Permanent Spinal Cord Stimulator Placement

August 4, 2016

Question:
Our pain management doctor did a trial spinal cord neurostimulator electrode placement a month ago. Our neurosurgeon is now placing the permanent electrode, via laminectomy, along with the generator. Do we need to use modifier 58 on the neurosurgeon’s codes?

Answer:
Modifier 58 is used on the procedures performed within a global period for a previous procedure when the second and subsequent procedures are planned/anticipated, or more extensive than the original procedure, or for therapy following a surgical procedure. However, the postoperative global period for the trial electrode placement (63650) is 10 days. Your neurosurgeon is placing the permanent system a month afterward; therefore, a global period modifier such as 58 is not necessary. Another reason why a global period modifier is not necessary is because the neurosurgeon is not in the pain management physician’s global period since they are of different specialties.

*This response is based on the best information available as of 08/04/16.
Use of Ultrasonic Aspirator with Brain Tumor Removal

July 21, 2016

Question:
My doctor while doing a craniectomy for tumor removal, along with using the microscope and Brain lab navigation, is using the ultrasonic aspirator to remove tissue. Can I bill for this? I don’t see a CPT code.

Answer:
Good question! Use of an aspirator to remove tissue is not separately reportable which is why you can’t find a CPT code for the service. The brain tumor removal codes include removing the tumor regardless of how you do it (e.g., with ultrasonic aspirator, without ultrasonic aspirator, suction, scalpel).

*This response is based on the best information available as of 07/21/16.*

Reduction of Kyphotic Deformity

July 7, 2016

Question:
When we reduce a kyphotic deformity as well as correcting stenosis and spondylosis on an anterior cervical discectomy,
decompression and fusion, can we bill 22808 along with 22551?

**Answer:**
No. CPT 22808 is a separate stand-alone procedure for an anterior fusion for spinal deformity and should not be reported with 22551 for procedures at the same level(s). Any deformity corrected as a result of the ACDF procedure are included in 22551 and not separately reported. Reporting 22808 and 22551 together is also not accurate because both codes include an arthrodesis; so you’re coding the arthrodesis twice.

*This response is based on the best information available as of 07/07/16.*

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**Myelogram Coding**

June 23, 2016

**Question:**
What codes are used for a myelogram? Our schedulers have been told different things, the last being to just use 76000 and that it included the myelo and fluoro regardless of level.

**Answer:**
Actually, that is incorrect. The codes changed in 2015 so now it depends on which provider performs what service. But first, 76000 should never be reported with any of the myelogram injection codes.

Here are the guidelines:

- Use a combined injection / reading code (62302 – 62305)
if the same provider performs both injection and radiological supervision and interpretation.

- The same provider should not report 62284 and the associated radiology code (e.g., 72240, 72255, 72265, or 72270). Rather, use the appropriate new combined service code (62302 – 62305).

- If different providers perform the injection and radiological supervision/interpretation, use 62284 for the provider performing the lumbar injection. The provider doing the radiological supervision will report 72240, 72255, 72265, or 72270. Basically, each provider reports his/her own service.

*This response is based on the best information available as of 06/23/16.

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**AVM Embolization**

June 9, 2016

**Question:**
We’ve been told by our outsourced coding company to use 61710 for catheter-based embolization of an AVM. Is that right?

**Answer:**
Actually, 61710 is a craniotomy code and not one used for transcatheter procedures. You’ll use 61624 as the primary procedure code for transcatheter embolization of an arteriovenous malformation (AVM).

*This response is based on the best information available as of 06/09/16.*
Neuroendovascular Procedure Coding

May 26, 2016

Question:
We are hiring a neurosurgeon who also does neuroendovascular procedures. We’ve never had to code for neuroendovascular procedures before – HELP!

Answer:
Oh, that’s great! We think it is fun to learn something new! Here are the principles of neuroendovascular procedure coding – there are 4 types of codes: 1) diagnostic (e.g., angiogram), 2) interventional (e.g., aneurysm coiling), 3) catheterization (e.g., selective catheterization of the T2 spinal arteries), and 4) radiologic supervision and interpretation (e.g., 7xxxx codes). The key is knowing when to use which type of code and understand the necessary documentation. We offer a coding course specifically for neuroendovascular procedures. Please click here to contact us for more information. There are also some previously asked Q&As as well as a webinar on our website that might help you. You can access the Coding Update for Neurosurgery here. Good luck!

*This response is based on the best information available as of 05/26/16.*
**Modifier 57**

May 12, 2016

**Question:**
If I see a consult in the ER and during that visit I identify the need for surgery the same day, can I append a Modifier 57 to the E/M service and get paid?

**Answer:**
You determine during the evaluation that the patient would need surgery the same or next day for a major procedure (90 day global), append modifier 57 to the E/M service. If the procedure is a minor procedure with a 0- or 10 day global and the E/M service is significantly separately identifiable, report the E/M service with modifier 25. Use caution when appending the 25 Modifier as CMS has indicated that there is an inherent E/M service in every procedure and routine use of Modifier 25 may create payer scrutiny.

*This response is based on the best information available as of 05/12/16.*

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**Source for a Consult**

April 28, 2016

**Question:**
What is an appropriate “source” for a consult? I asked at a recent workshop and the instructors did not have an answer.

**Answer:**
The guidelines for a consultation (inpatient or outpatient) must be requested by a physician, or qualified non-physician
practitioner. Guidelines are not clear regarding individuals who may be considered an appropriate source, but some likely examples include a physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech language therapist, psychologist, social worker, lawyer, or insurance company.

Do not report a consultation requested by a patient or family member, etc., using a consultation code.

*This response is based on the best information available as of 04/28/16.

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**New or Existing Patient Coding**

April 14, 2016

**Question:**
If I see a new patient (9920x) for a spine problem, then they come back to me for carpal tunnel syndrome two months later, can I bill as a new patient visit (9920x) the second time or is it an established patient to me (9921x)?

**Answer:**
No, this would be an established patient (99211-99215). If you or another neurosurgeon in the same group practice treat the patient in the past three years (face-to-face), the patient visit would be coded as an established patient even if you are evaluating a new problem. By CPT definition, “a new patient is one who has not received any face-to-face professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the
past three years.” An established patient is one who has received professional services (face-to-face) from the physician or another physician in the same group and the same specialty within the prior three years. Unfortunately, payers do not recognize the different subspecialties of neurosurgery.

*This response is based on the best information available as of 04/14/16.

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**Intraoperative Ultrasound**

March 31, 2016

**Question:**
We used an outside coding consulting company (not yours!) to review some notes. They told us we could bill 76998-26 for intraoperative ultrasound when we also bill for a brain tumor removal (e.g., 61510, 61512). We tried it on a couple of claims and we were paid. But now one of the insurance companies is requesting a refund. Should we return the payment? It wasn’t very much money. But if they want the money back, it makes me think we shouldn’t have billed it. But that coding company said we could!

**Answer:**
Yes, you should return the money. The AANS says that intraoperative ultrasound is included in the global surgical package for the neurosurgery codes and it makes sense. If you’re going to bill for removing a brain tumor then you’re expected to find it after the incision has been made and you’re in the operative field. Do not report 76998 (Ultrasonic guidance, intraoperative).

*This response is based on the best information available as
of 03/31/16.