Neurosurgery/ Neurology
A comprehensive illustrated guide to coding and reimbursement

2017 

ICD-10
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20664
Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta)

Explanation
The physician places a cranial halo on the skull of a child whose skull is unusually thin because of a congenital or developmental problem. The physician sterilizes the skin and scalp with a povidone-iodine solution. The halo is positioned on the patient's head with six or more pins, which are advanced until firm, but not to the tension allowed by a normal skull. Diagonally opposed pins are tightened simultaneously. All are secured with nuts. This code includes the removal of the halo.

Coding Tips
Report 20664 for patients with thin skull osteology where additional pins (six or more) are required for halo application. This procedure includes removal of the device. For application of a cranial halo with fewer than six pins, see 20661.

ICD-10-CM Diagnostic Codes
Q03.0 Malformations of aqueduct of Sylvius
Q03.1 Atresia of foramina of Magendie and Luschka
Q03.8 Other congenital hydrocephalus
Q03.9 Congenital hydrocephalus, unspecified
Q05.0 Cervical spina bifida with hydrocephalus
Q05.1 Thoracic spina bifida with hydrocephalus
Q05.2 Lumbar spina bifida with hydrocephalus
Q05.3 Sacral spina bifida with hydrocephalus
Q05.4 Unspecified spina bifida with hydrocephalus
Q05.9 Spina bifida, unspecified
Q07.01 Arnold-Chiari syndrome with spina bifida
Q07.02 Arnold-Chiari syndrome with hydrocephalus
Q07.03 Arnold-Chiari syndrome with spina bifida and hydrocephalus
Q75.0 Craniosynostosis
Q75.1 Craniofacial dysostosis
Q75.2 Hypertelorism
Q75.3 Macrocephaly
Q75.4 Mandibulofacial dysostosis
Q75.5 Oculomandibular dysostosis
Q75.8 Other specified congenital malformations of skull and face bones
Q75.9 Congenital malformation of skull and face bones, unspecified
Q78.0 Osteogenesis imperfecta
Q87.0 Congenital malformation syndromes predominantly affecting facial appearance

T84.226A Displacement of internal fixation device of vertebrae, initial encounter
T84.89XA Other specified complication of internal orthopedic prosthetic devices, implants and grafts, initial encounter
T84.9XXA Unspecified complication of internal orthopedic prosthetic device, implant and graft, initial encounter

HCPCS Equivalent Codes
N/A

Medicare Edits

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<td>25.56</td>
<td>90</td>
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* with documentation
Explaination
The physician remedies a stroke-causing blood clot obstructing blood flow to the brain. The physician infuses a thrombolytic (“clot-busting”) drug through an intravenous catheter to help dissolve the clot and restore normal blood flow to the brain.

Coding Tips
Codes for catheter placement and the radiological supervision and interpretation should also be reported in addition to the code for the therapeutic aspect of the procedure.

ICD-10-CM Diagnostic Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>G45.8</td>
<td>Other transient cerebral ischemic attacks and related syndromes</td>
</tr>
<tr>
<td>G45.9</td>
<td>Transient cerebral ischemic attack, unspecified</td>
</tr>
<tr>
<td>G46.0</td>
<td>Middle cerebral artery syndrome</td>
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<td>G46.1</td>
<td>Anterior cerebral artery syndrome</td>
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<td>G46.2</td>
<td>Posterior cerebral artery syndrome</td>
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<td>Cerebral infarction due to thrombosis of unspecified cerebral artery</td>
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<td>I63.311</td>
<td>Cerebral infarction due to thrombosis of right middle cerebral artery</td>
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<td>I63.312</td>
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<td>I63.39</td>
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<td>I63.511</td>
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<td>I66.11</td>
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<tr>
<td>I66.12</td>
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Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace (63075)

- Each additional interspace (List separately in addition to code for primary procedure) (63076)

**Explanation**

The physician performs a cervical discectomy to remove all or part of a herniated intervertebral disc. The patient is placed supine with a head halter on the jawbone (mandible). The physician makes a transverse incision overlying the intervertebral disc. The sternocleidomastoid muscle and the carotid artery are retracted. The physician excises the anterior anulus of the disc and uses pituitary forceps to remove as much disc material as possible. A spreader and microscope are used to enhance the evacuation. A drill is used to remove the transverse bar above and below. Graft material is obtained from the ilium and fashioned into a T-shape. The graft is placed into the disc space and traction is released. The muscles fall back into place and the incision is closed with layered sutures. Report 63075 if the discectomy is in a single interspace. Report 63076 for each additional cervical interspace.

**Coding Tips**

As an "add-on" code, 63076 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice 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. Use 63076 in conjunction with 63075. Any bone graft is reported separately, see 20930–20938. For anterior thoracic discectomy, see 63077–63078. Do not report 22554 in conjunction with 63075 or 63076 for single or multiple surgeons. When anterior cervical discectomy and interbody fusion are performed at the same operative session and the same level, only 22551 or 22552 should be reported. If the services of two primary surgeons performing separate and distinct components of the procedure are required, a co-surgery scenario exists. Both surgeons should report the primary procedure with modifier 62 and submit the claim with operative notes attached. The use of the operating microscope is not reported separately for 63075–63076.

**ICD-10-CM Diagnostic Codes**

- M43.02 Spondylolysis, cervical region
- M43.03 Spondylolysis, cervicothoracic region
- M43.12 Spondylolisthesis, cervical region
- M43.13 Spondylolisthesis, cervicothoracic region
- M45.2 Ankylosing spondylitis of cervical region
- M45.3 Ankylosing spondylitis of cervicothoracic region
- M46.23 Osteomyelitis of vertebra, cervicothoracic region
- M47.12 Other spondylolysis with myelopathy, cervical region
- M47.13 Other spondylolysis with myelopathy, cervicothoracic region
- M47.22 Other spondylolysis with radiculopathy, cervical region
- M47.23 Other spondylolysis with radiculopathy, cervicothoracic region
- M47.812 Spondylisis without myelopathy or radiculopathy, cervical region
- M47.813 Spondylisis without myelopathy or radiculopathy, cervicothoracic region
- M47.892 Other spondylolysis, cervical region
- M47.893 Other spondylolysis, cervicothoracic region
- M48.02 Spinal stenosis, cervical region
- M48.03 Spinal stenosis, cervicothoracic region
- M48.8X2 Other specified spondylopathies, cervical region
- M48.8X3 Other specified spondylopathies, cervicothoracic region
- M50.01 Cervical disc disorder with myelopathy, high cervical region
- M50.02 Cervical disc disorder with myelopathy, mid-cervical region
- M50.03 Cervical disc disorder with myelopathy, cervicothoracic region
- M50.11 Cervical disc disorder with radiculopathy, high cervical region
- M50.12 Cervical disc disorder with radiculopathy, mid-cervical region
- M50.13 Cervical disc disorder with radiculopathy, cervicothoracic region
- M50.21 Other cervical disc displacement, high cervical region
- M50.22 Other cervical disc displacement, mid-cervical region
- M50.23 Other cervical disc displacement, cervicothoracic region
- M50.31 Other cervical disc degeneration, high cervical region
- M50.32 Other cervical disc degeneration, mid-cervical region
- M50.33 Other cervical disc degeneration, cervicothoracic region
- M50.81 Other cervical disc disorders, high cervical region
- M50.82 Other cervical disc disorders, mid-cervical region
- M50.83 Other cervical disc disorders, cervicothoracic region
- M54.12 Radiculopathy, cervical region
- M54.13 Radiculopathy, cervicothoracic region

**HCPCS Equivalent Codes**

N/A

**Terms To Know**

cervicalgia. Pain localized to the cervical region, generally referring to the posterior or lateral regions of the neck.
cervicobrachial syndrome. Neuropathy of the brachial plexus causing pain leading from the neck and radiating down the arm.
decompression. Release of pressure.
spondylolisthesis. Forward displacement of one vertebra slipping over another, usually in the fourth or fifth lumbar area.
spondylosis. Noninflammatory degenerative changes of the spine with excessive bone growth of the vertebra (osteophytes). Can be associated with stress microfractures of the pars articularis, known as Gill fragment, pars defect, or pars stress fracture.

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* with documentation

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**63077-63078**

63077  Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace

63078  thoracic, each additional interspace (List separately in addition to code for primary procedure)

**Explanation**

The physician makes an incision along the rib corresponding to the second thoracic vertebra above the involved intervertebral disc, except in cases involving the top five discs. The rib is removed for access and eventually used in the graft, which is obtained through an extrapleural or transpleural approach. Vessels are tied away from the spine. The disc is removed to the posterior ligament using a microscope and nibbling instruments. The end plates are stripped of their cartilage. The physician makes a slot in one vertebral body and a hole in the other to accept the graft, which is made of several sections of rib. The physician ties the grafts together with heavy suture material and closes the tissue with layered sutures. A chest drain may be inserted. Report 63077 for a single thoracic interspace. Report 63078 for each additional thoracic interspace.

**Coding Tips**

As an "add-on" code, 63078 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice 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. Use 63078 in conjunction with 63077. Arthrodesis is reported separately, see 22554–22585. Any bone graft is also reported separately, see 20930–20938. The use of the operating microscope is not reported separately for 63077–63078. For anterior cervical discectomy, see 63075–63076. 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-10-CM Diagnostic Codes**

M43.03  Spondylolysis, cervicothoracic region