Spine Surgery Coding: Are You Breaking Your Back Trying To Figure It Out?

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Agenda

- Coding Controversies
  - Interspace vs. Segment
  - +22851 vs. +20931
  - Reporting +69990 with Spine Surgery Codes
  - 22630: Can I Bill a Laminectomy Code Too?
- Use of the Laminectomy/Discectomy Codes
- New Technology in Spine Procedures – Coding and Reimbursement Challenges
- When is a “Corpectomy” Coded as Corpectomy?
- CPT® 2011 Update
Coding Controversies

- Interspace vs segment
- +22851 vs. +20931
- Reporting +69990
- 22630: Can I Bill a Laminectomy Code Too?

Interspace vs. Segment

**CPT® Says:**

- A *vertebral segment* describes the basic constituent part into which the spine may be divided. It represents a single complete vertebral bone with its associated articular processes and laminae.
- A *vertebral interspace* is the nonbony compartment between two adjacent vertebral bodies which contains the intervertebral disc, and includes the nucleus pulposus, annulus fibrosus, and two cartilagenous endplates.
Why is an Arthrodesis Performed?

- To correct instability of the spinal motion unit.
- What is a spinal motion unit? Two vertebra, and the tissues that connect then, comprise the smallest working unit of the spine. This unit is referred to as the "spinal motion unit."
- What is done in an arthrodesis? Fusion of the transverse processes and/or interspace to stabilize the spinal motion unit.

Arthrodesis Codes

**CPT® Says:**

- 22612 Arthrodesis, posterior or posterolateral technique, single level; lumbar
- +22614 each additional vertebral segment (List separately in addition to code for primary procedure)

Example in **CPT®**: Posterior arthrodesis of L4-S1, utilizing morselized autogenous iliac bone graft harvested through separate fascial incision, and pedicle screw fixation. **CPT®** says to report as 22612, +22614, 22842, and 20937. L4-L5 = 22612, L5-S1 = +22614
How Many Levels?

Q: How would you code a fusion of L4 to S1? What are the appropriate procedure codes? Is it 22612, +22614, +22614 for three vertebral segments (L4, L5, S1)? OR is it 22612, 22614 for two interspaces (L4-L5, L5-S1)?

A: An arthrodesis occurs when two segments are fused together – it cannot occur on a single segment. Therefore, you will report one arthrodesis code per “motion segment” which is two adjacent vertebrae. Use 22612 (L4-L5) and +22614 (L5-S1).

How Many Levels?

Q: My spine surgeon did a C3-C6 laminectomy and fusion. We are debating on how to code the fusion. I say it is 22600 and 22614 x2. He says it is 22600 and 22614 x3. Who is right?

A: Which answer is correct?
1) Hold your hand up in front of your face and count down from the thumb (C3), then the index finger (C4), long finger (C5) and ring finger (C6). The first segment is the thumb (C3). Counting to the ring finger, you find 3 more segments. So you’d use four codes: 22600 and 22614 x3.
2) The surgeon did three levels of fusion, C3-4, C4-5 and C5-6. So use three codes: 22600 and 22614 x2.

Answer #2
Arthrodesis Codes

CPT® Says:

- **22554 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below C2**
- **+22585 each additional interspace** (List separately in addition to code for primary procedure)
- Procedure codes 22554-22558 are for SINGLE interspace; for additional interspaces, use +22585. A vertebral interspace is the non-bony compartment between two adjacent vertebral bodies, which contains the intervertebral disc, and includes the nucleus pulposus, annulus fibrosus, and two cartilagenous endplates.

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+20931 vs. +22851

CPT® Says:

- **+20931 Allograft for spine surgery only; structural** (List separately in addition to code for primary procedure)
- **+22851 Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace** (List separately in addition to code for primary procedure)
True or False

- Report +20931 per interspace – structural allografts placed at C5-6 and C6-7 is reported using +20931 x 2.
- Report +22851 per device inserted – bilateral devices placed at L4-5 is reported using +22851 x 2.
- Both statements are false.

Reporting Multiple Codes

Q: I received a rejection stating one of the 22851 codes I billed is a “duplicate charge.” My surgeon did a two level fusion and put two devices in at each level. I billed 22851 four times.

A: Report one 22851 code for each interspace or vertebral defect, NOT necessarily for each device.
   For example:
   22851 L3-4 1 unit (2 cages in the interspace)
   22851-59 L4-5 1 unit (2 cages in the interspace)
What is it: An Allograft or a Biomechanical Device?

- +20931 = Allograft bone (typically cadaver bone)
  - Allograft is bone obtained from a donor and not from the patient (that’s an autograft). An allograft bone contains no living cells.
- +22851 = Biomechanical device
  - Synthetic cage(s), threaded bone dowel(s), methylmethacrylate (MMA), Polyether ether ketone (PEEK)

**Question:**

Is it appropriate to report code 22851, Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace, for the placement of Tangent bone grafts?

**AMA Comment:**

“From a CPT coding perspective, threaded bone dowel is the only bone allograft that would qualify for code 22851. All other bone allografts are structural allografts and should be reported with CPT code 20931, Allograft for spine surgery only; structural. Tangent bone grafts are not threaded bone dowels and as such should be reported with code 20931 and not 22851. Additionally, tangent carbon fiber, titanium, or PEEK cages (ie, intervertebral devices) should be reported with code 22851. In this case, the word tangent refers to the shape of the device and does not address the material that helps distinguish between 22851 and 20931.”
+20931 Products

<table>
<thead>
<tr>
<th>Code</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>+20931</td>
<td>VG1 ALIF spacer&lt;br&gt;VG2 PLIF intervertebral device&lt;br&gt;Osteotech intradiscal device&lt;br&gt;Cornestone cortical wedge&lt;br&gt;Tangent graft&lt;br&gt;Graftech spacer&lt;br&gt;Wedge spacer&lt;br&gt;Fibular strut graft&lt;br&gt;Femoral ring&lt;br&gt;Notched graft</td>
</tr>
</tbody>
</table>

(List separately in addition to code for primary procedure)

+20931 Products

- VG2™ PLIF allograft
- Tangent graft
- Graftech cortical spacer
**+22851 Products**

**Examples:**
PEEK, BAK, HARMS, Brantigan and titanium cages, LT cage, lumbar fusion device, carbon fiber intervertebral device

**TIP:** Placement of methylmethacrylate (or “bone cement” to augment pedicle screws is not separately reported – do not use +22851).

+22851 Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure).

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**+22851 Products**

**LT-CAGE**

LUMBAR TAPERED FUSION DEVICE

Bullet Cage - made from titanium and comes in a range of sizes to treat the lumbar region.

GraftCage and Capstone are made of polyetheretherketon (PEEK), a radiolucent polymer.
By the Way: +22851 AND +22845?

- Medtronic PEEK Prevail
- Surgicraft STALIF C

Reporting +69990 in Spine Surgery

CPT® Says:

- +69990 Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)
- The surgical microscope is employed when the surgical services are performed using the techniques of microsurgery. Code 69990 should be reported (without modifier 51 appended) in addition to the code for the primary procedure performed. Do not use 69990 for visualization with magnifying loupes or corrected vision. Do not report 69990 in addition to procedures where use of the operating microscope is an inclusive component (15756-15758, 15842, 19364, 19368, 20955-20962, 20969-20973, 22856-22861, 26551-26554, 26556, 31526, 31531, 31536, 31541, 31545, 31546, 31561, 31571, 43116, 43496, 49906, 61548, 63075-63078, 64727, 64820-64823, 65091-68850, 0184T).
Reporting +69990 in Spine Surgery

Medicare Says:

- Correct Coding Initiative (CCI) edits determine when +69990 is paid

Dilemma:

- Can you report +69990 with 63030 or 63047?
- What if the spine surgeon dictates "microdiscectomy" and "use of the operating microscope for microdissection" when removing the lumbar disc?
- CPT® does not list 63030 or 63047 as an exclusion for +69990.
- Medicare lists these as "0" edits: "Modifier 0 indicates that there are no circumstances in which a modifier would be appropriate. The services represented by the code combination will not be paid separately."
22630: Can I Report a Laminectomy Code Too?

CPT® Says:

- 22630 Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
- 63047 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; lumbar

CPT® Assistant, January 2001

- For both codes 22554 and 22630, if the surgeon is removing disk and/or bony endplate solely with the need to prepare the vertebrae for fusion; then no additional 63000 series code(s) is reported. The appropriate 63045-63048, 63075-63078 code(s) should be reported, when in addition to removing the disk and preparing the vertebral endplate, the surgeon removes posterior osteophytes and decompresses the spinal cord or nerve root(s), which requires work in excess of that normally performed when doing a posterior lumbar interbody fusion (PLIF).

- To report code 22630 in addition to code 63047, again additional procedure(s) must have been performed. For example, in spinal procedures performed on patients having lateral lumbar stenosis, the surgeon may need to perform additional work above and beyond that described by the PLIF, including facetectomy(ies) and/or foraminotomy(ies), to adequately decompress the nerve roots. For the purpose of this example, code 63047 should be reported in addition to code 22630.
22630: Can I Report a Laminectomy Code Too?

Dilemma:
- There is overlap between 22630 and 63047
- Documentation must clearly support additional work of “decompression”
- May need to append modifier 59 Distinct Procedural Service to denote this separate activity.

22630: Can I Report a Posterolateral Fusion Code Too?

CPT® Says:
- 22612 Arthrodesis, posterior or posterolateral technique, single level; lumbar (with or without lateral transverse technique)
- Yes – 22630 and 22612 may be reported together because each code represents separate work
**PLF L4-L5 & PLIF L4-L5 with Decompression, Pedicle Screws/Rods, PEEK Device, Bone Marrow Aspiration from Iliac Crest, Infuse & Local Autograft**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>22612</td>
<td>L4-L5 posterolateral fusion</td>
</tr>
<tr>
<td>22630-51</td>
<td>L4-L5 posterior interbody fusion</td>
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<tr>
<td>63047-51*</td>
<td>L4-L5 laminectomies, foraminotomies, facetectomies</td>
</tr>
<tr>
<td>+22840</td>
<td>L4-L5 pedicle screws/rods</td>
</tr>
<tr>
<td>+22851</td>
<td>L4-L5 PEEK intervertebral device</td>
</tr>
<tr>
<td>38220-51</td>
<td>Bone marrow aspiration, iliac crest</td>
</tr>
<tr>
<td>+20930</td>
<td>Infuse (morselized allograft)</td>
</tr>
<tr>
<td>+20936</td>
<td>Local autograft</td>
</tr>
</tbody>
</table>

*Note: Modifier 59 may be needed to denote separate activity of decompression*
Laminectomy Coding Building Blocks

1. Identify the condition: stenosis, disc disease, spondylolisthesis, neoplasm, etc.

2. Identify the spine area, cervical, lumbar, etc., and the approach.

3. Identify the number of vertebral segments or interspaces involved.

4. Identify with or without facetectomy, foraminotomy, discectomy, re-exploration, removal of tumor for specific code selection.

Spine Anatomy

ANTERIOR
- Vertebral body
- Pedicle
- Transverse Process
- Spinal Canal
- Articular Process

POSTERIOR
- Lamina
- Spinous Process
Spine Anatomy

- Spinal segment
- Intervertebral disc
- Foramen

Facet Joints

Lamina

Spine Anatomy

- Vertebral Body
- Nerve Root
- Spinal Cord
- Neuroforamen

Spinal cord
- Pia mater
- Arachnoid mater
- Dura mater
- Epidural space
- Vertebra
- Intervertebral disc
- Facet joint
- Spinous process
- Transverse process
Laminectomy Codes for Stenosis

63001 - 63005
Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (e.g., spinal stenosis), one or two vertebral segments

Example of 63001:
Decompressive laminectomies at C2 and C3 for stenosis.

- Cervical (63001), thoracic (63003), lumbar (63005) and sacral (63011)
- No additional level codes
- Primary diagnosis is stenosis
- May not report with modifier 50, procedure is inherently bilateral
- Report per level/vertebral segment of lamina removed

63015 - 63017
Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (e.g., spinal stenosis), more than 2 vertebral segments

Example of 63015:
Decompressive laminectomies at C2, C3, C4 and C5 for stenosis.

- Cervical (63015), thoracic (63016) and lumbar (63017)
- No additional level codes
- Primary diagnosis is stenosis
- May not report with modifier 50, procedure is inherently bilateral
- Report per level/vertebral segment of lamina removed
Laminectomy Codes for Stenosis

63045 - +63048

Laminectomy, facetectomy and foraminotomy (unilateral or bilateral) with decompression of spinal cord, cauda equina and/or nerve root(s), (e.g., spinal or lateral recess stenosis), single vertebral segment

- Cervical (63045), thoracic (63046) and lumbar (63047)
- +63048 is the add-on code for this family of codes
- May not report with modifier 50, code says "unilateral or bilateral"
- Primary diagnosis is usually stenosis or spondylosis
- Use for revision (re-do) laminectomy when performed due to stenosis – do not report 63042.
- Report one code per level of foraminotomy (or exiting nerve root decompressed)

Example of 63047:
L4-5 partial laminectomies, foraminotomies and partial facetectomies for stenosis.

Laminectomy Codes for Disc Disease

63020 – +63035

Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; including open and endoscopically assisted approaches; 1 interspace.

- Cervical (63020) or lumbar (63030); no thoracic code
- +63035 is the add-on code for this family of codes
- May report with modifier 50, these are unilateral codes
- Primary diagnosis is disc disease
- Report one code per interspace
Laminectomy Codes for Disc Disease

63040 – +63044

- Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, **reexploration**, single interspace

- These codes are used for re-exploration **discectomy** procedures performed at the exact same level(s) as the previous procedure when the surgeon is out of the global period for the first procedure

- Cervical (63040) or lumbar (63042) no thoracic codes, +63043 is the add-on code for a reexploration cervical level; +63044 is the add-on code for reexploration lumbar level

- May report with modifier 50, these are unilateral codes

- Codes are valued higher to account for additional work involved with performing a re-exploration (e.g., excision of scar tissue, distorted landmarks)

- Report one code per interspace

Example of 63042:
Reexploration left L4-5 partial laminectomies, foraminotomy and partial facetectomy for disc disease.

New Technology in Spine Surgery: Coding and Reimbursement Challenges
Minimally Invasive Treatment of a Herniated Disc

Example:
Use of the METRx™ system to perform a left lumbar endoscopic discectomy

Recommendation:
Use CPT® 63030 or 63020 (new in 2009). Do not separately bill fluoroscopy (e.g., 77003).

Minimally Invasive Treatment of a Stenosis

Example:
Use of the METRx™ system to perform a left lumbar endoscopic foraminotomy and hemilaminotomy

Recommendation:
Use CPT® 63047. Use the appropriate code based on the diagnosis and not necessarily the instrument used in the procedure. Do not separately bill fluoroscopy (e.g., 77003).
Minimally Invasive TLIF (Transforaminal Lumbar Interbody Fusion)

- In a minimally invasive TLIF, the procedure is performed through a posterior approach off to one side of the spine using specialized retractors and endoscope, microscope, or loupes/headlight.

- A TLIF is performed through the more painful side of the patient’s body. A facetectomy allows access to a disc space from underneath the pedicle. Facetectomy and discectomy prepares the disc space and a single cage or interbody spacer and bone graft fuses the spine. Pedicle screws with rods or plates provide supplemental stabilization.

Minimally Invasive TLIF (Transforaminal Lumbar Interbody Fusion)

- Also known as MAST™ Transforaminal Lumbar Interbody Fusion (TLIF), ATAVITM, and other trade names by the companies that manufacture the tools and implants for the TLIF.

Recommendation:
Use CPT® 22630. Do not separately bill fluoroscopy (e.g., 77003).
Extreme Lateral Interbody Fusion (XLIF) (a.k.a. DLIF – Direct Lateral Interbody Fusion)

- XLIF, or DLIF, is a minimal access procedure performed through the side of the body (retroperitoneal).
- After discectomy, a special cage is inserted into the interbody space to provide spinal stabilization. Pedicle screws may be used for added stabilization.

**Recommendation:**
Use CPT® 22558. Do not separately bill fluoroscopy (e.g., 77003). Do not use the lateral extracavitary spine codes for these procedures.

TransS1 AxiaLIF® Fusion

- A paracoccygeal, transsacral approach to the L5-S1 interspace with a posterior incision underneath the sacrum.
- The discectomy is performed from the midline with the device coming up through the vertebral body of S1, and does not violate the annulus or surrounding tissues.
- The area around the disc, great vessels, and neural elements are typically untouched and therefore free of surgical scarring.

**Recommendation:**
Use CPT® 0195T (new in 2009) and +0196T (each additional interspace). Prior to 2009 an unlisted code, such as 22899, was recommended. Do not separately report fluoroscopy (e.g., 77003).
TransS1 AxiaLIF® Fusion

X STOP®

- A nonfusion surgical implant for use in treating lumbar spinal stenosis while preserving motion.
- X STOP® is a titanium alloy device implanted between the spinous processes.

**Recommendation:**
Use CPT® 0171T / +0172T.
Aspen™ Posterior Spinous Process Plating Device

- Non-pedicle fixation device for placement in the lumbo-sacral spine (L1-S1).
- Designed for plate attachment to spinous processes to achieve supplemental fusion in patients who suffer from degenerative disc disease and/or spondylolisthesis.
- Is used with bone graft material for a facet fusion and is not intended as a stand-alone device.

Recommendation:
Use CPT® 22899 for placing the device and the facet fusion.

Dynesys® Dynamic Stabilization System

- A pedicle-screw fixation system using an implant device consisting of a spacer, flexible cord and pedicle screw.

Recommendation:
Use CPT® +22840 or +22842 as appropriate per number of segments as an add-on code to a stand-alone procedure code. Use an unlisted code (e.g., 22899) if this is the only procedure performed, such as placement during the post-operative global period of an anterior lumbar interbody fusion. Do not separately bill fluoroscopy (e.g., 77003).
PEEK Implant with Plate/Screws

- Intervertebral body fusion device composed of a PEEK implant with an attached anterior plate or screws (that insert into the vertebral bodies above and below the level of fusion).

Examples:
Zero-P, Mosaic, STALIF, Prevail, Coalition

Recommendation:
Use +22851 alone and not +22845. If the purpose of the fixation (e.g., “plate” or buttress screw) is to hold the interbody device in place, then +22845 is not separately coded (it is incidental).

X-Close™

- Tissue repair system for closing the annulus after a discectomy.

Recommendation:
This is part of the global surgical package for performing a discectomy and not separately billable. Do not report an unlisted code such as 22899 for this activity.
ON-Q Pain Delivery System

- Intraoperative pain management is not separately reported – do not bill a separate code for this, or for placement of an intraoperative catheter for postoperative pain management.

When is a “Corpectomy” Coded as a Corpectomy?
Corpectomy Examples

- C5 corpectomy with anterior discectomies at C4-C5 and C5-C6, anterior fusion C4-C6 with placement of intervertebral cage
- Partial C4, partial C5, and partial C6 corpectomies with discectomies at C4-C5 and C5-C6, anterior fusion C4-6 with placement of PEEK devices at C4-C5 and C5-C6
- Can corpectomy codes (i.e., 63081, 63082) be used in both examples?

63081

- Vertebral corpectomy (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
- Corpectomy = the removal of the body of a vertebrae (the portion anterior to the spinal canal)
- CPT® says: Procedures 63081-63091 include discectomy above and/or below vertebral segment
Corpectomy Coding Tips

- Document removal of at least 50% of the vertebral body in the **cervical** area to justify reporting a “partial” **cervical** corpectomy code.
- Document removal of at least one-third of the vertebral body in the **thoracic** and **lumbar** spine to justify reporting a “partial” corpectomy code.
- Must be significantly greater than just removing endplates to facilitate fusion.

Corpectomy Examples Again

- C5 corpectomy with anterior discectomies at C4-C5 and C5-C6, Anterior fusion C4-C6 with placement of intervertebral cage.
- Partial C4, partial C5, and partial C6 corpectomies with discectomies at C4-C5 and C5-C6, anterior fusion C4-6 with placement of PEEK devices at C4-C5 and C5-C6.
- Can corpectomy codes be use in both examples?
Corpectomy Q&A

Q: Dr. documented partial midline C3-4 corpectomies and diskectomy. I am trying to figure out if he should code 63081 or 63075?

A1: 63081 removes the vertebrae thru the abdomen.
A2: The corpectomy is when part or all of the actual vertebral body is removed. The discectomy is when the cartilage cushion between the vertebrae (disc) is removed.
A3: If he removes 50% or more of the vertebral body, you would use 63081. If he doesn’t, then use 63075.

CPT® 2011 Update
CPT® +20930

- 2010: Allograft for spine surgery only; morselized (List separately in addition to code for primary procedure)
- 2011: Allograft, morselized, or placement of osteoporotective material, for spine surgery only (List separately in addition to code for primary procedure)
- 0 RVUs
- Why should you bill this code?

New Technology in Spine Surgery

Stereotactic Navigation

+61783  Stereotactic computer-assisted (navigational procedure; spinal (List separately in addition to code for primary procedure) (7.13 RVUs)

- CPT® +61795 was deleted in 2011
- Report when a stereotactic navigational planning system is utilized (e.g., SpineStealth)
- Do not report for use of advanced imaging (eg, FluoroNav, O-arm, Iso-C)
**New Technology in Spine Surgery**

Percutaneous Laminotomy/Laminectomy Procedures

*Use:*
- 0274T effective 7/1/11.
- Until then, use an unlisted code (22899).

**Anterior Cervical Decompression and Fusion**

- 22551 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2 (51.14 RVUs)
- +22552 cervical below C2, each additional interspace (List separately in addition to code for primary procedure) (11.92 RVUs)

May also report instrumentation and bone graft codes
# Anterior Cervical Discectomy/Decompression and Fusion with Plate and Structural Allograft

<table>
<thead>
<tr>
<th>CPT® Codes</th>
<th>2010 Billed RVUs</th>
<th>2011 Billed RVUs</th>
<th>2011 Paid RVUs</th>
<th>2011 CPT® Codes</th>
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For Updated Slides
Challenges in Coding and Reimbursement for Spine Surgery

CEU Code:

Presented to:
AAPC
Annual Meeting
Long Beach, California April 5, 2011

Presented by:
Kim Pollock, RN, MBA, CPC
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