Coding Companion for Neurosurgery/Neurology
A comprehensive illustrated guide to coding and reimbursement
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63306
Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; intradural, thoracic by thoracolumbar approach

Explanation
This procedure is performed to remove a lesion of the vertebral body, which compresses the spinal cord. The patient is placed in a lateral decubitus position with supports under the buttocks and shoulder, and the muscle, fascia, ribs, and organs are incised or retracted. The dura may be incised. An incision is made in the diaphragm to purchase access to the spine. The physician makes a groove in the vertebral bodies above and below the crushed vertebra and removes the discs above and below. Tricortical iliac crest grafts are obtained, prepared, and tapped into the grooves with a Moe impactor. An AO plate is screwed to the vertebra above and below the injured level to maintain fusion. A separately reported radiograph is obtained to assure proper placement, and the wound closed with layered sutures.

Coding Tips
Note that 63306 reports thoracolumbar vertebral corpectomy, intradural, thoracic, for excision of an intraspinal lesion of one vertebral segment. Report 63308 for each additional segment. If this procedure is completed through an operating microscope, report 69990 in addition to the primary procedure. However, head gear (e.g., loupes or binoculars) is considered an integral part of this procedure. Arthrodesis is reported separately; see 22554–22585. Bone graft is reported separately; see 20930–20938. When an anterior approach to the thoracic cavity is performed, the negative pressure is lost and a thoracotomy tube is routinely inserted to help establish the normal negative pressure and re-inflate the lung(s) after closure. This is a life sustaining measure that must be performed in order to complete the procedure, and as such, tube thoracostomy (32551) should not be reported separately. When an anterior approach to the spine is achieved using the skills of two surgeons of different specialties (e.g., a thoracic or general surgeon provides exposure and the neurosurgeon provides the definitive procedure), this is a co-surgery scenario. Both surgeons report the primary procedure with modifier 62 and submit the claim with operative notes attached.

ICD-9-CM Procedural
03.39 Other diagnostic procedures on spinal cord and spinal canal structures
03.4 Excision or destruction of lesion of spinal cord or spinal meninges
03.6 Lysis of adhesions of spinal cord and nerve roots

Anesthesia
63306 00620, 00625, 00626

ICD-9-CM Diagnostic
192.2 Malignant neoplasm of spinal cord
192.3 Malignant neoplasm of spinal meninges
198.3 Secondary malignant neoplasm of brain and spinal cord
199.0 Disseminated malignant neoplasm
225.3 Benign neoplasm of spinal cord
225.4 Benign neoplasm of spinal meninges
237.5 Neoplasm of uncertain behavior of brain and spinal cord
237.6 Neoplasm of uncertain behavior of meninges
239.7 Neoplasm of unspecified nature of endocrine glands and other parts of nervous system
324.1 Intraspinal abscess
336.1 Vascular myelopathies

Terms To Know
corpectomy. Removal of the body of a bone, such as a vertebra.
decompression. Release of pressure.
disseminated. Spread over an extensive area.

fascia. Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.
lesion. Area of damaged tissue that has lost continuity or function, due to disease or trauma. Lesions may be located on internal structures such as the brain, nerves, or kidneys, or visible on the skin.
meninges. Tough membranous protectors of the central nervous system that cover the brain and spinal cord comprising three layers: the dura mater, arachnoid mater, and pia mater.
neoplasm. New abnormal growth, tumor.
vertebral body. Disc-shaped portion of a vertebra that is anteriorly located and bears weight.

CCI Version 17.3
Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Spells
Fac RVU Non-Fac RVU FUD Status
63306 65.33 65.33 90 A

MUE Modifiers
63306 1 51 N/A 62* 80
* with documentation

Medicare References: None
70010

Myelography, posterior fossa, radiological supervision and interpretation

Explanation

A radiographic study using fluoroscopy is performed on the posterior fossa when a lesion is suspected, or to detect cerebrospinal fluid (CSF) leaks or normal pressure hydrocephalus (NPH). Contrast medium, usually barium sulfate, may be used to enhance visibility and is instilled in the patient through a lumbar area puncture into the subarachnoid space. The radiologist takes a series of pictures by sending an x-ray beam through the body, using fluoroscopy to view the enhanced structure on a television camera. The patient is angled from an erect position through a recumbent position with the body tilted so as to maintain feet higher than the head to help the flow of contrast into the study area.

70015

Cisternography, positive contrast, radiological supervision and interpretation

Explanation

A radiographic study that maps the tumor pathology of a mass within the posterior fossa. The brainstem and cerebellum are contained within the posterior fossa and the cerebellopontine angle cistern is often the location of a mass such as a schwannoma or meningioma. Images are taken sequentially over a period of hours and days after introducing a radioactive intrathecally by lumbar puncture. Cisternography may also be used to detect cerebrospinal fluid (CSF) leaks or normal pressure hydrocephalus (NPH).

70240

Radiologic examination, sella turcica

Explanation

Films are taken of the sella turcica, the depression within the sphenoid bone that houses the pituitary gland. The patient is placed in the prone semibl ques position and the x-ray beam is directed to a spot slightly anterior and superior to the external auditory meatus while the patient’s head is maintained in a lateral position.

70240-70260

Radiologic examination, skull; less than 4 views

70260

Complete, minimum of 4 views

Explanation

Films are taken of the skull bones. In 70250, three or less views are taken, and in 70260, a complete exam with a four view minimum is performed. The most common projections for routine skull series are AP axial (front to back), lateral, and PA axial (back to front). X-rays may be taken with the patient placed erect, prone, or supine and either code may include stereoradiography, which is a technique that produces three-dimensional images.

70360

Radiologic examination; neck, soft tissue

Explanation

The technologist uses x-rays to obtain soft tissue images of the patient’s neck rather than bone. The radiologist obtains two views, typically front to back (AP), and side to side (lateral). This procedure is performed to visualize abnormal air patterns or suspected foreign bodies or obstructions within the throat or neck.

70450-70470

Computed tomography, head or brain; without contrast material

70460

With contrast material(s)

70470

Without contrast material, followed by contrast material(s) and further sections

Explanation

Computed axial tomography directs multiple narrow beams of x-rays around the body structure being studied and uses computer imaging to produce thin cross-sectional views of various layers (or slices) of the body. It is useful for the evaluation of trauma, tumor, and foreign bodies as CT is able to visualize soft tissue as well as bones. Patients are required to remain motionless during the study and sedation may need to be administered as well as a contrast medium for image enhancement. These codes report an exam of the head or brain. Report 70450 if no contrast is used. Report 70460 if performed with contrast and 70470 if performed first without contrast and then again following the injection of contrast.

70480-70482

Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material

70481

With contrast material(s)

70482

Without contrast material, followed by contrast material(s) and further sections

Explanation

Computed axial tomography directs multiple narrow beams of x-rays around the body structure being studied and uses computer imaging to produce thin cross-sectional views of various layers (or slices) of the body. It is useful for the evaluation of trauma, tumor, and foreign bodies as CT is able to visualize soft tissue as well as bones. Patients are required to remain motionless during the study and sedation may need to be administered as well as a contrast medium for image enhancement. These codes report an exam of the soft tissue of the neck. Report 70490 if no contrast is used. Report 70491 if performed with contrast and 70492 if performed first without contrast and then again following the injection of contrast.

70496-70498

Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing
Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $32 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician’s office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician is on call or covering for another physician, the patient’s encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient’s attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as “observation status” in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician “admitting” the patient for observation.

Codes 99224-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and preparation of the discharge records. It should not be used when admission and discharge are on the same date of service. As mentioned above, report codes 99234-99236 to appropriately describe same day observation services.

If a patient is in observation longer than one day, subsequent observation care codes 99224-99226 should be reported. If the patient is discharged on the second day, observation discharge code 99217 should be reported. If the patient status is changed to inpatient on a subsequent date, the appropriate inpatient code, 99221-99223, should be reported.

Initial hospital care is defined as E/M services provided during the first hospital inpatient encounter with the patient by the admitting physician. (If a physician other than the admitting physician

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

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