Optum

Coding Companion

Neurosurgery/ Neurology

A comprehensive illustrated guide to coding and reimbursement

2024

optumcoding.com

Contents

Getting Started with Coding Companion

Coding Companion for Neurosurgery/Neurology is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to neurosurgery/neurology are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT/HCPCS code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum *Coding Companion* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features.

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT code description, followed by an easy-to-understand explanation.

The codes in the appendix are presented in the following order:

- HCPCS
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 28.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2024 edition password is: **XXXX**. Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

61635 Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed

could be found in the index under the following main terms:

Arteriovenous Malformation
Cranial
Intravascular Stent(s), 61635

or **Catheter**
Placement
Stent, 61635

or **Cerebral Vessel(s)**
Stent Placement, 61635

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xiv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

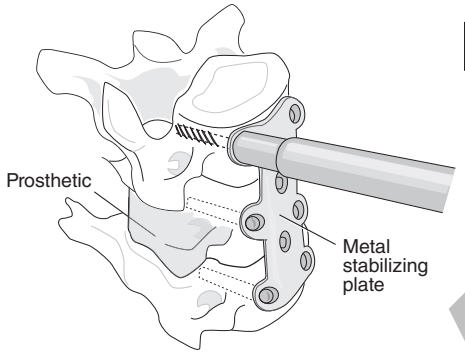
The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

22853-22854

1

+ **22853** Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)
+ **22854** Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)

2



Biomechanical device

Explanation

3

The physician replaces an intervertebral disc or a partial or complete vertebral body is resected due to destruction by disease, trauma, or other processes. Once the disc or body has been removed by a separately identifiable procedure, a hole is cored out of the vertebral bodies above and below the removed vertebrae to secure a biomechanical device (synthetic cage or mesh) into the resulting intervertebral disc space. The physician selects the biomechanical device best suited to the location and type of deformity being corrected. Screws, wires, or plates may be used to secure the device. Muscles are allowed to fall back into place and the wound is closed over a drain with layered sutures. Report 22853 for replacement of an intervertebral disc. Report 22854 for replacement of a partial or complete vertebral body.

Coding Tips

4

Report 22853 or 22854 in addition to 22100–22102, 22110–22114, 22206–22207, 22210–22214, 22220–22224, 22310–22327, 22532, 22533, 22548–22558, 22590–22612, 22630, 22633, 22634, 22800–22812, 63001–63030, 63040–63042, 63045–63047, 63050–63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170–63290, and 63300–63307. Report 22853 or 22854 for each noncontiguous defect. Application of an intervertebral bone device/graft is reported separately, see 20930–20938. Report separately treatment of a fracture/dislocation (22325–22328) and arthrodesis (22548–22812). It is inappropriate to append modifier 62 to spinal instrumentation codes.

ICD-10-CM Diagnostic Codes

5

This/these CPT code(s) are add-on code(s). See the primary procedure code that this code is performed with for your ICD-10-CM code selections.

Associated HCPCS Codes

6

C1831 Interbody cage, anterior, lateral or posterior, personalized (implantable)

AMA: **22853** 2021,Dec; 2021,Jul; 2020,May; 2018,Aug; 2018,Jul; 201 7
2017,Mar **22854** 2021,Dec; 2021,Jul; 2020,May; 2018,Aug; 2017,Mar

Relative Value Units/Medicare Edits

8

Non-Facility RVU	Work	PE	MP	Total
22853	4.25	2.08	1.28	7.61
22854	5.5	2.68	1.7	9.88
Facility RVU	**Work**	**PE**	**MP**	**Total**
22853	4.25	2.08	1.28	7.61
22854	5.5	2.68	1.7	9.88

	FUD	Status	MUE	Modifiers				IOM Reference
22853	N/A	A	4(3)	N/A	N/A	62	80	None
22854	N/A	A	4(3)	N/A	N/A	62	80	

* with documentation

Terms To Know

9

arthrodesis. Surgical fixation or fusion of a joint to reduce pain and improve stability, performed openly or arthroscopically.

corpectomy. Removal of the body of a bone, such as a vertebra.

stabilization. Fixed, firm state that is resistant to change.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2024.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- ✚ This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 93 or 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services, when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96160	96161	97802	97803	97804
99406	99407	99408	99409	99497	99498	

2. Illustrations

The illustrations that accompany the *Coding Companion* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most pages will have an illustration, there will be some pages that do not.

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes the most common method of performing each procedure.

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right or left) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2023.

The 2024 Medicare edits were not available at the time this book went to press. Updated 2024 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2023 edition password is **23SPECIALTY**.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

▶The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◀

Classification of Evaluation and Management (E/M) Services

▶The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.◀

New and Established Patients

▶Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

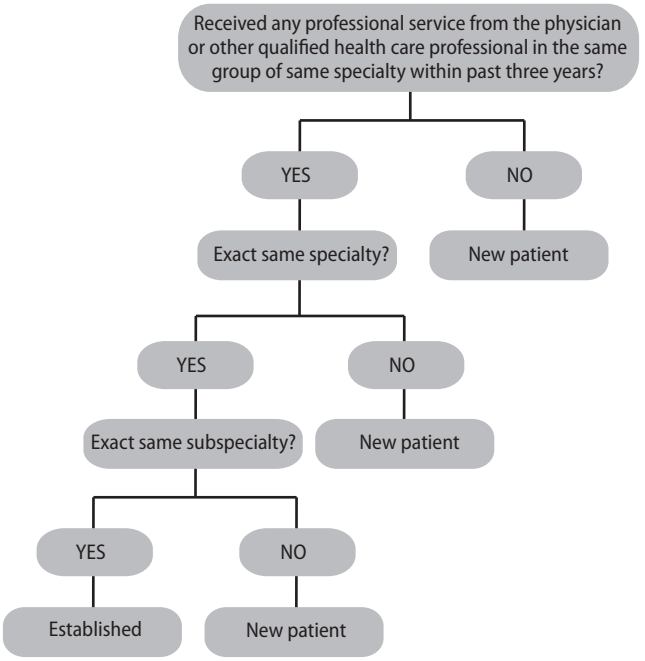
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.◀

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

▶◀ = Contains new or revised text

99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99203** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99204** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99205** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.12	0.09	2.14
99203	1.6	1.52	0.17	3.29
99204	2.6	2.06	0.24	4.9
99205	3.5	2.66	0.32	6.48
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.17	2.44
99204	2.6	1.11	0.24	3.95
99205	3.5	1.54	0.32	5.36

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

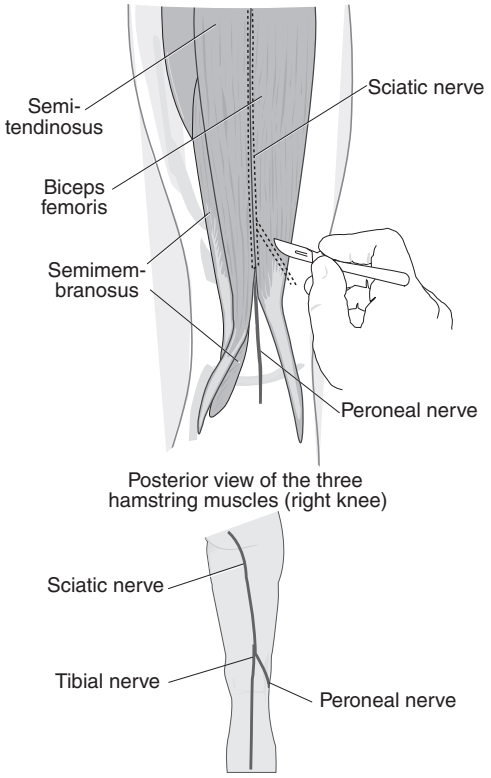
* with documentation

Terms To Know

new patient. Patient who is receiving face-to-face care from a physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice for the first time in three years. For OPPS hospitals, a patient who has not been registered as an inpatient or outpatient, including off-campus provider-based clinic or emergency department, within the past three years.

27325

27325 Neurectomy, hamstring muscle



Explanation

The physician performs an incisional resection of a segment of a nerve. The physician makes a transverse incision over the hamstring muscle. The fascia is divided to expose the nerves that supply the muscle. The appropriate nerve branch is identified by stimulating it with an electrical current or gently pressing it with forceps. Once this is accomplished, the nerve is divided and removed from the muscle, resolving the clonus or spasm. The incision is repaired in layers.

Coding Tips

For popliteal (gastrocnemius) neurectomy, see 27326.

ICD-10-CM Diagnostic Codes

G57.71 Causalgia of right lower limb ☑
G57.72 Causalgia of left lower limb ☑
G57.73 Causalgia of bilateral lower limbs ☑
G57.83 Other specified mononeuropathies of bilateral lower limbs ☑

Relative Value Units/Medicare Edits

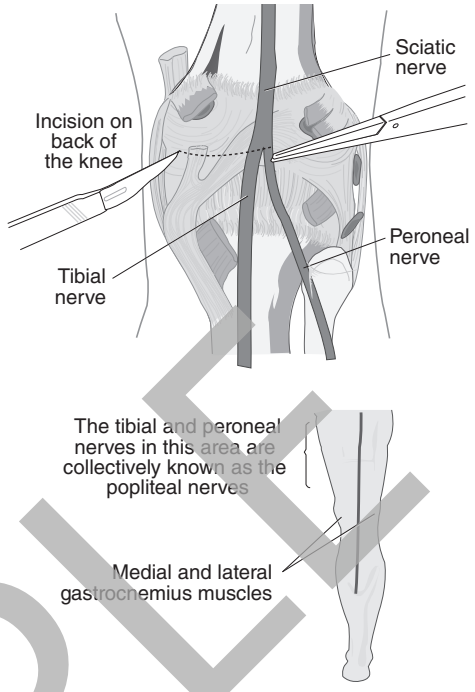
Non-Facility RVU	Work	PE	MP	Total
27325	7.2	8.19	1.48	16.87
Facility RVU	**Work**	**PE**	**MP**	**Total**
27325	7.2	8.19	1.48	16.87

	FUD	Status	MUE	Modifiers				IOM Reference
27325	90	A	1(2)	51	50	N/A	80	None

* with documentation

27326

27326 Neurectomy, popliteal (gastrocnemius)



Explanation

The physician performs an incisional resection of a segment of a nerve. The physician makes a transverse incision over the distal portion of the popliteal (back of the knee) fossa. The fascia is divided to expose the tibial nerve. The appropriate nerve branch is identified by stimulating it with an electrical current or gently pressing it with forceps. Once this is accomplished, the nerve is divided and removed from the muscle, resolving the clonus or spasm. The incision is repaired in layers.

Coding Tips

For neurectomy, hamstring muscle, see 27325.

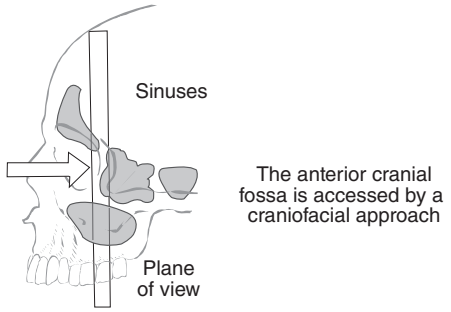
ICD-10-CM Diagnostic Codes

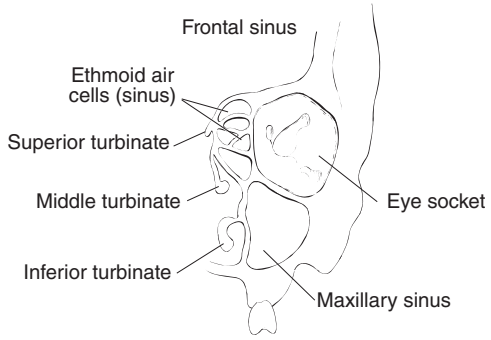
G57.31 Lesion of lateral popliteal nerve, right lower limb ☑
G57.32 Lesion of lateral popliteal nerve, left lower limb ☑
G57.33 Lesion of lateral popliteal nerve, bilateral lower limbs ☑
G57.41 Lesion of medial popliteal nerve, right lower limb ☑
G57.42 Lesion of medial popliteal nerve, left lower limb ☑
G57.43 Lesion of medial popliteal nerve, bilateral lower limbs ☑
G57.71 Causalgia of right lower limb ☑
G57.72 Causalgia of left lower limb ☑
G57.73 Causalgia of bilateral lower limbs ☑
G57.81 Other specified mononeuropathies of right lower limb ☑
G57.82 Other specified mononeuropathies of left lower limb ☑
G57.83 Other specified mononeuropathies of bilateral lower limbs ☑

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

61581

61581 Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, orbital exenteration, ethmoidectomy, sphenoidectomy and/or maxillectomy





Mid frontal cutaway view

Explanation

In this approach procedure, the physician exposes the anterior cranial fossa using a craniofacial approach to an extradural (outside the dura) lesion or defect at the skull base. To adequately expose the lesion or defect, the physician performs an orbital exenteration, a lateral rhinotomy, ethmoidectomy, sphenoidectomy and/or maxillectomy all of which are included in the approach procedure. For full exposure of the lesion, the brain may need to be retracted from the skull base.

Coding Tips

Because skull base procedures often require the skills of several surgeons, separate codes must be assigned for each component, including approach, definitive procedure, and extensive reconstruction/repair. Procedure 61581 is an approach procedure to the anterior cranial fossa. The definitive procedure (61600–61601) is reported separately. When one physician performs the approach, another physician performs the definitive procedure, and another physician performs the reconstruction/repair, each physician reports only the code for the specific procedure performed. If one physician performs more than one procedure, then all applicable codes are reported, adding modifier 51 to the secondary procedure.

ICD-10-CM Diagnostic Codes

C30.0 Malignant neoplasm of nasal cavity
C31.1 Malignant neoplasm of ethmoidal sinus
C31.3 Malignant neoplasm of sphenoid sinus
C31.8 Malignant neoplasm of overlapping sites of accessory sinuses
C41.0 Malignant neoplasm of bones of skull and face
C72.21 Malignant neoplasm of right olfactory nerve ☑
C72.22 Malignant neoplasm of left olfactory nerve ☑
C72.31 Malignant neoplasm of right optic nerve ☑
C72.32 Malignant neoplasm of left optic nerve ☑
C77.0 Secondary and unspecified malignant neoplasm of lymph nodes of head, face and neck
C79.49 Secondary malignant neoplasm of other parts of nervous system
D33.3 Benign neoplasm of cranial nerves
G06.0 Intracranial abscess and granuloma

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
61581	39.13	38.79	6.95	84.87
Facility RVU	**Work**	**PE**	**MP**	**Total**
61581	39.13	38.79	6.95	84.87

	FUD	Status	MUE	Modifiers				IOM Reference
61581	90	A	1(2)	51	50	62	N/A	None

* with documentation

Terms To Know

anterior cranial fossa. Supports the frontal lobes of the brain and is composed of the frontal bone (anteriorly), the ethmoid bone (in the middle), and the body and lesser wings of the sphenoid bone (posteriorly).

congenital. Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.

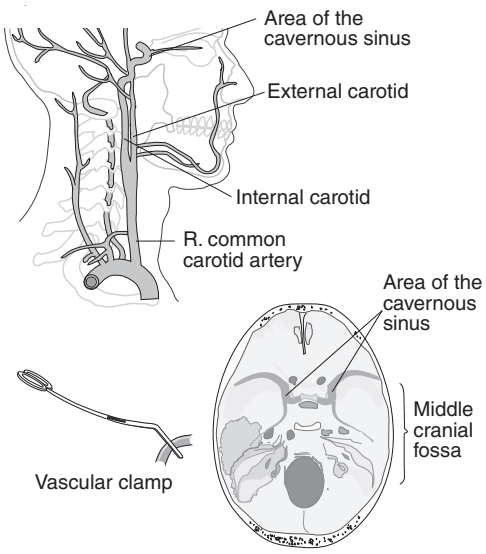
malignant. Any condition tending to progress toward death, specifically an invasive tumor with a loss of cellular differentiation that has the ability to spread or metastasize to other body areas.

skull base. Anterior, middle, and posterior fossa; occiput bone; orbital roof; ethmoid and frontal sinus; sphenoid and temporal bones.

 N Newborn: 0 **P** Pediatric: 0-17 **M** Maternity: 9-64 **A** Adult: 15-124 ♂ Male Only ♀ Female Only

61705-61710

61705 Surgery of aneurysm, vascular malformation or carotid-cavernous fistula; by intracranial and cervical occlusion of carotid artery
61708 by intracranial electrothrombosis
61710 by intra-arterial embolization, injection procedure, or balloon catheter



Explanation

The physician clips an aneurysm, vascular malformation, or carotid-cavernous fistula. The physician makes a high neck incision and locates the ipsilateral carotid artery. Next, the physician performs a craniotomy to access the defect. In 61705, the physician performs a craniotomy to access the intracranial aneurysm, vascular malformation or carotid-cavernous fistula. Once the lesion is located, the cervical carotid is clamped and the carotid artery proximal and distal to the lesion is ligated to prevent blood flow to the lesion. The cervical carotid is unclamped while monitoring for bleeding in the craniotomy site. In 61708, the lesion is obliterated using electrothrombosis. In 61710, the physician embolizes the lesion with an intra-arterial balloon catheter or injects material to form a regional clot to obliterate the blood supply to the lesion. After the lesion has been obliterated, the dura is closed. The bone flap is repositioned and secured; the scalp is reanastomosed and sutured in layers.

Coding Tips

For intensity modulated beam delivery plan and treatment, see 77301. For ligation or gradual occlusion of the internal/common carotid artery, see 37605–37606.

ICD-10-CM Diagnostic Codes

I67.1	Cerebral aneurysm, nonruptured
I67.89	Other cerebrovascular disease
I68.8	Other cerebrovascular disorders in diseases classified elsewhere
I72.0	Aneurysm of carotid artery
I77.71	Dissection of carotid artery
I77.75	Dissection of other precerebral arteries
I77.76	Dissection of artery of upper extremity
I77.77	Dissection of artery of lower extremity
Q28.2	Arteriovenous malformation of cerebral vessels
Q28.3	Other malformations of cerebral vessels

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
61705	38.1	24.53	14.63	77.26
61708	37.2	24.1	14.27	75.57
61710	31.29	20.45	11.99	63.73
Facility RVU	**Work**	**PE**	**MP**	**Total**
61705	38.1	24.53	14.63	77.26
61708	37.2	24.1	14.27	75.57
61710	31.29	20.45	11.99	63.73

	FUD	Status	MUE	Modifiers				IOM Reference
61705	90	A	1(3)	51	N/A	62*	80	None
61708	90	A	1(3)	51	N/A	N/A	80	
61710	90	A	1(3)	51	N/A	N/A	80*	

* with documentation

Terms To Know

aneurysm. Circumscribed dilation or outpouching of an artery wall, often containing blood clots and connecting directly with the lumen of the artery.

anomaly. Irregularity in the structure or position of an organ or tissue.

balloon catheter. Any catheter equipped with an inflatable balloon at the end to hold it in place in a body cavity or to be used for dilation of a vessel lumen.

congenital. Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.

craniotomy. Surgical incision made into the cranium or skull for a number of surgical reasons (e.g., decompression, implantation of electrode array, excision, etc.).

dura mater. Outermost, hard, fibrous layer or membrane that surrounds the brain and spinal cord.

intracranial. Within the cranium (skull).

ligation. Tying off a blood vessel or duct with a suture or a soft, thin wire.

subarachnoid. Space located between the arachnoid membrane and the pia mater that contains cerebrospinal fluid.

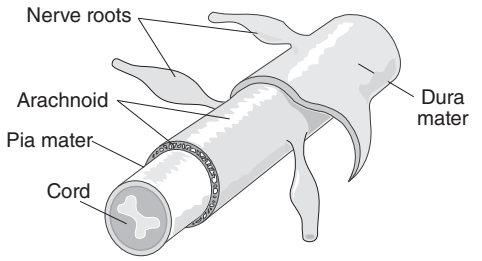
N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

62280-62282

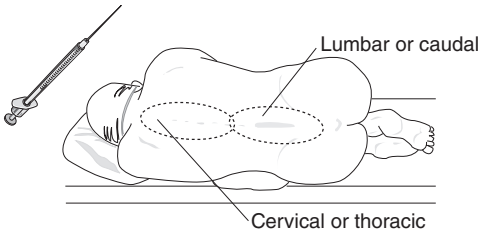
62280 Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid

62281 epidural, cervical or thoracic

62282 epidural, lumbar, sacral (caudal)



Schematic of spinal cord layers



Explanation

This procedure is performed to destroy nerve tissue or adhesions. The patient is placed in a spinal tap position. The site is sterilized, and the needle is inserted under fluoroscopic guidance. The needle is placed at the proper level and the neurolytic substance is administered. Once the injection/infusion is completed, the needle is removed and the wound dressed. Report 62280 if the substance is administered to the subarachnoid level. Report 62281 if the needle is inserted in the epidural region of a cervical or thoracic level. Report 62282 if the needle is inserted in the epidural region of a lumbar or sacral (caudal) level.

Coding Tips

The subarachnoid space is the space between the arachnoid and the pia mater. The epidural space is the space outside the dura mater. Injection of contrast is included and should not be reported separately. For fluoroscopic guidance and localization, see 77003.

ICD-10-CM Diagnostic Codes

A52.11 Tabes dorsalis

G90.511 Complex regional pain syndrome I of right upper limb ☑

G90.512 Complex regional pain syndrome I of left upper limb ☑

G90.513 Complex regional pain syndrome I of upper limb, bilateral ☑

G90.521 Complex regional pain syndrome I of right lower limb ☑

G90.522 Complex regional pain syndrome I of left lower limb ☑

G90.523 Complex regional pain syndrome I of lower limb, bilateral ☑

G90.59 Complex regional pain syndrome I of other specified site

I73.89 Other specified peripheral vascular diseases

M47.21 Other spondylosis with radiculopathy, occipito-atlanto-axial region

M47.22 Other spondylosis with radiculopathy, cervical region

M47.23 Other spondylosis with radiculopathy, cervicothoracic region

M47.24 Other spondylosis with radiculopathy, thoracic region

M47.25 Other spondylosis with radiculopathy, thoracolumbar region

M47.26 Other spondylosis with radiculopathy, lumbar region

M47.27 Other spondylosis with radiculopathy, lumbosacral region

M47.28 Other spondylosis with radiculopathy, sacral and sacrococcygeal region

M50.11 Cervical disc disorder with radiculopathy, high cervical region

M50.121 Cervical disc disorder at C4-C5 level with radiculopathy

M50.122 Cervical disc disorder at C5-C6 level with radiculopathy

M50.123 Cervical disc disorder at C6-C7 level with radiculopathy

M50.13 Cervical disc disorder with radiculopathy, cervicothoracic region

M51.14 Intervertebral disc disorders with radiculopathy, thoracic region

M51.15 Intervertebral disc disorders with radiculopathy, thoracolumbar region

M51.16 Intervertebral disc disorders with radiculopathy, lumbar region

M51.17 Intervertebral disc disorders with radiculopathy, lumbosacral region

M54.11 Radiculopathy, occipito-atlanto-axial region

M54.12 Radiculopathy, cervical region

M54.13 Radiculopathy, cervicothoracic region

M54.14 Radiculopathy, thoracic region

M54.15 Radiculopathy, thoracolumbar region

M54.16 Radiculopathy, lumbar region

M54.17 Radiculopathy, lumbosacral region

M54.18 Radiculopathy, sacral and sacrococcygeal region

M54.2 Cervicalgia

M54.31 Sciatica, right side ☑

M54.32 Sciatica, left side ☑

M54.41 Lumbago with sciatica, right side ☑

M54.42 Lumbago with sciatica, left side ☑

M54.6 Pain in thoracic spine

M54.81 Occipital neuralgia

M54.89 Other dorsalgia

AMA: **62280** 2017,May **62281** 2017,May **62282** 2017,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
62280	2.63	6.94	0.28	9.85
62281	2.66	4.2	0.25	7.11
62282	2.33	7.16	0.2	9.69
Facility RVU	**Work**	**PE**	**MP**	**Total**
62280	2.63	1.74	0.28	4.65
62281	2.66	1.73	0.25	4.64
62282	2.33	1.67	0.2	4.2

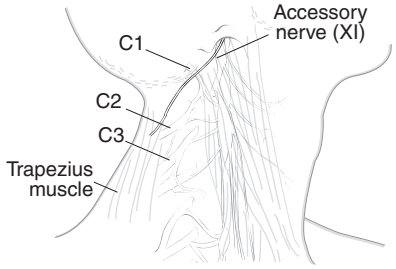
	FUD	Status	MUE	Modifiers				IOM Reference
62280	10	A	1(3)	51	N/A	N/A	N/A	None
62281	10	A	1(3)	51	N/A	N/A	N/A	
62282	10	A	1(3)	51	N/A	N/A	N/A	

* with documentation

 N Newborn: 0 **P** Pediatric: 0-17 **M** Maternity: 9-64 **A** Adult: 15-124 ♂ Male Only ♀ Female Only

95867-95868

95867 Needle electromyography; cranial nerve supplied muscle(s), unilateral
95868 cranial nerve supplied muscles, bilateral



Examples of cranial nerve supplied muscles that may be examined by needle EMG

Explanation

Needle electromyography (EMG) records the electrical properties of muscle using an oscilloscope. Recordings, which may be amplified and heard through a loudspeaker, are made during needle insertion, with the muscle at rest, and during contraction. These codes are specific to the 12 nerves that emerge from or enter the cranium. These codes are reported when there are no nerve conduction studies performed in conjunction with these procedures during the same day. Report 95867 for unilateral studies and 95868 for bilateral studies.

Coding Tips

Procedures 95867 and 95868 have both technical and professional components. To claim only the professional component, append modifier 26. To claim only the technical component, append modifier TC. To claim the complete procedure (i.e., both the professional and technical components), submit without a modifier. For EMG of the thoracic paraspinal muscles, see 95869.

ICD-10-CM Diagnostic Codes

G12.23 Primary lateral sclerosis
G12.24 Familial motor neuron disease
G12.25 Progressive spinal muscle atrophy
G12.29 Other motor neuron disease
G37.0 Diffuse sclerosis of central nervous system
G37.1 Central demyelination of corpus callosum
G37.2 Central pontine myelinolysis
G37.3 Acute transverse myelitis in demyelinating disease of central nervous system
G37.4 Subacute necrotizing myelitis of central nervous system
G37.5 Concentric sclerosis [Balo] of central nervous system
G37.8 Other specified demyelinating diseases of central nervous system
G54.3 Thoracic root disorders, not elsewhere classified
G60.2 Neuropathy in association with hereditary ataxia
G60.3 Idiopathic progressive neuropathy
G60.8 Other hereditary and idiopathic neuropathies
G70.00 Myasthenia gravis without (acute) exacerbation
G70.01 Myasthenia gravis with (acute) exacerbation
G70.1 Toxic myoneural disorders
G70.2 Congenital and developmental myasthenia
M47.13 Other spondylosis with myelopathy, cervicothoracic region
M47.14 Other spondylosis with myelopathy, thoracic region
M47.15 Other spondylosis with myelopathy, thoracolumbar region
M47.23 Other spondylosis with radiculopathy, cervicothoracic region
M47.24 Other spondylosis with radiculopathy, thoracic region
M47.25 Other spondylosis with radiculopathy, thoracolumbar region
M48.03 Spinal stenosis, cervicothoracic region

AMA: **95867** 2021,Mar **95868** 2021,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
95867	0.79	2.39	0.05	3.23
95868	1.18	3.04	0.06	4.28
Facility RVU	**Work**	**PE**	**MP**	**Total**
95867	0.79	2.39	0.05	3.23
95868	1.18	3.04	0.06	4.28

	FUD	Status	MUE	Modifiers				IOM Reference
95867	N/A	A	1(3)	N/A	N/A	N/A	80*	None
95868	N/A	A	1(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

cerebral palsy. Brain damage occurring before, during, or shortly after birth that impedes muscle control and tone.

electromyography. Test that measures muscle response to nerve stimulation determining if muscle weakness is present and if it is related to the muscles themselves or a problem with the nerves that supply the muscles.

hemiplegia. Paralysis of one side of the body.

idiopathic. Having no known cause.

monoplegia. Loss or impairment of motor function in one arm or one leg.

myelopathy. Pathological or functional changes in the spinal cord, often resulting from nonspecific and noninflammatory lesions.

neuropathy. Abnormality, disease, or malfunction of the nerves.

quadriplegia. Loss or impairment of the nerves and muscles of the arms and legs that impedes normal activity or movement or results in paralysis.

syringomyelia. Progressive condition that may be either from developmental origin or caused by trauma, tumor, hemorrhage, or infarction. An abnormal cavity (syrinx) forms in the spinal cord and enlarges over time, resulting in symptoms of muscle, weakness and stiffness in the back, shoulders, arms, or legs, atrophy, headaches, dissociated memory loss and a loss of sensory ability to feel pain and extremes of hot or cold temperatures.

75894

75894 Transcatheter therapy, embolization, any method, radiological supervision and interpretation

Explanation

A blood vessel is blocked by inserting an occlusive agent under fluoroscopic monitoring to stop or restrict the blood flow. This is done to restrict blood supply to a tumor, treat vascular malformations, or control hemorrhaging. A local anesthetic is given at the puncture site and a needle is inserted into the selected vessel followed by a guidewire. The needle is removed. A catheter is inserted over the guidewire and advanced to the vessel requiring treatment. A blocking agent is injected or inserted and monitored. The effect may remain permanent or require another transcatheter embolization with time. This code reports the radiological supervision and interpretation only. Use a separately reportable code for the catheterization.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
75894	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
75894	0.0	0.0	0.0	0.0

75898

75898 Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis

Explanation

Angiography is performed during or following transcatheter infusion or embolization through the existing catheter to reassess the therapy's effectiveness. A radiopaque contrast medium is injected through the catheter and by fluoroscopic images recorded of the vessel, the radiologist interprets the status of the blood vessel and the effectiveness of treatment rendered.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
75898	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
75898	0.0	0.0	0.0	0.0

76000

76000 Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time

Explanation

A radiologist or other qualified health care provider supplies separate fluoroscopic monitoring of the body for up to one hour for procedures that do not include fluoroscopy as an integral component. This code is reported separately to describe the professional work component entailed in providing fluoroscopic monitoring. If formal contrast x-ray studies are done and included as a part of the procedure to produce films with written interpretation and report, fluoroscopy is already included and cannot be separately reported.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
76000	0.3	0.93	0.05	1.28
Facility RVU	**Work**	**PE**	**MP**	**Total**
76000	0.3	0.93	0.05	1.28

76506

76506 Echoencephalography, real time with image documentation (gray scale) (for determination of ventricular size, delineation of cerebral contents, and detection of fluid masses or other intracranial abnormalities), including A-mode encephalography as secondary component where indicated

Explanation

Echoencephalography is done to determine ventricular size, investigate suspected fluid masses or other intracranial abnormalities, and define cerebral contents. During the test, the radiation technician guides the transducer over the area of the brain to be examined. The transducer sends an ultrasound beam through the tissue. The reflected sound waves are converted into electrical impulses and displayed on a video screen for interpretation or photographing for later interpretation. Abnormal results may indicate cerebral edema, lesions, or subdural and extradural hemorrhage. The gray (Gy) scale refers to the amount of energy absorbed by the tissue. Real-time scan is a two-dimensional scanning procedure with display of both two-dimensional structure and motion with time. A-mode is a one-dimensional measurement procedure. This code includes A-mode encephalography as a secondary component where indicated.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
76506	0.63	2.78	0.06	3.47
Facility RVU	**Work**	**PE**	**MP**	**Total**
76506	0.63	2.78	0.06	3.47

76883

● **76883** Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity

Explanation

Comprehensive ultrasonography of one or more nerves and accompanying structures in one extremity is performed throughout their entire anatomic course. Cross-sectional areas of a nerve are measured at various sites throughout the length of the limb, ratios are calculated, vascularity is checked, and echo intensity of affected muscles is evaluated. Patterns of peripheral nerve involvement are evaluated and cine loops (a series of rapidly recorded multiple images that are taken at sequential cycles of time and displayed on a monitor) are saved. Diagnostic ultrasound is an imaging technique that bounces soundwaves far above the level of human perception through interior body structures. The soundwaves pass through different tissue densities and reflect back to a receiving unit at varying speeds. The unit converts the waves to electrical pulses that are immediately displayed in picture form on a screen. Real-time cine imaging with image documentation is included. Report 76883 once per extremity.

Correct Coding Initiative Update 28.3

❖Indicates Mutually Exclusive Edit

0075T 01924-01926, 0213T, 0216T, 0708T-0709T, 34713-34716, 34812-34820, 34833-34834, 35201-35206, 35226, 35261-35266, 35286, 36000, 36100, 36140, 36200, 36215-36217, 36410, 36591-36592, 36620-36625, 36831-36833, 36860-36861, 37236, 37246-37247, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 69990, 75600, 75605, 76000, 76380, 76942, 76998, 77001-77002, 77012, 77021, 93050, 96360, 96365, 96372, 96374-96377, 96523, 99446-99449, 99451-99452

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