Anterior Spine Procedure Coding

Question:
I routinely provide exposure for a neurosurgeon doing an anterior spine procedure. After I’ve done the exposure, I leave and don’t return until he is ready to close. Is a co-surgeon modifier still appropriate or am I acting as an assistant since I wasn’t there the entire time?

Answer:
You are acting as a co-surgeon – a different specialty performing a distinct and separate part of a single CPT code. You provided the approach and closure of the CPT code. You do not have to be present for the entire surgery.

Fat Graft

September 4, 2014

Question:
What code would I use for placement of a fat graft at the pituitary region?

Answer:
Good question, and this brings up an important CPT coding concept. Placement of graft material is typically included in the primary procedure code; in this example, removal of the pituitary tumor code (e.g., 61548, 62165). However, harvesting of graft material through a separate skin incision is
separately reported. Harvest of abdominal fat for grafting is best reported using 20926 (Tissue grafts, other (e.g., paratenon, fat, dermis)). Why not report 15770 (Graft; derma-fat-fascia)? Because 15770 is for a composite graft which means, according to a previous CPT Assistant article, the tissue used for the graft would be “a continuous portion (containing all three of the layered components), individual parts (grafted layer by layer), or inserted in combination (such as a fascia-fat layer, later covered by a dermal layer)” – this is not what’s being done in the pituitary procedure.

Fluoroscopy

August 21, 2014

Question:

I use intraoperative fluoroscopy to localize the disc space prior to a discectomy. Can I bill 76000 for this?

Answer:

Localization is included in the global surgical package and not separately reported for most neurosurgical procedure codes. It would not be appropriate to report 76000 (or any other fluoroscopy code) with codes such as a discectomy, laminectomy, fusion, etc.
Fusion – Multiple Codes

August 7, 2014

Question:

If I do a posterior T11-L5 fusion, do I code it as 22610 (thoracic, first level, T11-T12), 22612 (lumbar, first level, L1-L2) and 22614 x 4 (T12-L1, L2-L3, L3-L4, L4-L5)?

Answer:

Actually, only one stand-alone code – either 22610 or 22612 – may be reported, and the remaining levels are the add-on code, 22614. Since the majority of levels performed were lumbar, then you’d use 22612 as your sole stand-alone code. You’ll then have five additional levels (22614) to report.

Is Physician Presence Required to Report CPT Code 22310?

July 24, 2014

Question:

Our neurosurgeon saw a patient in the office and diagnosed the patient as having a vertebral body fracture. The neurosurgeon ordered a brace to be applied, which was done when she was not present in the office. She wants us to report CPT code 22310, but we are saying that in order to bill this, the surgeon must be present for the application of the brace. Is this correct, or can she report 22310 just for diagnosing the fracture and
ordering the brace?

**Answer:**

CPT code 22310 reads “Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing.” The surgeon **must** be present for the application or personally apply the brace to report this code.

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**Fusion – Number of Levels**

July 10, 2014

**Question:**

Is a posterior L4-L5 fusion coded as 22612 (L4-L5) or 22612 (L4) with 22614 (L5)?

**Answer:**

Good question because the CPT language can be a bit misleading. A fusion occurs at the joint between two bones; therefore, a fusion code such as 22612 requires 2 bones. So an L4-L5 fusion is 2 bones and reported with 1 code, 22612.

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**Placement of Gardner Wells Tongs**

June 26, 2014

**Question:**
Can we separately code for placement of Gardner Wells tongs (20660) when we do an ACDF?

Answer:

Actually, stabilization of the head, including placement of tongs, is included in the global surgical package for an ACDF and not separately reported.

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**Allograft in Spine Surgery**

June 12, 2014

**Question:**

What code do I use for the allograft sponges placed for a spinal fusion procedure? I think the code is 20930, but my coder says the sponges are structural so suggests using 20931.

**Answer:**

You are correct – the appropriate code is 20930.

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**ORIF Spine Fracture Codes**

May 29, 2014

**Question:**

When is it appropriate to use the posterior spine ORIF codes? I’ve got a patient with a degenerative pars fracture that I’m going to repair and I was looking at those codes.
Actually, the posterior spine fracture open treatment codes, 22325-22328, should be used for treatment of traumatic spine fractures and/or dislocations rather than degenerative pathology. The spine fracture open treatment codes include any laminectomy performed at the same level(s), so you would not also bill a laminectomy code (e.g., 630xx). Look at the laminectomy for decompression codes (e.g., 630xx) for the procedure you’re planning to see if one of those codes meets your needs.

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**Laminoplasty**

May 15, 2014

**Question:**

My surgeon did a C2-C7 laminoplasty and reconstructed with mini-plates. What code should I use?

**Answer:**

This procedure is covered using CPT 63051 (Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices (e.g., wire, suture, mini-plates), when performed). CPT 63051 includes all levels of laminectomy required for the laminoplasty. It is not accurate to also bill a laminectomy code such as 63001 or 63015 for procedures at the same level(s). CPT 63051 also includes placement of any instrumentation, such as the mini-plates, so do not also report an instrumentation code like 22842.