Programming a Spinal Cord Neurostimulator

August 10, 2017

Question:
My surgeon wants to bill 95972 for programming along with placement of a spinal neurostimulator. Isn’t the programming inclusive to the surgical codes?

Answer:
Good question. No, the programming is not inclusive to the surgical codes. However, the billable programming must be real programming and not just a check of the impedance or ensuring the connection of the lead to the generator is working or turning the system on and off. Billable programming must include documentation of the actual programming parameters such as rate, pulse amplitude, pulse duration, pulse frequency.

Additionally, the programming must be performed by the billing physician. The physician may not bill for the vendor’s representative doing the programming in the recovery room or in the office.

*This response is based on the best information available as of 08/10/17.*
Neuronavigation (+61781) with Pituitary Tumor Procedure (61548)

July 27, 2017

Question:
Can we bill neuronavigation when billing for a transsphenoidal resection of a pituitary tumor?

Answer:
Yes. The transsphenoidal code, 61548 says “Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic” so that means the stereotactic navigation is not included in the code. Therefore, you may separately report the add-on code +61781 (Stereotactic computer-assisted (navigational) procedure; cranial, intradural). However, use of the microscope is included in 61548 so +69990 should not be separately reported.

CPT +61781 may also be reported with the other two pituitary tumor removal codes, 61546 and 62165, when appropriately documented.

*This response is based on the best information available as of 07/27/17.
Reading MRIs During an Office Visit

July 13, 2017

Question:
I oftentimes read a cervical MRI (without contrast) done at an outside facility during the course of a new patient visit. Can I bill 72141-26 along with my new patient E/M code (9920x)?

Answer:
The Medical Decision Making (MDM) component of the E/M code includes data review – this is how you will get “credit” for your personal review and interpretation of the outside MRI. It is not accurate for you to also report 72141-26 because the radiologist who did the formal interpretation reported this code/modifier.

*This response is based on the best information available as of 07/13/17.

Scraping the Vertebral Endplates

June 22, 2017

Question:
Our spine surgeon recently attended a presentation (not KZA’s which is why I’m questioning the advice!). He said the spine
surgeon speaker advised that he could bill a corpectomy code if he documented “scraping or smoothing of vertebral endplates.” He told me we had missed out on a lot of reimbursement because I was coding these as a traditional anterior cervical decompression/discectomy and fusion (ACDF) procedure. Was I wrong in how I coded these procedures, and if yes, should I go back and submit a corrected claim?

Answer:
You were absolutely correct in not interpreting this work as a corpectomy. The work or preparing the endplates for fusion is included in the ACDF code (22551) assuming all other appropriate work is performed and documented.

*This response is based on the best information available as of 06/22/17.

Reinsertion (22849) vs. Segmental (22842) Instrumentation

June 8, 2017

Question:
I have a question about reinsertion of spinal instrumentation vs posterior segmental instrumentation. We have a patient who our neurosurgeon performed an exploration previous L4-S1 fusion with removal of rods bilaterally, L3-L4 laminectomy with PLIF and posterolateral fusion with placement of pedicle screws at L3 and new rods from L3-S1.
I have researched and would like to verify if we could bill the CPT 22849 for replacement of the instrumentation from L4-S1 plus CPT 22842 for the new pedicle screws and rods. I spoke to a coding hotline who said 22849 and 22842 were accurate but I thought I better check with an expert – you!

Answer:
I’m so glad you asked because you’ve been give inaccurate advice. CPT 22849 is reported when you remove and replace instrumentation at the exact same level(s); in this case you extended the instrumentation so 22849 does not apply. When you extend the instrumentation meaning adding it to an adjacent level, you report only the “new code” such as 22842.

*This response is based on the best information available as of 06/08/17.

Intervertebral Device 22853

May 25, 2017

Question:
I code for a neurosurgeon and he insists that I bill the cage code, 22853, for each interspace. However, the CPT book lists as cage(s) therefore our thinking is that no matter how many are placed this code is only allowed one time per surgery. His note states “C3-C4, C4-C5, C5-C6 anterior cervical interbody fusion using PEEK interbody spacers.” So is it 22853 x 1 unit or 22853 x 3 units?

Answer:
Your neurosurgeon is correct. CPT code 22853 is reported per
interspace to describe intervertebral biomechanical devices, including PEEK cages. The term is both single or plural, “cage(s)”, because sometimes there are two devices placed at a single spinal level.

*This response is based on the best information available as of 05/25/17.

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**Vena Cava Coding**

May 11, 2017

**Question:**
While placing a vena cava filter, the physician documented a venogram and intravascular ultrasound. Can these imaging procedures be reported separately?

**Answer:**
No, vena cava filter placement, 37191, is an all-inclusive code that includes all imaging including a venogram and intravascular ultrasound (IVUS) codes, 37252 and 37253. Vena cava filter placement also includes all access including the catheterization.

*This response is based on the best information available as of 05/11/17.*
Corpectomy Denial

April 27, 2017

Question:
We submitted an op note at the request of a payer (not Medicare) and they denied the corpectomy code we billed, 63081 with the fusion code, saying the documentation doesn’t support it. Instead, they paid us for 22551. I don’t understand this because my neurosurgeon’s operative note says he did a corpectomy.

Answer:
Ah, but does the operative note specifically state he removed at least 50% of the cervical vertebral body – or that he did a total corpectomy – to justify using a corpectomy code. I suspect not which is why the payer “downcoded” 63081 and the fusion code to the anterior cervical decompression/discectomy and fusion code, 22551.

CPT guidelines specifically state that at least 50% of the cervical vertebral body must be removed to support using a corpectomy code. Recently, Cigna released guidance that says: “A targeted subset of cervical vertebral corpectomy claims billed with CPT codes 63081 and 63082, and where abuse is probable, will be pended. The operative report will then be reviewed before reimbursement to determine if the corpectomy criterion is met. If it is not met, the claim will be denied.”

The point is that the percentage of the vertebral body removed must be documented in the operative note to justify reporting a corpectomy code.

*This response is based on the best information available as of 04/27/17.*
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.*

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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.*