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.

## 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
interospace, 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.

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Treatment of Vasospasm 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.*
Question:
Thank you so much for your help in getting 61323 payable for an assistant, we appreciate it! When will this become effective and can we bill retrospectively for services in the past year?

Answer:
You are welcome! This change becomes effective 1/1/2017 and unfortunately, retroactive payment is not likely. You can try, but we doubt it will happen.

*This response is based on the best information available as of 11/17/16.*
**Question:**
We got a denial for assistant surgery charges by our PA for CPT 61323 with the reason as Medicare disallows. I looked at Medicare’s guidelines and confirmed this. It seems rather odd that they would not pay for assist on brain surgery but routinely do on laminectomies and discectomies. What are your thoughts?

**Answer:**
I also looked at Medicare’s guidelines and saw that Medicare does allow an assistant to be paid on CPT 61322 but not on 61323. This didn’t seem right to me – perhaps an oversight when the codes were introduced in 2003.

So I asked the neurosurgery specialty societies to help rectify the issue. Success! They were able to get Medicare to approve 61323 for assistant surgery payment (modifier 80, 82, AS). Thank you for being an “eagle-eyed administrator”!

*This response is based on the best information available as of 10/27/16.*

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**Reimbursement: Assistant Surgeon**

October 13, 2016

**Question:**
What is the reimbursement for an assistant surgeon using modifier 80? Is the payment different for the primary and the assistant?
Answer:
Assistant surgeon is described as one surgeon, of the same or a different specialty, providing assistance during a surgical procedure or CPT code. Modifier 80 (modifier 82 for an assistant surgeon in an academic setting when a qualified resident is not available) is appended to any CPT code the assistant participates in. Medicare reimburses 16% of the allowable for the assistant surgeon (modifier 80 or 82), to the codes where an assistant payment is allowed, and multiple procedure/bilateral procedure reductions also apply. The primary surgeon’s fee is not affected. In an assistant surgeon scenario, the assistant need not and should not dictate a separate note. However, it is critical that the primary surgeon document in his/her note, specifically what the assistant did. Stating an assistant was needed because the case was complex is not sufficient. The primary surgeon must state what the assistant did, for example, assisting with the resection, anastomosis, etc. For private payers, coding guidelines and payment may vary.

*This response is based on the best information available as of 10/13/16.

Global Period Modifiers: How Do They Impact Reimbursement?

September 29, 2016

Question:
What reimbursement should we expect when using the global period modifiers 58, 79 and 78?
Global period modifiers are used to indicate that a subsequent procedure was performed during the global period of a prior procedure. Modifiers alert the payer of your rationale for allowing payment for the subsequent procedure. The modifiers and reimbursement impact of each is shown below:

Modifier 58: Indicates that a subsequent procedure was performed as a (1) planned or anticipated (staged); (2) more extensive than the original procedure; or (3) for therapy following a surgical procedure. Reimbursement should be 100% of the allowable and the global period is extended to that of the subsequent procedure.

Modifier 79: Is appended to CPT code to show that an unrelated procedure was performed during the global period of a prior procedure. Again, reimbursement should be at 100% of the allowable and you’re now in a separate global period that is related to the subsequent procedure.

Modifiers 78: Indicates that an unplanned, related procedure was performed in the operating room, catheterization or endoscopy suite. Typically this is treatment of a complication such as wound dehiscence, infection, etc. Reimbursement is typically at 70-80% of the allowable. Why? The reduction accounts for overlapping pre- and post-op care which was paid under the original procedure. Therefore, the payment for modifier 78 is for only the intra-operative portion of the unplanned, related procedure.

*This response is based on the best information available as of 09/29/16.