North American Spine Society
CODING UPDATE 2017

22000 Codes
Musculoskeletal Section

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22000 Series

I&D
Excision of Bony Lesions
Osteotomies
Fractures of the Spine
Vertebroplasty/ Kyphoplasty
Arthrodesis
Disc Arthroplasty

Spine Codes

Incision
22010-22015
(work must be done below fascia)
Incision and Drainage Codes

22010
Incision and Drainage, open, of deep abscess, subfascial, posterior spine; cervical, thoracic or cervicothoracic.

22015
Incision and Drainage, open, of deep abscess, subfascial, posterior spine lumbar, sacral or lumbosacral.

Spine Codes

Bone Excision

22100 - 22226

Excision Posterior Elements Non Biopsy

22100
Partial excision posterior vertebral component for intrinsic bony lesion: Cervical

22101
Thoracic

22102
Lumbar

22103
additional segment

Not for decompression, not for biopsy, not for corpectomy

Osteoid Osteoma
Osteomyelitis
Excision Vertebral Body (Anterior) Non Biopsy

- 22110 Cervical Partial excision Vertebral body for intrinsic bony lesion
- 22112 Thoracic
- 22114 Lumbar
- 22116 additional level

Not for decompression, not for biopsy, not for corpectomy
Excision cervical osteophyte
Osteomyelitis

Osteotomy (fixed deformities)

3 column model
Osteotomy Posterior (Three Column)

22206
Osteotomy posterior three columns, thoracic, e.g. pedicle subtraction

22207
Lumbar

22208
Each additional level

Includes all bone/soft tissue decompression

Osteotomy – Posterior Column

22210
Posterior cervical

22212
Thoracic

22214
Lumbar

22216
Additional segment

Osteotomy – Anterior

22220
Cervical

22222
Thoracic

22224
Lumbar

22226
Additional segment
Spine Fracture Codes

Fracture
22305 - 22328

Fracture – Closed Treatment

22305
Closed treatment, vertebral process fractures, Spinous process & Transverse process

22310
Closed treatment, bracing/cast - No manipulation

22315
Closed treatment, bracing/cast - with manipulation

Fracture – Open Treatment Anterior

22318
Open treatment odontoid INCLUDING internal fixation, no grafting

22319
Open treatment odontoid INCLUDING internal fixation, with grafting

Only two codes here
Fracture – Open Treatment Anterior

No specific fracture treatment codes
Cervical below C2
Thoracic
Lumbar

Corpectomy codes
Discectomy codes
Fusion codes
Instrumentation codes

Fracture: Open Treatment Posterior

22325  Lumbar
Open treatment/reduction posterior one vertebra or segment

22326  Cervical

22327  Thoracic

22328  Additional segment
Jumped facets, Fracture/Dislocation
Will still code for arthrodesis and instrumentation
All above NOT for use with Vertebroplasty or Kyphoplasty

Manipulation

22505  Manipulation of spine requiring anesthesia any region
Vertebroplasty

22510 Percutaneous vertebroplasty (bone biopsy included unless performed), 1 vertebral body, unilateral or bilateral injection; including all image guidance; cervicothoracic.

22511 lumbosacral

22512 additional level

Replaces 22520-22522

Kyphoplasty

22513 Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included) using mechanical device, unilateral or bilateral, including all image guidance – thoracic.

22514 lumbar

22515 additional level

Replaces 22523-22525

Vertebroplasty/ Kyphoplasty

In other words:
It is not appropriate to code for

Bone biopsy

Radiologic Supervision

Fracture treatment

Sacroplasty: Cat. III codes 0200T and 0201T
Percutaneous Intradiscal Electrothermal Annuloplasty (IDET)

22526
Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance.

22527
One or more additional levels

CMS issued NCD (noncoverage decision) effective January 5, 2009

Arthrodesis Codes

22532 - 22812

Arthrodesis

Anterior
Direct lateral
Pre-sacral

Posterior or Posterior lateral
Trans pedicular/ Costotransversectomy
Far lateral/ Extracavitary

MUST LOOK AT OPERATIVE REPORT CAREFULLY - EASILY CONFUSED DUE TO ALL NEW “MINIMAL ACCESS” APPROACHES
Arthrodesis (Posterior) Lateral Extracavitary

22532
Arthrodesis lateral extracavitary approach, thoracic (includes minimal discectomy)

22533  Lumbar

22534  Additional level

See 63101-63103 for decompression

Arthrodesis – Anterior

22548  Anterior (above C2)
(Transoral technique C1-2….with or without excision of odontoid process)

22554  Cervical (below C2)
22556  Thoracic
22558  Lumbar
22585  Additional level

No decompression…discectomy strictly for fusion

Arthrodesis - Anterior (Including Decompression)

22551  Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophypectomy and decompression of spinal cord and/or nerve roots; cervical

22552  Cervical below C2, each additional interspace
**XLIF / DLIF**

Direct lateral approach

Dissection thru Obliques/ Transversus Abdominus muscles

*Code exactly like an ALIF*

22558

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**Arthrodesis (Pre-Sacral) Approach**

22586

Arthrodesis, pre-sacral interbody technique, includes discectomy, image guidance, bone graft & posterior instrumentation, L5-S1.

*(Cat III 0309T – L4-5 Add-on)*

DO NOT USE WITH

22840-22848 Posterior Inst codes

20930-38 Bone graft codes

No Posterior Inst use Cat III codes

0193T L5-S1 No Inst

0196T L4-5 Add-On

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**Posterior Arthrodesis (Skull, C1, C2)**

22590

Occiput - C2 posterior fusion

22595

C1-C2 posterior fusion
### Arthrodesis – Posterior/Posterolateral

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22600</td>
<td>Cervical Arthrodesis, posterior/posterolateral, cervical below C2</td>
</tr>
<tr>
<td>22610</td>
<td>Thoracic</td>
</tr>
<tr>
<td>22612</td>
<td>Lumbar</td>
</tr>
<tr>
<td>22614</td>
<td>each additional interspace</td>
</tr>
</tbody>
</table>

### Arthrodesis (Posterior) Interbody

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22630</td>
<td>Arthrodesis, posterior lumbar interbody technique including laminectomy and/or discectomy to prepare interspace (other than for decompression) single interspace, lumbar</td>
</tr>
<tr>
<td>22632</td>
<td>each additional level</td>
</tr>
</tbody>
</table>

*No prep/ fusion material in posterolateral gutters
MIS technique

### Combined Posterior Interbody/Posterolateral Arthrodesis

<table>
<thead>
<tr>
<th>Code</th>
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</tr>
</thead>
<tbody>
<tr>
<td>22633</td>
<td>Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace and segment, lumbar</td>
</tr>
<tr>
<td>22634</td>
<td>each additional level</td>
</tr>
</tbody>
</table>
Summary of Posterior Lumbar Fusion

Example

16 yo male with Grade IV-V spondy
PSF + IB L5-S1 22633
PL fusion L4-5 22614
Laminectomy L5 63012-59
IB L5-S1 22851
Inst L4-S1 22842
Local BG 20936
Cancellous allo 20930

In other words:

22614 is the additional level add-on code for posterior or posterolateral technique for fusion/arthrodesis
22632 is the additional level add-on code for PLIF
22634 is the additional level add-on code for combined PLIF and posterior or posterolateral technique for fusion/arthrodesis

*(For facet joint fusion, see 0219T-0222T)*
Arthrodesis – Spinal Deformity

**Posterior**

- 22800: 6 segments
- 22802: 7-12 segments
- 22804: 13 or more segments

*Use with Spinal deformity codes*

Arthrodesis – Spinal Deformity

**Anterior**

- 22808: 2-3 segments
- 22810: 4-7 segments
- 22812: 8 or more segments

Kyphectomy

- 22818: Circumferential exposure of spine AND resection of vertebral segment(s) up to 2
- 22819: 3 or more

*Pediatric code for Myelomeningocele patients*
Exploration

22830 Exploration of spinal fusion

(When exploration is reported with other definitive procedures, including arthrodesis and decompression, append modifier 51 to 22830)

Instrumentation Codes

22840 - 22849

Spinal Instrumentation – Posterior

22840
  Posterior Non Segmental instrumentation
  2 segments of fixation

22841
  Spinous process fixation, e.g. wiring

22842
  3-6 segments

22843
  7-12 segments

22844
  13 or more segments
Spinal Instrumentation – Anterior

22845  2-3 segments
22846  4-7 segments
22847  8 or more segments

Spinal Instrumentation – Special

22848  Pelvic fixation
22851  Application of intervertebral biomechanical device(s) (e.g., synthetic cage or methylmethacrylate) to vertebral defect or interspace - coded per interspace

Threaded Bone Dowels removed by editorial change

Spinal Instrumentation – Insertion and Removal

22849  Reinsertion of spinal fixation device (screws/plates not IB)
22850  Removal Prior to non-segmental instrumentation
22852  Removal Segmental Prior to instrumentation
22855  Removal Prior to instrumentation
New CPT language is added:

Codes 22849, 22850, 22852, and 22855 are subject to modifier 51 if reported with other definitive procedure(s), including arthrodesis, decompression, and exploration of fusion.

Code 22849 should not be reported in conjunction with 22850, 22852, and 22855 at the same spinal levels.

Example from prior

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ant Cervical fusion C6-7</td>
<td>22554</td>
</tr>
<tr>
<td>LB reinsertion C6-7</td>
<td>22851</td>
</tr>
<tr>
<td>Ant plate removal C4-C7 &amp; new plate placement C6-7</td>
<td>22849</td>
</tr>
</tbody>
</table>

Tips on Removal/ Reinsertion at same level

Only the appropriate insertion code (22840-22848) should be reported when previously placed spinal instrumentation is being removed or revised during the same session where new instrumentation is inserted at levels including all or part of the previously instrumented segments.

Do not report the reinsertion (22849) or removal (22850, 22852, 22855) procedures in addition to the insertion of the new instrumentation (22840-22848).

Disc Arthroplasty Codes

22856 - 22865
Cervical Disc Arthroplasty

22856 - Cervical TDA single level
   Includes discectomy, nerve/root decompression
   Excludes 22554, 22865, 22885, 63075

22858 second level TDA, Cervical
   (New 2015)

22861 - Revision Cervical TDA

22864 - Removal Cervical TDA
   Additional level: use T codes
   0098T for revision
   0169T for removal

Lumbar Disc Arthroplasty

22857 - Lumbar TDA
   Excludes 22558, 22845, 22851, 49010 (retroperitoneal approach)

22862 - Revision Lumbar TDA

22865 - Removal Lumbar TDA
   Additional level: use T codes
   0163T for arthroplasty
   0165T for revision
   0164T for removal

Bone Graft Codes

Non 22000
20930 - 20938
Percutaneous SI fusion

27279
Arthrodesis, SI joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed and placement of transfixing device

For bilateral procedures add modifier 50

For open SI fusion use 27280

Miscellaneous – Skull

20660 - Application Cranial Tongs

20661 - Application Halo

20664 - Application Halo 6 or More pins placed

20665 - Removal Halo/Tongs placed by another MD

Thank You
Principles of Spine Coding

- Four principal components
  - Decompression (Primary)
    - 63000 Series (Neurosurgical Section)
    - Add-On: Each additional level codes
      - No -51 modifier appended
      - Valued for intra-operative work only
  - Arthrodesis (Primary)
    - 22000 Series (Musculoskeletal)
    - Instrumentation (Add-on)
      - 22XXX Series
    - Bone Graft Harvest (Add-on)
      - 2093X Series

Choosing the Final Code

- Location (Spinal Segment)
  - Cervical, thoracic, lumbar, sacral
  - Junctions
- Surgical Approach
  - Anterior
  - Anterolateral/Lateral extracavitary
  - Transthoracic
  - Thoracolumbar/Posterior
  - Trans/Retroperitoneal
- Entry into Dura/Cord
  - Stays outside dura (extradural)
  - Cuts into dura (intradural)
  - Cuts into spinal cord (intramedullary)
- Pathology
  - Consider purpose of surgery
  - Disc
  - Neoplasm
  - Non-neoplasm
  - Vascular
Decompression Definitions

• Bone Segment
  – Single vertebra
    • Ex: L5 laminectomy
    • Anterior (Vertebral body)
    • Posterior (Pedicle, facet, lamina, sp, pars)
• Neurologic Decompression
  – Joint between adjacent segments
    • Ex: L4-L5 disc/foraminotomy
    • Nerve roots, foram
  – Interspace
    • Anterior (Disc space)
    • Posterior (Facet joint)

CPT Organization

• Percutaneous procedures
  – 62263-62319
• Posterior laminectomy for disc/stenosis
  – 63000-63066
• Anterior disc/corpectomy
  – 63075-63091
• Posterior laminectomy for neoplasm
  – 63250-63290
• Anterior corpectomy for neoplasm
  – 63300-63308
• Posterior laminectomy for CSF
  – 63170-63200
• Neurostimulators
  – 63650-63688

Percutaneous Spine

• Lumbar puncture, drainage
  – 0 Day Global
    • Lum Punct: 62270
      • wrRVU 1.37, rRVU 2.25
    • Lum Drain: 62272
      • wrRVU 1.39, rRVU 2.43
    • Blood Patch: 62273
      • wrRVU 2.15, rRVU 3.26
    • 77003 may be used
      • Fluoroscopic guidance and localization of needle or catheter tip
      • Includes injection of contrast
• Percutaneous disc decompression (Any method, laser)
  – 90 Day Global
    – 62287
      • wrRVU 9.05, rRVU 16.50
    • Reported once per session, even if multiple levels
    • Fluoroscopic guidance use 77002
    • NOTE: 62380 Endoscopic discectomy NEW for 2017
Percutaneous Disc Decompression

- Percutaneous intradiscal electrothermal annuloplasty
  - 10 Day Global
  - 22526
    - wRVU 5.85, tRVU 9.72
  - 22527 Add’l Level
    - wRVU 3.03, tRVU 4.60
    - Reported once (not per level)
    - Unilateral or bilateral
    - Do not append modifier 50
    - Includes fluoroscopy
    - Do not report 77002/77003
    - 01936
    - Anesthesia for percutaneous proc’s

Percutaneous Disc Decompression

- Percutaneous Annuloplasty (non-IDET)
  - 0062T
    - Percutaneous Intradiscal Annuloplasty, any method except electrothermal, unilateral or bilateral including fluoroscopic guidance; single level
  - 0063T
    - One or more additional levels

Endoscopic Disc Decompression

- Laminotomy, facetectomy, foraminotomy (Endoscopic)
  - 90 Day Global
  - “And Or Excision of Herniated Disc”
    - Use 62287 if percutaneous
  - 62380 L only
    - Carrier-priced
    - Endoscopic: continuous direct visualization via endoscope
    - Open: direct visualization through surgical opening
    - Percutaneous: indirect visualization
    - Unilateral code, -50 for bilateral
    - Do not report with 63030, 63056
Disc Decompression

- Laminotomy, facetectomy, foraminotomy (Open)
  - 90 Day Global
  - “And/Or Excision of Herniated Disc”
    - Use 63045-63048 if without disc excision
    - 63020 C
      - wRVU 16.20, tRVU 33.81
    - 63030 L
      - wRVU 13.18, tRVU 28.20
    - 63035 C/L add’l level (No -51)
      - wRVU 3.15, tRVU 5.61
      - Includes use of endoscope
      - Do not refer to as “Percutaneous, Endoscopic”
      - Unilateral codes, -50 for bilateral

Laminotomy - Disc

- Laminotomy (hemilam) with decompression and/or excision, re-exploration, single interspace
  - More than 90 days, later
  - Unilateral codes, -50 modifier if bilateral
  - 63040 C
    - wRVU 20.31, tRVU 40.58
  - 63043 C Add-on level
    - No -51, Carrier-priced
  - 63042 L
    - wRVU 18.76, tRVU 37.67
  - 63044 L Add-on level
    - No -51, Carrier-priced
  - Re-do laminectomy (uni or bilateral) without disc excision should use 63045-63048.

Laminectomy

- Laminectomy only, 1-2 segments
  - Central stenosis, decompression
    - Does not include facetectomy, foraminotomy or discectomy.
    - Partial laminectomy use 63020-63035, 63045-63048.
  - 63001 C
    - wRVU 17.61, tRVU 36.23
  - 63003 T
    - wRVU 17.74, tRVU 36.18
  - 63005 L (Except for spondylolisthesis)
    - wRVU 16.43, tRVU 34.45
  - 63011 S
    - wRVU 15.91, tRVU 31.72
Laminectomy

- Laminectomy only, > 2 segments
  - Central stenosis, decompression
    - Does not include facetectomy, foraminotomy or diskectomy.
    - Partial laminectomy use 63020-63035, 63045-63048.
  - 63015 C
    - wRVU 20.85, tRVU 43.30
  - 63016 T
    - wRVU 22.03, tRVU 44.52
  - 63017 L
    - wRVU 17.33, tRVU 36.67
    - Use 63012 if laminectomy for spondylolisthesis (Gill) and/or

Laminectomy for Spondylolisthesis

- 63012 (Gill Procedure)
  - Laminectomy with removal of abnormal facets and/or pars interarticularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar
    - wRVU 16.85, tRVU 34.69
  - May not report bilateral (No -50 modifier)
  - Used for diagnosis of spondylolisthesis, spondylosis, spondylosis
    - Not for disc disease or stenosis only

Laminectomy

- Laminectomy, facetectomy and foraminotomy, w/decomp
  - Diagnosis: Spinal or lateral recess stenosis
    - Use 63001-63011, 63015-63017 if no facetectomy, foraminotomy or diskectomy performed
  - Unilateral or bilateral
    - 63045 Cervical
      - wRVU 17.95, tRVU 37.58
    - 63046 T
      - wRVU 17.25, tRVU 35.58
    - 63047 L
      - wRVU 15.37, tRVU 32.06
    - 63048 C/T/L each additional (No -51)
      - wRVU 3.47, tRVU 6.19
    - 2008 change allowed add-on instrumentation codes (22840-22855) without a fusion
Laminoplasty

- Cervical spine
  - 2 or more segments
  - Foraminotomies not included
  - Alternative technique to 63001/63015
- 63050 Laminoplasty with decompression
  - wRVU 22.01, tRVU 43.79
- 63051 With reconstruction of posterior bony elements including miniplates and placing bone
  - wRVU 25.51, tRVU 49.79
  - Bone graft may be reported separately.
- Do not code with another decompression or instrumentation code at same level/segment.
  - For stenosis, if osteoplastic reconstruction after another primary intraspinal procedure then use 63205

Posterior/Post. Lat. Approach

- Transpedicular approach with decompression
  - Including transfacet, lat extrafacet approach
  - For lateral intervertebral disc, corpectomy
  - For excision of intraspinal lesions use 63210-63290
  - Bilateral code, disk or body
  - Unilateral typically does not remove much lamina
    - 63055 T
      - wRVU 23.55, tRVU 47.59
    - 63056 L
      - wRVU 21.86, tRVU 43.21
    - 63057 Each additional level
      - No -51, use for each add’l segment T or L
      - wRVU 5.25, tRVU 9.37

- Costovertebral approach with decompression
  - Costovertebral, costotransversectomy, costotransfacet
  - Herniated disk, corpectomy
    - For excision of intraspinal lesions use 63250-63290
    - 63064 T
      - wRVU 26.22, tRVU 51.75
    - 63066 Each additional level
      - No -51 as it is an add-on code
      - wRVU 3.26, tRVU 6.08
Lateral Extracavitary

- Lateral extracavitary approach
  - Vertebral corpectomy, partial or complete, LEC approach with decompression
  - Unilateral code
  - Disk or body for decompression
  - Typically for tumors, fractures
  - Not XLIF or AxiaLIF
- 63101 T
  - wRVU 34.10, rRVU 67.55
- 63102 L
  - wRVU 34.10, rRVU 66.29
- 63103 Each additional level
  - wRVU 4.82, rRVU 8.57

Note similar arthrodesis codes, microscope.

Anterior Approach

- Diskectomy, anterior, with decompression, including osteophytectomy
  - Microdissection (69990) included.
  - Arthrodesis use 22554-22885.
  - Bone graft use 20930-20938.
- 63075 C
  - wRVU 19.60, rRVU 39.44
- 63076 C Each add’t level (No -51)
  - wRVU 4.04, rRVU 7.26
- 63077 T
  - wRVU 22.88, rRVU 43.40
- 63078 T each additional (No -51)
  - wRVU 3.28, rRVU 5.67

Corpectomy via Approach

- Vertebral corpectomy, part or comp, ant appr, w/ decomp

  Notes
  - Includes diskectomy above a/o below segment.
  - Cop for exc of imagy tissue use 63700-63708.
  - Transoral approach use 64378-64376.
- 63081 C (Ant-AntLat)
  - wRVU 26.10, rRVU 51.19
- 63083 T (Ant-AntLat) (Thoracic) (Transverse)
  - wRVU 29.47, rRVU 55.80
- 63087 TL (Thoracolumbar)
  - wRVU 37.35, rRVU 70.26
- 63090 L (Trans/retroperitoneal)
  - wRVU 30.93, rRVU 56.83
  - Additional Levels (No -51)
    - 63082 C, 63084 T, 63086 TL, 63091 L.
Corpectomy - How Much?

- Cervical Corpectomy
  - 1/2 or more
- Thoracic & Lumbar Corpectomy
  - 1/3 or more
- Includes discectomies above and below

Laminectomy (Vascular)

- Irrespective of number of lamina excised
  - No additional segment or interspace codes
- Vascular malformation
  - 63250 C
    - wRVU 43.86, tRVU 87.67
  - 63251 T
    - wRVU 44.64, tRVU 88.74
  - 63252 L
    - wRVU 44.63, tRVU 89.06

Laminectomy (Non Neoplasm)

- No add’l seg or intersp codes
- Extradural, non-neoplasm
  - Include cysts, hematomas, and other masses.
  - Synovial cysts may be reported with this or laminectomy code.
  - 63265 C
    - wRVU 23.82, tRVU 48.79
  - 63266 T
    - wRVU 24.68, tRVU 50.28
- Intradural, non-neoplasm
  - 63270 C
    - wRVU 29.80, tRVU 60.97
  - 63271 T
    - wRVU 29.92, tRVU 60.42
  - 63272 L
    - wRVU 27.50, tRVU 55.20
  - 63273 S
    - wRVU 26.47, tRVU 53.65
Laminectomy (Neoplasm)

- Irrespective of number of laminae excised
- Extradural, neoplasm
  - 63275 C
    - wRVU 25.86, tRVU 52.60
  - 63276 T
    - wRVU 25.69, tRVU 52.31
  - 63277 L
    - wRVU 22.39, tRVU 45.25
  - 63278 S
    - wRVU 22.12, tRVU 46.28
- Intradural, extramedullary neoplasm
  - 63280 C
    - wRVU 30.29, tRVU 61.81
  - 63281 T
    - wRVU 29.99, tRVU 61.34
  - 63282 L
    - wRVU 26.76, tRVU 55.34
- Intradural, intramedullary neoplasm
  - 63285 C
    - wRVU 38.05, tRVU 77.21
  - 63286 T
    - wRVU 37.39, tRVU 75.22
  - 63287 TL
    - wRVU 40.06, tRVU 81.02
- Combined intra/extradural
  - 63290 CTLS
    - wRVU 40.82, tRVU 81.98

Laminoplasty

- Add-on code
  - List separately in addition to code for primary procedure
  - Developed for tumor reconstruction
  - Osteoplastic reconstruction of dorsal spinal elements following primary intraspinal procedure
  - Do not code with fusion, instr, decom at the same vertebral segment.
- 63295
  - wRVU 5.25, tRVU 9.82
  - NOT 63050 or 63051!

Corpectomy (Neoplasm)

- Code each vertebral segment excised
  - Use 63290 if combined with lam for 5/c of intraspinal lesion of any level.
  - 63300 C (Ant-AntLat)
    - wRVU 26.80, tRVU 53.59
  - 63301 T (Transthoracic)
    - wRVU 31.57, tRVU 60.67
  - 63302 TL (Posterior)
    - wRVU 31.15, tRVU 63.13
  - 63303 L/S (Retrotransperitoneal)
    - wRVU 33.65, tRVU 66.02
- Intraspinal and intradural
  - 63304 C (Ant-AntLat)
    - wRVU 33.85, tRVU 67.99
  - 63305 T (Transthoracic)
    - wRVU 36.24, tRVU 70.45
  - 63306 TL (Posterior)
    - wRVU 35.55, tRVU 60.43
  - 63307 L/S (Retrotransperitoneal)
    - wRVU 34.96, tRVU 63.37
- Each additional level, intraspinal (Either ED/ID)
  - No -5
  - 63308 CTLS
    - wRVU 5.24, tRVU 9.47
Laminectomy (CSF)

- Irrespective of number of segments
- Shunt syrinx (includes laminectomy)
  - 63172 subarach
  - wRVU 19.76, tRVU 41.31
  - 63173 pleural/peritoneal
  - wRVU 24.31, tRVU 50.06
- Shunt CSF, lumboperitoneal shunt
  - 63740 with lami
  - wRVU 12.63, tRVU 27.28
  - 63741 without lami
  - wRVU 9.12, tRVU 19.69
  - 63744 revise, replace
  - wRVU 8.94, tRVU 19.27
  - 63746 remove w/o replace
  - wRVU 7.33, tRVU 17.60
- Repair dura/CSF leak
  - 63707 without lami
  - wRVU 12.65, tRVU 26.77
  - 63709 with lami
  - wRVU 15.65, tRVU 33.02
- 63710 spinal dural graft
  - wRVU 15.40, tRVU 31.47

Other Spine

- Computer-assisted Navigation 61783
  - No -51 modifier
  - Brain surgery using computer
  - wRVU 3.75, tRVU 6.83
  - Local coverage policies (Noridian, WPS)
- Microdissection 69990 (Microsurgery add-on)
  - Included in 63075-77
  - No -51 modifier
  - wRVU 3.46, tRVU 6.43
- Unlisted 64999 (Nervous System Surgery)
  - Carrier-priced

THANK YOU
Office of the Inspector General

**OIG Work Plan**

- 1,700 professionals—Conduct investigations, audits and evaluations aimed at identifying and fighting fraud, waste and abuse.
- Each year they develop a Work Plan in October which includes new and ongoing enforcement projects and high risk areas of activity they will be investigating in the upcoming fiscal year and reason why.
- OIG also reports to Congress twice a year via a second publication called the Semi-annual report which summarizes the OIG’s most significant findings and recommendations as well as investigative outcomes and outreach activities.
- A third publication, the Compendium of Unimplemented Recommendations, describes open recommendations from prior periods.
- All three serve to inform Congress on the OIG’s completed work and findings, their enforcement actions and recommendations, and how the HHS can save money and improve the Medicare and Medicaid programs.

**Office of the Inspector General**

**FY 2016 Accomplishments**

(OIG'S Semiannual Report form April 1, 2016-September 30, 2016)

- For first half of FY 2016, the OIG reported expected recoveries of over $5.66 billion
  - $1.2 billion in audit receivables
  - $4.46 billion in investigative receivables
  - $953 million in non-HHS investigative receivables resulting from our work in areas such as the States’ shares of Medicaid restitution
- 3,635 individuals and entities excluded from participation in Federal health care programs
- 844 criminal actions against individuals or entities that engaged in crimes against HHS programs
- 708 civil actions, which include false claims and unjust enrichment lawsuits filed in Federal district court, CMP settlements, and administrative recoveries related to provider self-disclosure matters.
In June 2016 the Health Care Fraud Strike Force led an unprecedented nationwide sweep in 36 Federal districts, with the assistance of 24 State Medicaid Fraud Control Units (MFCU). The sweep resulted in criminal and civil charges against 301 individuals, including 61 doctors, nurses, and other licensed medical professionals, for their alleged participation in health care fraud schemes involving approximately $900 million in false billings. For more information on this takedown, visit the Strike Force website at https://oig.hhs.gov/fraud/strike-force/highlights.html?width=600&height=540

OIG Work Plan

PAST TOPICS

Physicians: Incident-To Services—To determine whether payment for services had a higher error rate than that for non-incident-to services. A 2009 OIG review found that when Medicare allowed physicians’ billings for more than 24 hours of services in a day, half of the services were not performed by a physician. They also found that unqualified nonphysicians performed 21 percent of the services that physicians did not perform personally.

Physician-Owned Distributors of Spinal Implants—Review and determine the extent to which physician-owned distributors (POD) provide spinal implants purchased by hospitals. Determine whether PODs were associated with high use of spinal implants. Congress has expressed concern that PODs could create conflicts of interest and safety concerns for patients.

Evaluation and Management Services—Use of Modifiers During the Global Surgery Period. The global surgery payment includes a surgical service and related preoperative and postoperative E/M services provided during the global surgery period.

OIG Work Plan

RECENT TOPICS

Evaluation and management services—Review of multiple E/M services associated with the same providers and beneficiaries to determine the extent to which electronic or paper medical records had documentation vulnerabilities. Context—Medicare contractors noted an increased frequency of medical records with identical documentation across services.

Electrodiagnostic testing—Questionable billing and payments. Review of Medicare claims data to identify questionable billing for electrodiagnostic testing and determine the extent to which Medicare utilization rates differ by provider specialty, diagnosis, and geographic area for these services. Context—The use of electrodiagnostic testing for inappropriate financial gain could pose a growing vulnerability to Medicare.
OIG Work Plan

- **Chiropractic services—Part B Payments for Noncovered Services.** Medicare's covered chiropractic services include only treatment by means of manual manipulation of the spine to correct subluxation if there is a neuro-musculoskeletal condition for which such manipulation is appropriate treatment. Chiropractic maintenance therapy is not considered to be medically reasonable or necessary and is therefore not payable.

- **Chiropractic services—Questionable billing.** Previous OIG work demonstrated a history of vulnerabilities relative to inappropriate payments for chiropractic services, including recent work that identified a chiropractor with a 93-percent claim error rate and inappropriate Medicare payments of about $700,000. Although chiropractors may submit claims for any number of services, Medicare reimburses claims only for manual manipulations or treatment of subluxations of the spine that provides "a reasonable expectation of recovery or improvement of function."

DATA BRIEF—High Part D Spending on Opioids and Substantial Growth in Compounding Drugs

- Medicare Part D spending for commonly abused opioids exceeded $4 billion in 2015, and spending for compounded topical drugs increased more than 3,400 percent since 2006.

- This data brief builds on OIG's June 2015 data brief, which described trends in Part D spending and identified questionable billing by pharmacies.

- It updates information on spending for commonly abused opioids and provides data on the dramatic growth in spending for compounded drugs.

- OIG will conduct investigations and reviews to address the ongoing problems created by opioid abuse and the emerging problems linked to compounded drugs.

- CMS has already taken steps to combat the problems associated with commonly abused opioids, such as identifying outlier prescribers. However, the data brief concluded that CMS needs to take additional action.

- CMS also needs to assess the implications of the compounded drug trends identified in this data brief and take action where needed to protect the integrity of the program.

OIG WORK PLAN

**Payments to providers and nonphysician practitioners who order and refer Medicare services and supplies.** CMS requires that physicians and nonphysician practitioners who order certain services, supplies, and/or durable medical equipment (DME) be Medicare-enrolled physicians or nonphysician practitioners. Under this Work Plan target, the OIG will review select Medicare services, supplies, and DME to determine whether the payments made to the providers were in accordance with Medicare requirements. In other words, were the providers who billed these charges legally allowed to do so? If providers in your practice order such supplies and equipment, but are not enrolled in the Medicare program, that's a problem. If your practice has ineligible providers who have ordered and have been paid for these services and supplies, it may be at risk for an audit or payback.
SITE OF SERVICE CODING ISSUES

- The place of service can greatly affect reimbursement.
- Medicare reimburses physicians based on Relative Value Units (RVUs). An RVU has three components: work, practice expense, and malpractice. The place of service is part of the practice expense component, and procedures that can be performed in either a facility or nonfacility setting have different practice expense RVUs, depending on the place of service.

INPATIENT

- CMS’ Inpatient Prospective Payment System
  - Hospitals agree to pre-determined rates in order to serve Medicare patients.
  - About 3,400 acute-care hospitals and 435 long-term care hospitals receive payments under the IPPS.
  - Hospitals generally receive IPPS payment on a per-discharge or per-case basis for Medicare beneficiary inpatient stays.
  - Discharges are assigned to diagnosis-related groups, which sorts them by similar clinical conditions and procedures administered by the hospital during the stay.
CMS identifies services that should be performed in the inpatient setting. These services are itemized on the inpatient list, also known as the inpatient-only list.

Services will only be reimbursed to hospitals if they are provided in the inpatient setting. Services are included based on:

- The nature of the procedure
- The underlying physical condition of the patient
- The need for at least 24 hours of postoperative recovery time or monitoring before safe discharge

Medicare will not pay the facility for inpatient list services if they are provided outside of the inpatient setting.

The inpatient list does not affect physician reimbursement. If the medical record documents the medical necessity of a service, then the physician will typically receive the Medicare Part B reimbursement for an inpatient list service, regardless of the setting.

CMS maintains and updates the list annually as part of the OPPS rulemaking process.

As long as the medical record shows that the service was medically necessary, the physician and the hospital will generally be reimbursed.

Other factors could prevent a hospital from receiving full reimbursement for services provided in the inpatient setting that are not on the inpatient list.

- A RAC audit might determine that an inpatient admission was not medically necessary. Surgeons should clearly document both the medical necessity of the procedure as well as the medical necessity of the inpatient admission.
Where can I find the inpatient list?

- The list is included as Addendum E to the hospital OPPS rule and is posted on the CMS website under the “Hospital Outpatient Regulations and Notices” tab. (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html)

- On the same CMS website, under the ‘Addendum A and Addendum B Updates’ tab, Addendum B lists the payment status indicator (SI) for all CPT codes. The payment SIs are updated quarterly and indicate whether a service is payable under the Inpatient PPS, the Hospital Outpatient PPS, or another payment system.

- If a code has the SI of “C,” that code is on the inpatient list and the facility will receive payment only if performed in the inpatient setting.

- If a code has the SI of “T, J1, N,” the code is payable under the Hospital Outpatient PPS, but may also be paid under the Inpatient PPS.
Addendum B. Final OPPS Payment by HCPCS Code for CY 2016

Data Addendum B. Data Status Indicators, Data APC Assignments and Comment Indicators Used in the Development of the Geometric Mean Costs for HCPCS codes and APCs for CY 2016

Short Describer 2016 NPRM Data SI

• If a code has the SI of "C," that code is on the inpatient list and the facility will receive payment only if performed in the inpatient setting.
• If a code has the SI of "T, J1, N" the code is payable under the Hospital Outpatient PPS, but may also be paid under the Inpatient PPS.

Status Indicators

T – Procedure or Service, Multiple Procedure Reduction Applies
Paid under OPPS; separate APC payment.

N – Items and Services Packaged into APC Rates Paid under OPPS; payment is packaged into payment for other services. Therefore, there is no separate APC payment.

J1 – Hospital Part B services paid through a comprehensive APC Paid under OPPS; all covered Part B services on the claim are packaged with the primary "J1" service for the claim, except services with OPPS SI = F, G, H, L and U; ambulance services; diagnostic and screening mammography; all preventive services; and certain Part B inpatient services.

C – Inpatient Procedures Not paid under OPPS. Admit patient. Bill as inpatient

OUTPATIENT

More than 4,000 hospitals receive reimbursement through Medicare’s Outpatient Prospective Payment system.

Provides payment for most hospital outpatient department services and partial hospitalization services administered by hospital outpatient departments and community mental health centers.

OPPS rates vary depending on ambulatory payment classification groups for procedures and services.
CRITERIA CMS USES WHEN DETERMINING WHETHER TO REMOVE A PROCEDURE FROM THE INPATIENT ONLY LIST

CMS uses the following criteria:

- Most outpatient departments are equipped to provide the services to the Medicare population
- The simplest procedure described by the CPT code be performed in most outpatient departments
- The procedure is related to codes that CMS has already removed from the inpatient list
- The procedure is being performed in numerous hospitals on an outpatient basis
- The procedure can be performed appropriately and safely in an ASC and is on the list of approved ASC procedures, or CMS has proposed that it be added to the ASC list

There are more than 5,300 Medicare–certified ASCs paid under the OPPS. OPPS payment amounts vary based on the APC groups to which services or procedures are assigned.

Earlier this summer, in the same rule that included proposed payment and policy changes for hospital outpatient departments, CMS released proposed payment and policy updates for ASCs for 2015.

Addendum AA—Proposed ASC Covered Surgical Procedures for CY 2017 (Including Procedures for Which Payment Is Package)
### Changes for 2017

- **Removal of Spine Codes from the Inpatient-Only List.**
  - CMS has removed the following spine codes from the inpatient-only list:
    - CPT 22840 (Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation) (List separately in addition to code for primary procedure));
    - CPT 22842 (Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure));
    - CPT 22845 (Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure));
    - CPT 22858 (Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (List separately in addition to code for primary procedure))

- **CMS has added the following spine codes to the list of ASC Covered Surgical Procedures:**
  - 20936 Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from the same incision (List separately in addition to code for primary procedure)
  - 20937 Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)
  - 20938 Autograft for spine surgery only (includes harvesting the graft); structural, biocortical or tricortical (through separate skin fascial incision)
  - 22552 Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots, cervical C2, each additional interspace (List separately in addition to code for separate procedure)
  - 22840 Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)
  - 22842 Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)
  - 22845 Anterior instrumentation; 2 to 3 vertebral segments (List separately in addition to code for primary procedure)
  - 22851 Application of intervertebral biomechanical devices (eg, synthetic cages, multilevel/segmental to vertebral defect or interspace (List separately in addition to code for primary procedure))
WHY THIS MAKES A DIFFERENCE

› The Medicare program currently pays significantly different rates for the same services provided in different settings.

› According to the Medicare Payment Advisory Commission, Medicare paid hospital outpatient departments 78 percent more on average than ambulatory surgery centers for the same procedure in 2013.

DOCUMENTATION

› Denials today are becoming increasingly more common.
› One of the top reasons for denials is documentation or…. lack thereof
› WHY???
   ◦ Medical terminology doesn’t match the insurance company’s medical guidelines terminology for approval
   ◦ Documentation does not support the performance of the service.
   ◦ Documentation does not support medical necessity

DOCUMENTATION

› Medical terminology does not match the insurance company’s medical guidelines terminology for approval

   › USE CPT LANGUAGE

   ◦ INCORRECT - “L4–5 Spinal Stenosis Decompression”
   ◦ There are several different CPT codes for decompression that could be used to code this procedure
   ◦ CORRECT - “L4–5 Partial Laminectomy, Facetectomy, Foraminotomy for Stenosis Decompression”
**PREOPERATIVE DIAGNOSES:**
- L5 spinal stenosis, right lateral recess, secondary to ligamentum flavum infolding and hypertrophy, facet capsular and bony hypertrophy, neuroforaminal narrowing secondary to disc space height collapse and bulging
- Right leg radiculopathy/ radiculitis.
- Lesser Mechanical back pain.
- Epidural Fibrosis previous Laminectomy L5

**PROCEDURES:**
- L5 right unilateral spinal stenosis decompression: partial laminectomy, partial facetectomy, partial foraminotomy with decompression of cauda equina and nerve roots.
- Microscopic lysis of neural and vascular adhesions.

**DOCUMENTATION**
- Medical terminology doesn’t match the insurance company’s medical guidelines terminology for approval
- Documentation does not support the performance of the service
- When dictating, if a procedure appears in the procedure section of the operative report, make sure it also appears in the body of the report.
PREOPERATIVE DIAGNOSES:
- L5 spinal stenosis, right lateral recess, secondary to ligamentum flavum infolding and hypertrophy, facet capsular and bony hypertrophy, neuroforaminal narrowing secondary to disc space height collapse and bulging.
- Right leg radiculopathy/ radiculitis.
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PROCEDURES:
- L5 right unilateral spinal stenosis decompression: partial laminectomy, partial facetectomy, partial foraminotomy with decompression of cauda equina and nerve roots.
- Microscopic lysis of neural and vascular adhesions.

FINDINGS:
- Specific Findings/ Items of note include: Degenerative and mild congenital L5 nerve root compression and right lateral recess spinal stenosis was seen secondary to ligamentum flavum hypertrophy, facet capsular and bony hypertrophy, disc bulging, and foraminal narrowing secondary to disc space height loss, in addition to a boney osteophyte.
- Intra-canal decompression was performed using the microscope. Microscopic lysis of neural and vascular adhesions was performed using micro-instruments, including the Rhoton microscopic instruments (curettes and nerve hooks, etc.); the decompression was tedious because of the epidural fibrosis from the previous surgery. The micro-instruments were used to perform fine dissection of the neural and vascular structures and epidural fibrosis adhesions. The microscope was necessary, as the neural and vascular structures dealt with, as well as the epidural fibrosis adhesions, were too small to be safely seen and operated without the microscope.
- The L5 nerve root was seen to be compressed, and after the procedure were visualized as being decompressed.

Decompression Details
- Lumbar neural decompression of the stenosed L5 was then performed by partial laminectomies, partial facetectomies, and partial foraminotomies, as well as the excision of all neurologically compressive soft tissues. Ligamentum flavum and portions of the anterior facet capsule were resected as necessary to effect neurologic spinal stenosis decompression. Throughout the laminectomy procedures, the pars interarticularis were identified and carefully preserved.
- A right L5 laminectomy was performed. Using a combination of the high-speed diamond burr, Kerrison ronguers, and spinal micro-curettes and nerve hooks, partial inferior laminectomy was performed sufficient to expose the ligamentum flavum and safely resect it, revealing the cauda equina dura below. Decompressive partial medial facetectomy and foraminotomy were then performed, exposing laterally enough to reveal the exiting L5 nerve root, which was visualized as being compressed. This root was visualized and decompressed of bony and soft tissue stenotic elements, sufficient to relieve all spinal stenosis affecting the nerve root. At the end of this decompression portion of the procedure, the neural elements were free and clear of compression, impingement, or obstruction.
DOCUMENTATION

- Medical terminology doesn’t match the insurance company’s medical guidelines terminology for approval
- Documentation does not support the performance of the service.
- Documentation does not support medical necessity

PREOPERATIVE DIAGNOSES:
- L5 spinal stenosis, right lateral recess, secondary to ligamentum flavum infolding and hypertrophy, facet capsular and boney hypertrophy, neuroforaminal narrowing secondary to disc space height collapse and bulging
- Right leg radiculopathy/ radiculitis.
- Lesser Mechanical back pain.
- Epidural Fibrosis previous Laminectomy L5

PROCEDURES:
- L5 right unilateral spinal stenosis decompression: partial laminectomy, partial facetectomy, partial foraminotomy with decompression of cauda equina and nerve roots.
- Microscopic lysis of neural and vascular adhesions.

INDICATIONS FOR THE PROCEDURE:
- For the full indications for this surgery, please see the office notes.
- This patient has the diagnoses outlined above in the “Preoperative Diagnoses,” confirmed on X-ray and MRI and EMG, and has corresponding symptoms and examination findings consistent with an L5 Radiculopathy including muscle weakness and sensory deficit. She has residual back pain and L5 dermatomal radicular symptoms for over six months that have been refractory to multiple conservative approaches to pain, including steroid injections, oral medication, activity restrictions, home based exercise programs, and a rehabilitation-based physical therapy program including a home based exercise program, as well as epidural steroid injections which afforded no significant relief. Indeed, these symptoms are worsening and interfering greatly with daily activities. At this point in time, after failing a conservative approach to the problems outlined above, the patient has elected to proceed with the surgery as outlined above.

DOCUMENTATION

- Documentation does not support Medical Necessity
- Review Coverage Policies and Document Criteria for Medical Necessity
- To support medical necessity the physician must submit information such as:
  - History including the duration/character/location/radiation of pain
  - Any limitation of activities of daily living
  - Physical examination, and imaging reports specific to the surgical procedure
  - Conservative Therapy Course - History and Duration
In an October 2013 Pre-Payment Review, Medicare MAC Palmetto GBA either completely or partially denied 168 out of 251 Spinal Fusion claims (65%), rejecting $4.15 million out of $6.36 million in claims due to insufficient MND.

Some of the latest MAC Recovery Audit findings have revealed high percentages of Medical Necessity Documentation (MND) errors in Pre- & Post-Payment reviews of Spinal Fusion procedure DRG-460.

Deficiencies in MND lead to respectively reported error rates of 73% and 64% in Post-Payment reviews by Medicare MAC’s

MAINTAIN DOCUMENTATION IN THE MEDICAL RECORDS THAT SUBSTANTIATES THE NEED FOR LUMBAR SPINAL FUSION SURGERY

Office notes/hospital record, including history and physical

Documentation of the history and duration of unsuccessful conservative therapy (non-surgical medical management) when applicable. This therapy does not have to be under the direction of the operating surgeon.

Interpretation and reports for X-rays, MRI’s, CT

How to avoid an audit or recoupment

Documentaion of smoking history, and that the patient has received counseling on the effects of smoking on surgical outcomes and treatment for smoking cessation if accepted (if applicable)

Complete operative report outlining operative approach used and all the components of the spine surgery

Medical record documentation must be made available to Medicare upon request. If documentation does not meet the criteria for the service(s) rendered or if documentation does not establish the medical necessity for the service(s), such service(s) will be denied as not reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act Appendices
SPINAL FUSION DOCUMENTATION

- The most common reason for denial of spinal fusion services is lack of specific information regarding conservative treatment attempted and failed prior to surgery.
  - Documentation of prior conservative treatments attempted or completed and if not done:
  - Documentation of a condition that would make conservative treatment inappropriate.
- "Failed conservative/outpatient treatment" is not sufficient evidence of medical necessity for the procedure or inpatient admission.
- Conservative treatment documentation should include:
  - Physical Therapy
  - Occupational Therapy
  - Joint Injections/Epidural Injections
  - Anti-inflammatory/Analgesic medications
  - Assistive device use
  - Activity modification
  - Exercise

KEY SPINE RELATED DOCUMENTATION ISSUES

- CORPECTOMY CODES 63081 AND 63090
  - Must document % of vertebral body resected
    - Cervical Spine – 1/2
    - Lumbar Spine – 1/3

- 63047 AND 63048 FOR L4, L5 PARTIAL LAMINECTOMIES, FACETECTOMIES, FORAMINOTOMIES
  - Documentation to include that compression was noted on both individual nerve roots, that decompression was performed of both nerve roots, that each nerve root was visualized and that nerve roots were free of compression at conclusion of procedure

- OSTEOTOMY CODES 22214
  - Documentation must describe actual Osteotomy including resection of the Supra-spinous ligament, Intra-spinous ligament, ligamentum flavum, and superior and inferior articular processes
  - TAKING OFF OSTEOPHYTES DOES NOT CONSTITUTE AN OSTEOTOMY

CODING TOOLS

- SURGERY REIMBURSEMENT SHEET
- CCI SPINE EDITS
- E&M POCKET GUIDE
- ICD-9/ICD-10 CODE CROSSWALKER
- ICD-10 COMMON SPINE CODES
- AUTHORIZATION TEMPLATE LETTER
- DENIAL TEMPLATES
- SURGERY PRE-AUTHORIZATION TEMPLATE
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**Note:**

- *PTP code pair should be paid for the same beneficiary on the same day by the same provider.*
- *Column 2 code is denied. However, if both codes are clinically appropriate and an appropriate NCCI code pair is used, the denial may be rescinded.*
- *If a provider submits the two codes of an edit pair for payment for the same beneficiary on the same date of service, the Column 2 code is denied.*

**Indicators:**

- **(Not Allowed)**: There are no modifiers associated with NCCI that are allowed to be used with this PTP code pair; there are no clinical circumstances in which both procedures of the PTP code pair were deleted retroactively.
- **(Not Applicable)**: This indicator means that an NCCI edit does not apply to this PTP code pair. The edit for this PTP code pair was deleted retroactively.
- **(Allowed)**: The modifiers associated with NCCI are allowed with this PTP code pair when appropriate.
ICD–10 Coordination and Maintenance Committee

The ICD–10 Coordination and Maintenance Committee (C&M) is a Federal interdepartmental committee comprised of representatives from the Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention’s (CDC) National Center for Health Statistics (NCHS).

The committee is responsible for approving coding changes, developing errata, addenda and other modifications. Requests for coding changes are submitted to the committee for discussion at either the Spring or Fall C&M meeting.

Coordination and Maintenance Committee Meetings

The Committee provides a public forum to discuss proposed changes to ICD–10. The first day of the meeting is devoted to procedure code issues and is led by CMS. The second day is devoted to diagnosis code issues and is led by CDC. Tentative agendas for the meetings are posted one month in advance of the scheduled meetings.

CMS ICD–10–CM/PCS Coordination and Maintenance Committee meeting occurred on March 7 and 18. Next meeting in September

ICD–10–PCS Procedure Code Revisions

The request for a procedure code change should be submitted at least two months prior to the C&M meeting. The request should include the following in a background paper:

- **Issue:** Describe the procedure and why current ICD–10–PCS codes do not adequately capture the procedure
- **Background:** Provide detailed background information describing the procedure, patients on whom the procedure is performed, outcomes, any complications, and other relevant information. If this procedure is a significantly different means of performing a procedure that is already described in ICD–10–PCS, this difference should be clearly described. The manner in which the procedure is currently coded should be described along with information from the requestor on why they believe the current code is not appropriate.
- **Options:** Possible new or revised code titles should then be recommended.

THERE ARE VARIOUS RESOURCES AVAILABLE TO AID WITH ICD–10

CMS ICD–10 Issue Reporting

ICD-10 Resources

- ICD-10 coding resources for Providers: [https://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html](https://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html)
- AHIMA is providing coding advice for a fee through their Code Check service. You can learn more information at this link: [https://www.cms.gov/Medicare/Coding/ICD10/2016](https://www.cms.gov/Medicare/Coding/ICD10/2016)
- For questions about Claims Processing and Payment or Local Coverage Determinations contact your Medicare Administrative Contractor (MAC) for guidance. You can find the list of MACs at this link: [https://www.cms.gov/Medicare/Coding/ICD10/Provider-Contact-Table.pdf](https://www.cms.gov/Medicare/Coding/ICD10/Provider-Contact-Table.pdf)
- For requests to update the ICD-10 CM codes, please note The Centers for Disease Control and Prevention (CDC) is responsible for the development and maintenance of ICD-10 CM. For requests to update the ICD-10 CM codes, please contact Donna Pickett, CDC [https://www.cdc.gov](https://www.cdc.gov)

### Appeal Letter for Modifier 59

```
<table>
<thead>
<tr>
<th>Date</th>
<th>Attn: _____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provider Appeals Department</td>
</tr>
</tbody>
</table>

We hereby request that your medical review area or other pertinent authorization department review this documentation in order to process this request. This letter documents our use of CPT modifier 59 reported with the ICD-10 code(s) to indicate that the services are not typically performed together and should be recognized and the code paid.

```

### SUGICAL PREAUTHORIZATION REQUEST

```
<table>
<thead>
<tr>
<th>Claim Date:</th>
<th>Patient Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________</td>
<td>______________</td>
</tr>
</tbody>
</table>

Preauthorization #: _________________________________________

Subject: Denial of CPT code with modifier 59

We hereby request that your medical review area or other pertinent authorization department review and handle the preauthorization for this procedure(s). This patient has been seen and evaluated by our physician _______________________, and as a result of that evaluation the procedure(s) were determined to be medically necessary. The documentation is attached which demonstrates medical necessity for the procedure(s).

This letter is well documented in the patient's record and should be recognized and the code paid.
```

### ICD-10 Code Lookup Tool


### ICD-10 CM Guidelines

Updated codes sets may be obtained free of charge at the following websites:


Please refer to the following FAQ information on GEMS:

- [https://www.cms.gov/Medicare/Coding/ICD10/ICD10-Provider-Contact-Table.pdf](https://www.cms.gov/Medicare/Coding/ICD10/ICD10-Provider-Contact-Table.pdf)

### Coding Resources for Providers

- [https://www.cms.gov/Medicare/Coding/ICD10/ICD10-Provider-Contact-Table.pdf](https://www.cms.gov/Medicare/Coding/ICD10/ICD10-Provider-Contact-Table.pdf)

For questions about coding, please contact the American Health Information Management Association (AHIMA) at [https://www.ahima.org/topics/codecheck](https://www.ahima.org/topics/codecheck)

### Coding Resources for Providers

- [https://www.cms.gov/Medicare/Coding/ICD10/ICD10-Provider-Contact-Table.pdf](https://www.cms.gov/Medicare/Coding/ICD10/ICD10-Provider-Contact-Table.pdf)
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<th>SI</th>
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<td>22515</td>
<td>Perq vertebral augmentation</td>
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<td>22551</td>
<td>Neck spine fuse &amp; remov bel c2</td>
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<td>Thorax spine fusion</td>
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<td>63055</td>
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<td>63056</td>
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<td>63077</td>
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