
</table>

The codes, 61580 and 61600, are skull base codes which require an open approach and are not used to report transnasal procedures.

So there is a code for the procedure you describe and that is 62165. Remember to append modifier 62 (two surgeons) if the approach is performed by the otolaryngologist (both surgeons report 62165-62).

*This response is based on the best information available as of 03/30/17.*
Denials of 20930 and 20936

March 16, 2017

Question:
I’m new to neurosurgery coding and notice a big problem with denials. Medicare doesn’t pay us on 20930 and 20936. I’ve been appealing but don’t seem to have any success. Can you help?

Answer:
While CPT says it is accurate to code 20930 (morselized allograft) and 20936 (local autograft), Medicare considers both codes “bundled” into the primary code which is typically an arthrodesis/fusion code. Accept these denials and don’t waste your time appealing denials to Medicare.

*This response is based on the best information available as of 03/16/17.

Bilateral Laminectomy

March 2, 2017

Question:
Can we bill 63047 with modifier 50 when we do a bilateral procedure?

Answer:
The code descriptor for 63047 is:
Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; lumbar

Notice the words “unilateral or bilateral” which means this code includes removal of one or both sides; therefore, it would not be appropriate to append modifier 50 to 63047.

*This response is based on the best information available as of 03/02/17.

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**Removal of Posterior Segmental Instrumentation**

February 16, 2017

**Question:**
We removed posterior instrumentation from L3-L5 and I want to code it as 22852 x 3 units because there are three levels involved. My neurosurgeon doesn’t think that is right. What do you think?

**Answer:**
Your neurosurgeon is correct – the code is reported once regardless of the number of levels of contiguous levels are involved.

*This response is based on the best information available as of 02/16/17.
Assistant Surgeon – PA vs. Physician Payment

February 2, 2017

Question:
I am writing because I have a question that you might be able to help me with. My PA of several years who assists me in the operating room is retiring. There is a local family practitioner that is leaving her practice and it might be interesting to see if she would be interested in assisting me in surgery. Is there a difference in payment for the PA versus the physician?

Answer:
Yes, there is a difference in payment. Medicare allows 16%, for the physician as an assistant surgeon (modifier 80) of what is paid to the primary surgeon. For the PA, Medicare pays 85% (modifier AS) of what would have been paid to a physician (16% of the primary surgeon’s allowable) – that’s about 13.6% of the primary surgeon’s allowable.

*This response is based on the best information available as of 02/02/17.*
New Spinal Intervertebral Device Code +22853

January 19, 2017

Question:
OK, I’m still confused on the new codes. Can +22853 be used on the posterior spine? It talks about anterior instrumentation so it seems the code cannot be used for posterior procedures like a PLIF/TLIF.

Answer:
The description for +22853 says it includes anterior instrumentation “when performed.” So if anterior instrumentation is not performed, such as in posterior procedures, then the code still applies. Bottom line is that the code applies to an interbody fusion whether the procedure is performed from an anterior, posterior or even lateral approach.

*This response is based on the best information available as of 01/19/17.

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New Spinal Cage Codes – 2017

January 5, 2017

Question:
I see that CPT code +22851, Application of intervertebral biomechanical device(s) to vertebral defect or interspace was deleted effective 1/1/17. What code do I now use?
Answer:
Three codes have been added to CPT 2017 to replace +22851:

- +22853 is used for a device, with fusion, with or without integrated anterior fixation
- +22854 is used for a device to fill a corpectomy defect, with fusion, with or without integrated anterior fixation
- +22859 is used for interbody device insertion without fusion

Note that +22853 and +22854 include the integral anterior instrumentation for device anchoring when that type of device is used. If you do not use integrated fixation, it is still the same codes, +22853 or +22854. If you use a separate plate, you may separately report a code such as +22845 when the plate meets the code criteria (e.g., the plate crosses the interspace, can provide independent stabilization, and can be used with any other type of interspace device).

To learn everything you need to know about the NEW 2017 CPT codes for spine surgery click here.

*This response is based on the best information available as of 01/05/17.

Treatment of Vasospam During Intracranial Aneurysm Coiling

December 15, 2016

Question:
Thank you for the discussion yesterday! You are very insightful and a great educator on a complex topic. I have a question for you regarding treating vasospasm extracranially (not intracranially). Can I also use 61650 for a catheter that causes vasospasm on the way up to coil an aneurysm?

**Answer:**
There are a few issues with using 61650 in the situation you describe. First, 61650 is for treating *intracranial* vasospasm—in your example below the vasospasm is *extracranial* so 61650 cannot be used.

Also, there is no longer a peripheral code for treating vasospasm. That code 37202, non-thrombolytic infusion, was deleted in 2015. There was no replacement code because it is rarely appropriate to separately code the vasospasm treatment in the peripheral vascular system.

Lastly, if the catheter to treat an aneurysm causes the vasospasm, then we would not separately code for treating the vasospasm because you’re billing for the aneurysm coiling (61624).

*This response is based on the best information available as of 12/15/16.*

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**Global Period for ICP Monitor**

December 1, 2016

**Question:**
I did a consultation on an ICU patient (non-Medicare) and placed an intracranial pressure monitor (ICP) via twist drill
on a patient this morning. The global period for the ICP monitor code, 61107, is 90 days so I now can’t bill for any follow-up hospital care. What’s the point – I should just not bill for the ICP monitor placement so I can continue to bill for follow up hospital care.

**Answer:**
Actually, the postoperative global period for 61107 is not 90 days. Rather, it is 0 days so you may continue to bill your follow up hospital care using a subsequent hospital care code (9923x).

For today’s services you’ll report the consultation code, 9925x, appended with modifier 25 as well as 61107.

*This response is based on the best information available as of 12/01/16.*

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