Coding Companion for Orthopaedics—Upper: Spine & Above

A comprehensive illustrated guide to coding and reimbursement
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An excisional biopsy is not reported separately in conjunction with 22110-22114. As an "add-on" code, 22116 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intra-service work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as a stand-alone code. For partial resection of a posterior vertebral component (spinous processes, lamina or facet), for an intrinsically bony lesion, see 22100-22103. For complete or near complete resection of the intrinsic bony lesion, see 22100-22103. For partial excision of vertebral body, for an anterior incision to reach the vertebral body. With the patient stabilized by a halo or cranial tongs, the physician makes an anterior incision above the clavicle, dividing the superficial muscles and fascia and retracting the trachea, esophagus, and thyroid medially. After blunt division of the deep fascia and paravertebral muscles, the anterior aspect of the cervical spine is exposed. The bony lesion is identified and excised from the affected vertebral body. Once the lesion is removed, a drain is placed in layered sutures. The halo or tongs are attached to a body jacket to assure stabilization of the spine. Report 22110 for a cervical segment; 22112 for a thoracic segment; and 22114 for a lumbar vertebral segment. Report 22116 for each additional segment in conjunction with the code for the primary procedure.

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Appendix

70010
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.

70360
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.

70490-70492
70490 Computed tomography, soft tissue neck; without contrast material
70491 with contrast material(s)
70492 without contrast material followed by contrast material(s) and further sections

Explanation
Computed tomographic angiography (CTA) is a procedure used for the imaging of vessels to detect aneurysms, blood clots, and other vascular irregularities. Contrast medium is rapidly infused intravenously, at intervals, usually with an automatic injector, and the patient is scanned with thin section axial or spiral mode x-ray beams. The images obtained are acquired with narrower collimation and reconstructed at shorter intervals than standard CT images. Three-dimensional images are generated and postprocessing reconstruction is done at a workstation on the scanner. CTA also provides information unavailable with conventional angiography, such as vessel wall thickness (mural thrombus) and the venous anatomy of a target organ and/or associated organs within the scan range. Report 70496 for an exam of the head and 70498 for an exam of the neck. These codes report exams with contrast materials and image postprocessing. Noncontrast images, if performed, are also included in these procedures.

70540-70549
70540 Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)
70542 with contrast material(s)
70543 without contrast material(s), followed by contrast material(s) and further sequences

Explanation
Magnetic resonance imaging (MRI) is a radiation-free, noninvasive technique to produce high quality sectional images of the inside of the body in multiple planes. MRI uses the natural magnetic properties of the hydrogen atoms in our bodies that emit radiofrequency signals when exposed to radio waves within a strong electro-magnetic field. These signals are then processed and converted by the computer into high-resolution, three-dimensional tomographic images. Patients with metallic or electronic implants or foreign bodies cannot be exposed to MRI. The patient must remain still while lying on a motorized table within the large, circular MRI tunnel. A sedative may be administered as well as contrast material for image enhancement. These codes report and exam of the neck. Report 70547 if no contrast is used. Report 70548 if performed with contrast and then again following the injection of contrast.

72010
72010 Radiologic examination, spine, entire, survey study, anteroposterior and lateral

Explanation
The entire spine is surveyed in a radiologic exam that includes anteroposterior views, with the patient supine, knees flexed, and feet flat on the table; and lateral views, either recumbent or erect. Right and left posterior obliques may be performed with the patient in the semi-supine position with the spine at a 45 degree angle to the table.

72020
72020 Radiologic examination, spine, single view, specify level

Explanation
One film is taken of the spine that requires specification of the level examined.

72040-72052
72040 Radiologic examination, spine, cervical; 3 views or less
72050 4 or 5 views
72052 6 or more views
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 requirements for code selection are learned and used.

**Providers**

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group. In paragraphs 2 and 3 under “Instructions for Use of the CPT® Codebook” on page x 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).

The use of the phrase “physician or other qualified health care professional” (OQHCP) was adopted to identify a health care provider other than a physician. This type of provider is further described in CPT® as an individual “qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable)”

**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

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 or other qualified health care provider’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 or other qualified health care provider within the past three years. An established patient is a patient who has received face-to-face professional services from the physician or other qualified health care provider within the past three years. In the case of group practices, if a physician or other qualified health care provider of the exact same specialty or subspecialty has seen the patient within the past three years, the patient is considered established.

If a physician or other qualified health care provider is on call or covering for another physician or other qualified health care provider, the patient’s encounter is classified as it would have been by the physician or other qualified health care provider who is not available. Thus, a locum tenens physician or other qualified health care provider who sees a patient on behalf of the patient’s attending physician or other qualified health care provider may not bill a new