Coding Companion for Orthopaedics—Upper: Spine & Above

A comprehensive illustrated guide to coding and reimbursement

2013

Contents

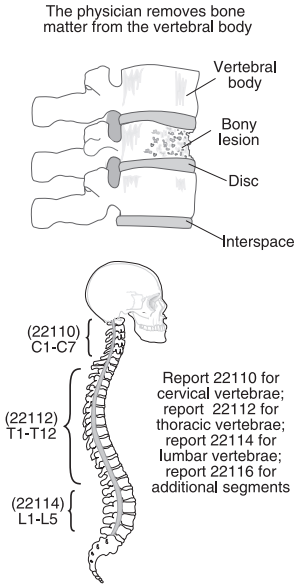
22110-22116

22110 Partial excision of vertebral body, for intrinsic bony lesion, without decompression of spinal cord or nerve root(s), single vertebral segment; cervical

22112 thoracic

22114 lumbar

22116 each additional vertebral segment (List separately in addition to code for primary procedure)



Explanation

The physician removes spurs, other growths, or bone disease by partial resection of a vertebral body. With the patient stabilized by a halo or cranial tongs, the physician makes an anterior incision to reach the vertebral body. Lower cervical vertebrae are approached 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 and the incision is closed 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.

Coding Tips

An excisional biopsy is not reported separately if a therapeutic excision is performed during the same surgical session. Use 22116 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 intrinsic bony lesion, see 22100–22103. For complete or near complete resection of the vertebral body, see vertebral corpectomy codes 63081–63091. For a bone graft for spinal procedures, see 20930–20938.

ICD-9-CM Procedural

77.89 Other partial ostectomy of other bone, except facial bones

Anesthesia

22110 00600, 00604, 00670

22112 00620, 00625, 00626, 00670

22114 00630, 00670

22116 N/A

ICD-9-CM Diagnostic

094.0 Tabes dorsalis — (Use additional code to identify any associated mental disorder. Use additional code to identify manifestation: 713.5)

098.53 Gonococcal spondylitis

170.2 Malignant neoplasm of vertebral column, excluding sacrum and coccyx

213.2 Benign neoplasm of vertebral column, excluding sacrum and coccyx

238.0 Neoplasm of uncertain behavior of bone and articular cartilage

721.5 Kissing spine

722.31 Schmorl's nodes, thoracic region

722.32 Schmorl's nodes, lumbar region

723.0 Spinal stenosis in cervical region

724.01 Spinal stenosis of thoracic region

724.02 Spinal stenosis of lumbar region, without neurogenic claudication

731.3 Major osseous defects — (Code first underlying disease: 170.0-170.9, 730.00-730.29, 733.00-733.09, 733.40-733.49, 996.45)

733.21 Solitary bone cyst

733.22 Aneurysmal bone cyst

CCI Version 18.3

92585, 95822, 95860-95861, 95867-95868, 95900, 95904, 95920, 95936-95939

Also not with 22110: 0213T, 0216T, 0228T, 0230T, 10060, 10140, 10160, 12001-12007, 12011-12057, 13100-13153, 20926, 22100, 22318-22319, 22326, 22505, 22808-22812, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 51701-51703, 62310-62319, 63075, 64400-64435, 64445-64450, 64479, 64483, 64490, 64493, 64505-64530, 69990, 76000-76001, 77001-77002, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95829, 95870, 95925-95934, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

Also not with 22112: 0213T, 0216T, 0228T, 0230T, 10060, 10140, 10160, 12001-12007, 12011-12057, 13100-13153, 20926, 22101, 22110, 22327, 22505, 22808, 22812, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 51701-51703, 62310-62319, 63077, 64400-64435, 64445-64450, 64479, 64483, 64490, 64493, 64505-64530, 69990, 76000-76001, 77001-77002, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95829, 95870, 95925-95934, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

Also not with 22114: 0213T, 0216T, 0228T, 0230T, 10060, 10140, 10160, 12001-12007, 12011-12057, 13100-13153, 20926, 22102, 22112, 22505, 22808-22812, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 49000-49010, 51701-51703, 62310-62319, 64400-64435, 64445-64450, 64479, 64483, 64490, 64493, 64505-64530, 69990, 76000-76001, 77001-77002, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95829, 95870, 95925-95934, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

Also not with 22116: 95925-95927, 95930-95934

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

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status
22110	32.09	32.09	90	A
22112	31.77	31.77	90	A
22114	29.65	29.65	90	A
22116	4.09	4.09	N/A	A

	MUE	Modifiers			
22110	1	51	N/A	62*	80
22112	1	51	N/A	62*	80
22114	1	51	N/A	62*	80
22116	3	N/A	N/A	62*	80

* with documentation

Medicare References: None

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

Computerized 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

70496 Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing

70498 Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing

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.

70540-70543

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 an exam of the orbit, face, and neck. Report 70540 if no contrast is used. Report 70542 if performed with contrast and 70543 if performed first without contrast and then again following the injection of contrast.

70547-70549

70547 Magnetic resonance angiography, neck; without contrast material(s)

70548 with contrast material(s)

70549 without contrast material(s), followed by contrast material(s) and further sequences

Explanation

Magnetic Resonance Angiography (MRA) is a special type of magnetic resonance imaging (MRI) that specifically visualizes blood vessels and blood flow to evaluate vascular disorders within the structure being studied. Unlike CT, it does not rely on the absorption of x-ray energy. Magnetic resonance imaging 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 70549 if performed first without 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

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 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)" 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 specified professional service, but who does not individually report that 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 other qualified health care provider of the exact same specialty or subspecialty has seen the patient within 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