Coding Companion for Neurosurgery/Neurology

A comprehensive illustrated guide to coding and reimbursement

2016
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63303 - Vertebral corpectomy (vertebral body resection), partial or complete, for excision of intraspinal lesion, single segment; extradural, lumbar or sacral by transperitoneal or retroperitoneal 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 approach from the left side, and the muscle, fascia, ribs, and organs are incised or retracted. 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 63303 reports transperitoneal or retroperitoneal vertebral corpectomy, extradural, lumbar or sacral, 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. Arthrodisis is reported separately, see 22548–22585. Bone graft is reported separately, see 20930–20938. For vertebral corpectomy for decompression, see 63085–63091. 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 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

HCPCS Equivalent Codes
N/A

Terms To Know
corpectomy. Removal of the body of a bone, such as a vertebra.
disseminated. Spread over an extensive area.
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.
myelopathy. Pathological or functional changes in the spinal cord, often resulting from nonspecific and noninflammatory lesions.
neoplasm. New abnormal growth, tumor.
sacrum. Lower portion of the spine composed of five fused vertebrae designated as S1-S5.
secondary. Second in order of occurrence or importance, or appearing during the course of another disease or condition.
vertebral body. Disc-shaped portion of a vertebra that is anteriorly located and bears weight.

Medicare Edits

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Modifiers

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* with documentation
G0453
Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)

Explanation
Continuous intraoperative neurophysiology monitoring (IONM) is performed by a qualified health care provider other than the surgeon or anesthesiologist involved in the surgical procedure. IONM may include various electrophysiologic modalities, such as electroencephalography (EEG), electromyography (EMG), and evoked potentials. The provider must be solely dedicated to monitoring the neurophysiological tests and available to intervene if necessary.

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 is performed 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 radiotracer intrathecally by lumbar puncture. Cisternography may also be used to detect cerebrospinal fluid (CSF) leaks or normal pressure hydrocephalus (NPH).

70240
Radiographic 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 semilouette 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.

70250-70260
Radiologic examination, skull; less than 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

Explanation
Computed 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 again following the injection of contrast.

70480-70482
Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material

Explanation
Computed 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 orbit, sella, posterior fossa, or outer, middle, or inner ear. Report 70480 if no contrast is used. Report 70481 if performed with contrast and 70482 if performed first without contrast and again following the injection of contrast.
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 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 (see paragraphs 2 and 3 under “Instructions for Use of the CPT® Codebook” on page xii 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 privileges (when applicable)” State licensure guidelines determine the scope of practice and a qualified health care professional must practice within these guidelines, even if more restrictive than the CPT guidelines. The qualified health care professional may report services independently or under incident-to guidelines. The professionals within this definition are separate from “clinical staff” and are able to practice independently. CPT defines clinical staff as “a person who works under the supervision of a physician or other qualified health care professional and who is allowed, by law, regulation, and facility policy to perform or assist in the performance of a service or professional service.” Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

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 another qualified health care provider of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

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If a physician or other qualified health care provider is on call or covering for another physician or other qualified health care provider, the provider’s encounter is classified as it would have been if the patient had been seen 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