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MEDICARE AUDIT INTEREST IN CO-SURGERY

NOTE: The OIG has placed modifier 62 on their Work Plan! That means it is an audit target

oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000449.asp

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Medicare Part B Payments to Physicians for Co-Surgery Procedures

Under Medicare Part B, when the individual skills of two surgeons are necessary to perform a specific surgical procedure or distinct parts of a surgical procedure (or procedures) simultaneously on the same patient during the same operative session (co-surgery), each surgeon should report the specific procedure(s) by billing the same procedure code(s) with a modifier "62." By appending modifier "62" to the procedure code(s), the fee schedule amount applicable to the payment for each co-surgeon is 62.5 percent of the global surgery fee schedule amount. We plan to audit a sample of claim line items - specifically where different physicians billed for the same co-surgery procedure code, for the same beneficiary, on the same date of service. Our objective is to determine whether Medicare Part B payments to physicians for co-surgery procedures were properly made.

Announced or Revised	Agency	Title	Component	Report Number(s)	Expected Issue Date (FY)
Revised	Centers for Medicare and Medicaid Services	Medicare Part B Payments to Physicians for Co-Surgery Procedures	Office of Audit Services	W-00-20-35844; W-00-22-35844	2022

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MEDICARE AUDIT INTEREST IN CO-SURGERY

- **Why is Co-surgery an audit target?**
  - Pays 9% more than billing the surgeon as assistant
  - Confusion surrounding Medicare's policy for co-surgeon resulting in mis-use and abuse
  - Gray area of when an orthopedic surgeon is and assist vs a co-surgeon

CO-SURGEON VS. ASSISTANT SURGERY: BASICS

	Co-Surgery	Assistant Surgery
Description	Two surgeons performing different parts of the same CPT/ procedure code	An MD or DO assisting another surgeon in all or part of a procedure code(s)
Surgical Specialties	Medicare and most payors require a different surgical specialty. For example, ENT, thoracic, general, or vascular surgery. (See next page for specific classifications)	Typically, the same specialty. An "extra pair of hands" for a complex case. A separate claim form is needed for the assistant surgeon codes
Documentation Requirements	Both surgeons dictate an operative note detailing their distinct parts of the procedure. **Example:** "Dr. B. providing the exposure & closure, see her note for a detailed description."	Only the primary surgeon dictates an operative note; detailing the specific role of the assistant. **Example:** "Dr. B assisted with the decompression, arthrodesis and instrumentation."

CO-SURGEON VS. ASSISTANT SURGERY: BASICS

	Co-Surgery	Assistant Surgery
Modifiers	Both surgeons **append a 62** modifier to the primary code and any related add-on codes. **Example**: 22558-62 and 22585-62 for a two level ALIF Remember, the 62 modifier may not be used on instrumentation codes: 22842, 22853, etc. May append 80 or 82 if the co-surgeon also participates in placing instrumentation (for example an interbody device)	No modifier is needed for the primary surgeon. The assistant surgeon **appends an 80 or 82** (academic center) to every CPT code for which his/her role is documented. **Example**: 22633-80, 63052-80, 22842-80. For academic centers, if the assistant is a partner, document that a qualified resident was not available and append 82 instead of 80.
Reimbursement	62.5% of increased fee, typically 125% of the allowable.	100% for the primary surgeon 16% for the assistant surgeon for Medicare. May vary for private payors.

MEDICARE UPDATE: 2023

MEDICARE PHYSICIAN FEE SCHEDULE LAST MINUTE CHANGES

- Congress passed an Omnibus spending bill in December 2022 that funds the Federal government through Fiscal Year 2023 and contains various provisions affecting healthcare providers. Among other things, the bill ameliorates planned Medicare provider cuts.
- In the bill, Medicare **waived the 4 percent reduction** for 2023 and 2024. .
- The bill reduced the Medicare Physician Fee Schedule proposed payment cut for two years, by reducing the proposed 4.47 percent payment reduction by 2 percent in 2023 and 1.25 percent in 2024.
  - The 2 percent adjustment for 2023 results in a Conversion Factor (CF) of approximately **$33.8872**, which represents an estimated final **2.08% reduction for 2023**. 2022 CF was $34.06

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MEDICARE UPDATE: 2023

RVU CHANGES TO SPINE CODES

- Lumbar laminectomy for stenosis, 63047. RVUs increased by 1.44 %, all in overhead
- Lumbar discectomy for disc, 63030 RVUs reduced by 5.07%. Work RVU from 13.18 to 12.00
- ACDF, 22551, Work RVU unchanged. Practice expense and malpractice portions increased slightly. Total RVU now 51.13. last year 50.50.

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MEDICARE UPDATE: 2023

TELEHEALTH POLICY CHANGES

- The Omnibus bill also extends the current telehealth waivers and flexibilities related to the COVID-19 public health emergency (PHE):
- The bill includes extensions of pandemic-related Medicare telehealth flexibilities for two years, **through December 31, 2024**.
- This includes of particular importance to neurosurgery:
  - Continuing **to waive geographic and originating site restrictions**, expanding the list of eligible practitioners and,
  - Allowing for the provision of telehealth through **audio-only telecommunications,**
  - Telehealth visits should use HIPAA approved formats

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NEW IN 2023: SI JOINT STABILIZATION/ARTHRODESIS

CPT Code	Description	Notes
Sacroiliac Joint Stabilization/Arthrodesis		
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	• Intended for percutaneous SI fusion by transfixing of the SI joint, fusing the ilium to the sacrum such as the use of pins passed through the joint to "transfix" the bones that constitute the joint. • For bilateral procedure, report 27279 with modifier 50 • Sacral screws included
▲27280	Arthrodesis, ~~open~~, sacroiliac joint, open, ~~including~~ includes obtaining bone graft, including instrumentation when performed	• Do not report 27280 in conjunction with 0775T • For percutaneous/minimally invasive arthrodesis of the sacroiliac joint without fracture and/or dislocation, utilizing a transfixing device, use 27279
● 0775T	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s])	• Do not report 0775T in conjunction with 27279, 27280 • For percutaneous arthrodesis, sacroiliac joint, with transfixing device, use 27279 • For removal or replacement of sacroiliac intra-articular implant[s], 27299 • For bilateral procedure, report 0775T with modifier 50

SI JOINT STABILIZATION/ARTHRODESIS

Coding Tips:

- Code 27280 has been revised slightly to reposition the word "open" and "includes…" replaces the word 'including". Clinically the use of this code has not changed. It is for an open procedure fully exposing the SI joint as described in the vignette, below
- Code 27279 describes percutaneous arthrodesis of the sacroiliac joint using a minimally invasive technique to place an **internal transfixing device(s)** that passes through the ilium, across the sacroiliac joint and into the sacrum, thus transfixing the sacroiliac joint. The approach in code 27279 is lateral and the procedure includes decortication in the joint to facilitate fusion of the bones and obtaining graft material.
- New Category III code 0775T is intended for a unique approach of stabilizing the SI joint via use of a **distracting intraarticular implant** placed between the two bony surfaces of the iliac and sacral bones. Tensioning accomplished the stabilization of the joint with different work and a different directional approach (posterior) and a different method than 27279.
- For percutaneous arthrodesis of the sacroiliac joint utilizing ***both*** a transfixing device and intra-articular implant(s), use 27299.

TOTAL DISC ARTHROPLASTY

Disc Placement

CPT Code	Description
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, **cervical**
#+22858	**second level, cervical** (List separately in addition to code for primary procedure)

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TOTAL DISC ARTHROPLASTY

Disc Placement

CPT Code	Description
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, **lumbar**
22860	**second interspace, lumbar** (List separately in addition to code for primary procedure) (Use 22860 in conjunction with 22857)

TOTAL DISC ARTHROPLASTY: DISC REMOVAL

CPT Code	Description
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; **cervical** (Do not report 22864 in conjunction with 22861, 69990) (For additional interspace removal of cervical total disc arthroplasty, use 0095T)
22865	**lumbar** (Do not report 22865 in conjunction with 49010) (For additional interspace, see Category III code 0164T) (22857-22865 include fluoroscopy when performed)

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ARTIFICIAL DISC

Remove and replace?

- Bill removal and 22554, cervical interbody fusion.
- Do not bill 22551 at the same level as removal. Bundled.

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CATEGORY III CODES NEW IN 2023

- 0735T Intraoperative radiation therapy. (IORT)
  - Preparation of cavity left by a tumor resection for placement of a radiation therapy application device .
  - Add on to craniotomy code
- 0719T Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment.

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NEW IN 2022- LASER INTERSTITIAL THERMAL THERAPY (LITT)

LASER INTERSTITIAL THERMAL THERAPY (LITT) – NEW CODES IN 2022

CPT Code	Description	Global Period
61736	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion	0 days
61737	multiple trajectories for multiple or complex lesion(s)	0 days

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LASER INTERSTITIAL THERMAL THERAPY (LITT)

Coding Tips:

- "Lesion" = diagnosis of brain tumor or epilepsy
- Codes include:
  - placement of headframe (20660),
  - navigation (+61781),
  - intraoperative MRI (70551, 70552, 70553, 70557, 70558, 70559),
  - and MRI guidance (77021, 77022).
- Report only one code – 61736 or 61737:
  - 61736 – "simple" = one trajectory or one lesion
  - 61737 – "complex" = more than one trajectory or more than one lesion
- A biopsy at the same operative session not for the purposes of definitive diagram is included in the resection.
- It would be highly unusual to biopsy a tumor at the same time – don't you need a tissue diagnosis prior to the procedure to ensure appropriate treatment?

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PRINCIPLES OF SPINE SURGERY CODING

1. What is the diagnosis?
Most spine codes are diagnosis-driven.

- Herniated / degenerative disc (e.g., 63030, 63042)
- Spinal stenosis, spondylosis (e.g., 63047, 63015, 63081)
- Abscess or hematoma (e.g., 63267)
- Tumor (e.g., 63301)
- Fracture (e.g., 22325)

LAIMECOTMY CODES: STILL MISUNDERSTOOD

Code by diagnosis ***not amount of bone removed***

- **Herniated / degenerative disc (e.g., 63030, 63042**
- **Spinal stenosis, spondylosis (e.g., 63047, 63015, 63081)**
- **If both at same level, stenosis codes override disc codes**

Code by interspace/motion segment, not vertebral segment

Q: We still do not understand the distinction of interspace and vertebral segment in codes 63045 – +63048. Why is a L4-L5 laminectomy for stenosis a single interspace (63047) and not two vertebral segments, 63047, +63048?

A: For codes 63045 – +63048, a segment means ***motion segment***. The decompression of the nerve root is performed in the interspace between the two vertebra, the motion segments. L4-L5 is a single interspace or motion segment and therefore is reported as a single code.

PRINCIPLES OF SPINE SURGERY CODING

1. **What decompression/ discectomy activity* was performed?** **Substitute a different stand-alone decompression/discectomy code (e.g., corpectomy- 63081, 63300, open treatment of a posterior fracture-22325-22328), if performed.**

Location	Cervical	Thoracic	Lumbar
Anterior	63075	63077	None
Anterior Decompression and Fusion	22551 / +22552	-	-
Posterior	63001, 63015, 63020 / +63035, 63040 / +63043, 63045 / +63048	63003, 63016, 63046/+63048	63005, 63017, 63030 / +63035, 63042 / +63044, 63047 / +63048 +63052 / +63053

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PRINCIPLES OF SPINE SURGERY CODING

3. **Was an arthrodesis/ fusion performed?** **Document decortication of spinal elements such as transverse processes, endplates AND placement of bone graft(s) to support a fusion code.**

Location	Cervical	Thoracic	Lumbar
Anterior	22548, 22554 / +22585	22556 / +22585	22558 / +22585
Anterior Decom-pression and Fusion	22551 / +22552	-	-
Posterior	22590 (Occ-C2), 22595 (C1-C2), 22600 / +22614 (C2-x)	22610 / +22614	22612 (PL) / +22614, 22630 (PLIF/TLIF) / +22632
Posterior Combined Fusions	-	-	22633 / +22634 (both fusions)

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PRINCIPLES OF SPINE SURGERY CODING

4. **If an arthrodesis/fusion was performed, then there must be a bone graft code(s).** **Document all bone grafts harvested, osteopromotive substance used, separate fascial incision.**

Type	Morselized	Structural
Allograft	+20930	+20931
Autograft	+20936, +20937	+20938
Bone Marrow Aspirate	+20939	

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PRINCIPLES OF SPINE SURGERY CODING

5. **If an arthrodesis/fusion was performed, was instrumentation or fixation also used? Document trade name of all hardware / implants used to support these codes. For example, the new intervertebral device codes (more later) include integrated anterior instrumentation if used – so document the name of the intervertebral device (e.g., PEEK) AND the plate name so two codes can be used when appropriate (e.g., +22853 and +22845) instead of one (+22853 only).**

Location		
Anterior	+22845 - +22847	
Posterior	+22840	+22842 - +22844
Intervertebral	+22853, +22854, +22859	
Pelvic	+22848	

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PRINCIPLES OF SPINE SURGERY CODING

6. **Were any other services provided and documented?**
   - Use of the operating microscope for microdissection/microsurgery (+69990)
   - Spinal stereotactic navigational planning (+61783)
   - Use of a robot (+S2900 – typically not paid but good for tracking purposes)

Document these in the Procedure statement as well as in the detail of the operative report.

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PRINCIPLES OF SPINE SURGERY CODING

General Guidelines:

- ✓ Report one stand-alone code and appropriate add-on codes when the procedure crosses spinal junctions. Do not report two stand-alone similar codes.
- ✓ Typically, T12-L1 is considered a "lumbar" level while C7-T1 is considered cervical.
- ✓ A "segment" is a motion segment.

Example: T10-S1 arthrodesis

(T10-T11, T11-T12, T12-L1, L1-L2, L2-L3, L3-L4, L4-L5, L5-S1 = 8 levels)

DO Use:	
22612	Lumbar
+22614 x 7	

Do NOT Use:	
22612	Lumbar
22610	Thoracic
+22614 x 6	

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LAMINECTOMY WITHOUT FACETECTOMY, FORAMINOTOMY: CERVICAL

LAMINECTOMY ONLY (no facetectomy, foraminotomy)	
CPT Code	**Description**
	Cervical
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), **1 or 2 vertebral segments**; cervical
63015	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), **more than 2 vertebral segments**; cervical

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LAMINECTOMY WITH FACETECTOMY, FORAMINOTOMY: CERVICAL, THORACIC, AND LUMBAR

LAMINECTOMY WITH FACETECTOMY/FORAMINOTOMY	
CPT Code	**Description**
63045	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; **cervical**
63046	**thoracic**
63047	**lumbar**
+63048	**each additional** vertebral segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

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LAMINECTOMY WITH FACETECTOMY, FORAMINOTOMY: CERVICAL, THORACIC, AND LUMBAR

Q: We still do not understand the distinction of interspace and vertebral segment in codes 63045 – +63048. Why is a L4-L5 laminectomy for stenosis a single interspace (63047) and not two vertebral segments, 63047, +63048?

A: For codes 63045 – +63048, a segment means motion segment. The decompression of the nerve root is performed in the interspace between the two vertebra, the motion segments. L4-L5 is a single interspace or motion segment and therefore is reported as a single code.

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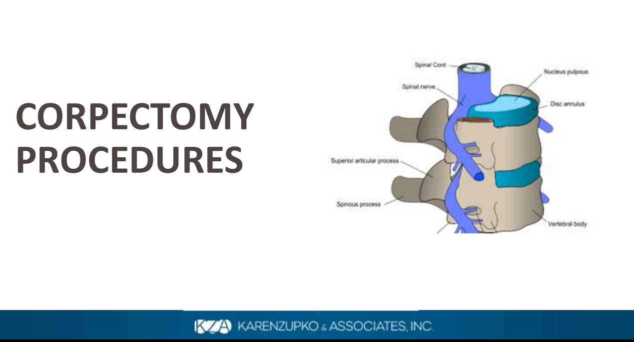
CORPECTOMY PROCEDURES



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CORPECTOMY: UNDER CODING AND INCORRECT CODING

Issues:

- Requires removal of at least 50% of vertebral body at cervical level, 1/3 of thoracic or lumbar. If not, its not a coprectomy
- Discectomies above and below are included (not billed) but fusion above and below are.
- Single vertebral body corpectomy, means two fusion codes.
- Corpectomies are diagnosis drive; stenosis/fracture corpectomies pay less than corpectomies for lesions.

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CORPECTOMY BASICS

- A corpectomy is removal of all or a portion of the vertebral body or corpus (the anterior portion of the vertebra)
- Minimal removal is 50% at the cervical level and one third (33.3%) at the thoracic and lumbar levels. The percentage of the vertebral body removed is essential documentation.

50 % remove

50 % removed

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CORPECTOMY BASICS

- Removal is calculated as the percentage of a single vertebral body (typically endplate to endplate), not a portion of the inferior and superior portion of two adjacent vertebra as shown below. The below is an ACDF – not a two-level corpectomy:
- Corpectomies at any spinal level are diagnosis driven. Corpectomies for stenosis or anterior fracture repair are different (and valued differently) than corpectomies for tumors or non-neoplasm lesions.

Bone removed from inferior portion

Bone removed from superior portion

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GRAPHIC CODING: CORPECTOMY CASE 1

C2
63081
C3
+22845
22554
+22854
+20936
+22585
C5

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POSTERIOR DISCECTOMY: CERVICAL AND LUMBAR

INITIAL DISCECTOMY – CERVICAL, LUMBAR	
CPT Code	**Description**
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, **cervical**
63030	1 interspace, **lumbar**
+63035	**each additional** interspace, cervical or lumbar (List separately in addition to code for primary procedure)

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GLOBAL SURGICAL PACKAGE: WHEN CAN STEREOTACTIC NAVIGATION BE SEPARATELY REPORTED?

SPINAL NAVIGATION

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

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SPINE NEURONAVIGATION NOT GETTING PAID

Code 61783

- What are the issues?
  - Code should not be billed for the use of the O-Arm/Iso-C. This advanced imaging is not separately billable.
  - It is not stereotaxis.
  - Does not require pre planning like the cranial neuronavigation, 61781
  - Does require taking data from the O-Arm, Iso-C and loading it into a stereotactic system (Stealth, BrainLab) and documenting the system used.
- Use for placement of pedicle screws. Add the code directly under the instrumentation code.
  - 22842
  - 61783

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GLOBAL SURGICAL PACKAGE: WHEN CAN STEREOTACTIC NAVIGATION BE SEPARATELY REPORTED?

Coding Tips

- You must document the additional use of a stereotactic navigational system (e.g., BrainLab, Spine Stealth) to support +61783, ie loading the O-arm data into the Brain Lab system and using that data to place pedicle screws.
- Code does not accept modifier 80, 82 or AS, per Medicare.
- State the name of the system in the operative note so +61783 is validated.

Example Documentation

The images obtained from the O-arm were then loaded into the BrainLab to obtain stereotactic images. These were reviewed to guide placement of the pedicle screws.

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CERVICAL CORPECTOMY AND ARTHRODESIS (NON-LESION/NON-TUMOR)

CPT Code	Description
	Corpectomy Codes
63081	Vertebral **corpectomy** (vertebral body resection), partial or complete, anterior approach with decompression of spinal cord and/or nerve root(s); cervical, single segment
+63082	cervical, each additional segment (List separately in addition to code for primary procedure)
	Arthrodesis Codes
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)

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CERVICAL CORPECTOMY CASE 2

This is a pleasant 77-year old gentleman with cervical stenosis and myelopathy from C3 through C6. He underwent posterior cervical decompression three days ago and now we will do the anterior procedure.

Procedures:

1. C4 corpectomy with use of the operating microscope for microdissection.
2. C3-C5 anterior arthrodesis with expandable cage placement packed with autologous bone.
3. C5-C6 anterior cervical discectomy, decompression and arthrodesis using a PEEK device.
4. Anterior cervical plating C3-C6.

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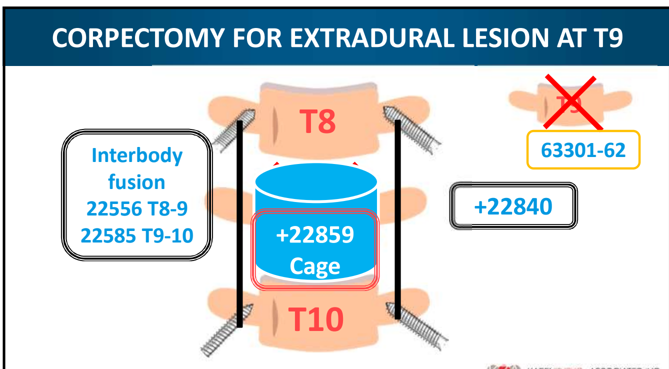
CORPECTOMY FOR EXTRADURAL LESION AT T9



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POSTERIOR ARTHRODESIS CODES: LUMBAR

POSTERIOR LUMBAR ARTHRODESIS (PL Fusion)	
CPT Code	Description
	Posterior / Posterolateral Arthrodesis Codes
22612	Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)
+22614	each additional interspace (List separately in addition to code for primary procedure)

Lumbar posterior lateral fusion alone is not bundled with and decompression or disc codes

POSTERIOR ARTHRODESIS CODES: POSTERIOR LUMBAR INTERBODY

POSTERIOR ARTHRODESIS – INTERBODY (PLIF/TLIF) & COMBINED POSTEROLATERAL/INTERBODY	
CPT Code	Description
	Posterior Interbody Arthrodesis Codes
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar
+22632	each additional interspace (List separately in addition to code for primary procedure)
	COMBINED Posterior/Posterolateral AND Interbody Arthrodesis Codes
22633	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; lumbar
+22634	each additional interspace (List separately in addition to code for primary procedure)

2023: WHAT'S BUNDLED BY MEDICARE WITH 22630 (TLIF/PLIF) AND 22633 (TLIF/PLIF PLUS PL FUSION)?

- Laminectomy for disc (new -63030 and re-explore-63042)
  - Reasonable, disc removal is inherent in 63030/63042)
- Laminectomy for stenosis (63047)
  - Not reasonable. Code says without decompression
- Gill procedure (63012)
  - Not reasonable
- Laminectomy for non neoplasms and neoplasms
  - Not reasonable

POSTERIOR ARTHRODESIS CODES: NEW DECOMPRESSION CODE WHEN PERFORMED WITH A LUMBAR INTERBODY ARTHRODESIS

DECOMPRESSION WITH POSTERIOR LUMBAR INTERBODY ARTHRODESIS

CPT Code	Description	Guidelines
#+63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)	• Use +63052 with 22630 or 22633 • Use +63053 for additional segments in conjunction with +22632 or +22634 • Once per interspace
#+63053	each additional vertebral segment (List separately in addition to code for primary procedure)	

= code out of sequence

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POSTERIOR ARTHRODESIS CODES: NEW DECOMPRESSION CODE WHEN PERFORMED WITH A POSTERIOR INTERBODY ARTHRODESIS

DECOMPRESSION WITH POSTERIOR LUMBAR INTERBODY ARTHRODESIS

- Must document additional work above and beyond the laminectomy and/or discectomy sufficient to prepare the interspace. "Decompression" (lateral recess decompression, foraminotomy) will be key documentation to support additional decompressive work.
- Note codes say "unilateral or bilateral." A bilateral decompression with a TLIF is reported with a single additional code, +63052. Code +63053 is only reported for decompression with a lumbar interbody fusion at a second interspace/level.

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INTERVERTEBRAL DEVICE CODES: +22853, +22854, +22859

CPT Code	Descriptor	Comments
+22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) *with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed*, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)	• Code per each treated intervertebral disc space with arthrodesis • Example: PEEK (or titanium metal) device *without* integrated anterior instrumentation; low profile or integrated device placed in an interspace for arthrodesis

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INTERVERTEBRAL DEVICE CODES: +22853, +22854, +22859

CPT Code	Description
+22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) *with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect*, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)
+22859	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) *to intervertebral disc space or vertebral body defect without interbody arthrodesis*, each contiguous defect (List separately in addition to code for primary procedure)

INTERVERTEBRAL DEVICE CODES: +22853, +22854, +22859

Coding Tips:

- If the anterior instrumentation is indeed separate, then Medicare allows appending modifier 59 to the anterior instrumentation code (+22845, +22846) to show that it was truly a separate device and not integrated with the intervertebral device (+22853, +22854).
- Placement of methylmethacrylate around the pedicle screws in a patient with severe osteoporosis, to reinforce the instrumentation, is not separately reported with +22853 or any other code. This is considered part of the instrumentation code (e.g., +22840).
- Use +22859 for an "open kyphoplasty" or "open vertebroplasty" where a vertebral body defect is filled with a substance, such as methylmethacrylate, in an open procedure.
- Remember: CPT guidelines do not allow modifier 62 on spinal instrumentation codes.

INTERBODY DEVICE AND ANTERIOR PLATE CONFUSION: IS IT "INTEGRATED " OR SEPARATE?

Issues with interbody device codes:

- Must be a separate interbody device and plate to bill both. Always append a 59 to the plate as evidence that two separate devices were used.
- Vendors have become very creative in describing interbody devices. Mini "plates" etc. Even googling may not help.
  - Solution? Investigate devices used by your surgeons. Document device name in op note. Develop a cross walk for coders/surgeons listing device names and if integrated or separate.
- **Do not** code a kyphoplasty or vertebroplasty codes
  - For placement of methylmethacrylate around the pedicle screws to reinforce the instrumentation. This is included in the instrumentation code. This is not separately billable with any code, even unlisted
  - For placement of cement in the vertebral body for osteoporotic bone. Use code 22859, . Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) *to intervertebral disc space or vertebral body defect without interbody arthrodesis*, each contiguous defect

SPINE FRACTURE CODES – OPEN TREATMENT

Open Treatment	
CPT Code	Description
Odontoid Fracture	
22318	Open treatment and/or reduction of odontoid fracture(s) and or dislocation(s) (including os odontoideum), **anterior approach**, including placement of internal fixation; without grafting
22319	with grafting
Posterior Cervical, Thoracic, Lumbar Fracture	
22325	Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), **posterior approach**, one fractured vertebrae or dislocated segment; lumbar
22326	cervical
22327	thoracic
+22328	each additional fractured vertebrae or dislocated segment (List separately in addition to code for primary procedure)

SPINE FRACTURE CODES – ISSUES

- Use for **traumatic fractures only**. Not pathological fractures or spondylolisthesis.
- Must include either bone removal, (removal of bone fragments, laminectomy), or unlocking facet joints
- If instrumentation alone reduces the fracture, report only the instrumentation code. This is not reported as an ORIF.
- These are posterior codes!
  - If a fracture is treated from an anterior approach, report the anterior code; corpectomy, ACDF etc.

SPINAL DEFORMITY CODES: POSTERIOR OSTEOTOMY

POSTERIOR COLUMN OSTEOTOMY CODES		
CPT Code	Description	Comments
22210	Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; cervical	• Code is reported per segment bone is removed; L1-L2 is one code (22214) while L2-L3 is a second code (+22216). • Includes laminectomy and decompression activity (do not separately report code such as 63047 at the same level). • Do not report with 22206-22208 (pedicle subtraction osteotomy) at the same level. • May also report codes for arthrodesis, bone grafts, instrumentation, etc. as appropriate. • Do not use an osteotomy code just because 63047 is included in 22633/22630 – there must be a documented deformity to support these codes.
22212	thoracic	
22214	lumbar	
+22216	each additional vertebral segment (List separately in addition to code for primary procedure)	

BEWARE: These codes are on the radar screen when reported with 22630/22633 (interbody arthrodesis).

SPINAL DEFORMITY CODES: POSTERIOR ARTHRODESIS

Posterior		
CPT Code	Description	CPT Vignette
22800	Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments	A 20-year-old patient with achondroplastic dwarfism presents with progressive scoliosis. Using a posterior approach, a midline incision with bilateral subperiosteal retraction of muscle is performed. A bony bed over lamina and transverse process to accept a bone graft is prepared, and bone graft material is applied to the prepared bony surfaces with or without application of a cast.
22802	7 to 12 vertebral segments	A 7-year-old female presents with rapidly increasing congenital scoliosis beyond 70 degrees. Bending films correct the curve moderately. Using a posterior approach, a midline incision with bilateral subperiosteal retraction of muscle is performed. A bony bed over lamina and transverse process to accept a bone graft is prepared, and bone graft material is applied to the prepared bony surfaces, with or without application of a cast.
22804	13 or more vertebral segments	A 12-year-old male presents with a long paralytic scoliotic curve secondary to muscular dystrophy. Using a posterior approach, a midline incision with bilateral subperiosteal retraction of muscle is performed. A bony bed over lamina and transverse process to accept a bone graft is prepared, and bone graft material is applied to the prepared bony surfaces, with or without application of a cast.

SPINAL DEFORMITY CODES: POSTERIOR OSTEOTOMY

Issues with deformity coding/documentation

- An audit target!
- Deformity must be the primary diagnosis. Not for a slight degenerative curve in the context of severe stenosis.
- It is not enough to say “Smith-Petersen osteotomies were performed” – you must describe in detail how they were performed.
- Document the type of spinal deformity pre-op (e.g., Cobb angle) and at the degree of correction sought with the osteotomy. Be sure to document the PI-LL (pelvic incidence-lumbar lordosis) mismatch, positive balance, etc. for all deformity procedures.

SPINAL DEFORMITY CODES: POSTERIOR OSTEOTOMY

Issues with deformity coding/documentation

- What arthrodesis codes should be used?
- AANS/NASS say 22610-22614 codes, primary and add-on codes for each interspace fused
- Payors want the 228xxx codes, which allows a single code for a range of interspaces fused. Why? It pays less.
- They may kick back the claim and change to the lower values codes
- What can you do?

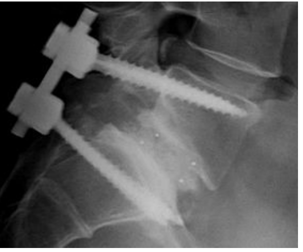
CPT ASSISTANT Q&A

The December 2021 CPT Assistant article "Reviewing Decompression, Arthrodesis, and Osteotomy Procedures" article supports:

1. Using the deformity arthrodesis codes (2280x) for "flexible" deformities "which are more common in the **adolescent deformity considerations**
2. Surgical correction of degenerative disease (fixed deformities) would be appropriately reported using the **degenerative disease** codes such as the 63xxx and 226xxx codes.
3. Bottom line, for arthrodesis with osteotomy codes in adults, typically fixed deformities, use arthrodesis codes 22600-22614. Payors routinely deny these codes and attempt to convert to the lower paying 22800-22894 codes. Appeal with the CPT Assistant 2021 direction.

EXPLORATION OF SPINAL ARTHRODESIS

CPT Code	Description
22830	Exploration of spinal arthrodesis



Source: https://upload.wikimedia.org/wikipedia/commons/thumb/7/7d/Roe_LWS_Spondylodese_L5-S1_seitlich.jpg/420px-Roe_LWS_Spondylodese_L5-S1_seitlich.jpg

EXPLORATION OF SPINAL ARTHRODESIS

Coding Tips:

- Reported once per operative session – not once per level of prior arthrodesis.
- Medical necessity must be documented (i.e., suspected pseudoarthrosis).
  - If you know prior to the procedure that the arthrodesis is solid, then do not report 22830.
  - If you know prior to the procedure that the arthrodesis is NOT solid, then do not report 22830.
- CPT says exploration of fusion includes removal of hardware and decortication of bony elements.
- Medicare bundles exploration and a new fusion at the same spinal level. Do not append modifier 59 to 22830 to bypass Medicare's NCCI edit in this situation.
- **Although CPT guidelines suggest that an exploration and new arthrodesis may both be reported at the same level, exploration and a new arthrodesis at the same spinal level represent subsequent clinical overlap. Both involve hardware removal and decortication. Reporting at the same spinal level is not recommended. Report the new arthrodesis only.**

INSTRUMENTATION REMOVAL / REINSERTION CODES

CPT Code	Description	Comments
Reinsertion of Instrumentation		
22849	Reinsertion of spinal fixation device	• Do not report with 22850, 22852, 22855 at the same level(s). • Use this code for removal and reinsertion at the same level(s). • **Also use for hardware revison**
Removal of Instrumentation		
22850	Removal of posterior nonsegmental instrumentation (eg, Harrington rod)	• Codes used when purpose of procedure is to remove instrumentation (e.g., painful hardware). • Do not separately report when instrumentation is extended at an overlapping level. Example: Removal of old plate at C6-C7 and placement of new plate at C5-C7. Report only "new" instrumentation code, +22845.
22852	Removal of posterior segmental instrumentation	
22855	Removal of anterior instrumentation	

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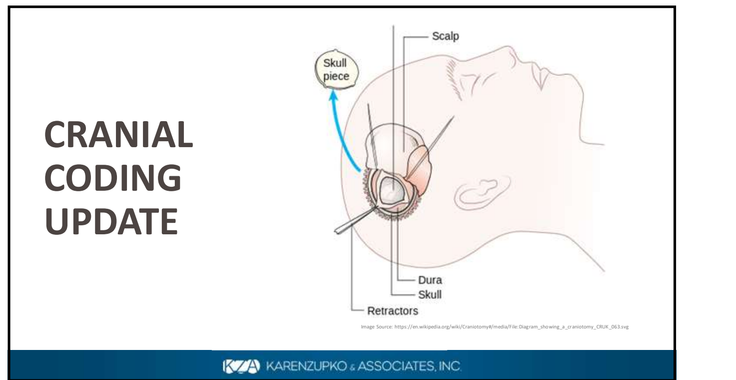

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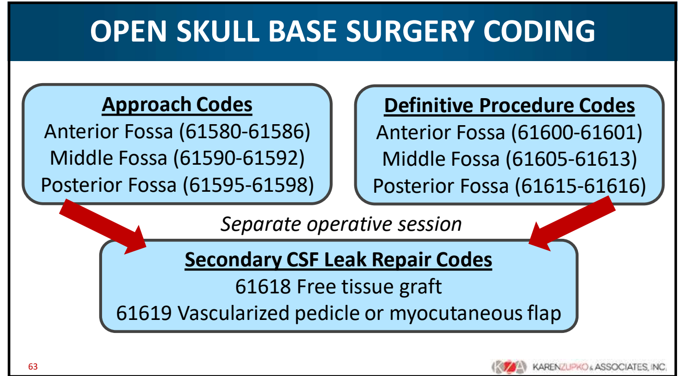

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OPEN SKULL BASE SURGERY CODING

Coding Tips:

- Codes were designed as "paired codes." If you use an open skull base approach code (e.g., 61580), then you cannot use a non-skull base craniotomy code (e.g., 61510). Alternatively, if you use an open skull base approach code then you (or someone else) must use an open skull base definitive procedure code.
- Diagnosis is neoplastic (tumor), vascular (e.g., cavernoma, cavernous malformation) or infectious (e.g., osteomyelitis) lesion – not aneurysm.
- Do not use these codes for translabyrinthine/transmastoid or suboccipital (retrosigmoid) resection of a cerebellopontine angle tumor (e.g., acoustic neuroma, vestibular schwannoma). Rather, refer to 61520 or 61526 instead.

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OPEN SKULL BASE SURGERY CODING

Anterior Fossa Codes

Approach		Definitive Procedure	
61580	Craniofacial approach; extradural, including lateral rhinotomy, ethmoidectomy sphenoidectomy, without maxillary or orbital exenteration;	61600	Resection or excision of neoplastic, vascular or infectious lesion, extradural;
61581	extradural with maxillectomy and/or orbital exenteration	**61601**	**intradural, including dural repair, with or without graft**
61582	extradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe(s), osteotomy of base of anterior fossa		
61583	intradural, including unilateral or bifrontal craniotomy, elevation of frontal lobe, osteotomy of base of anterior fossa		
61584	Orbitocranial approach, extradural, including supraorbital ridge osteotomy and elevation of frontal and/or temporal lobe(s), without orbital exenteration;		
61585	with orbital exenteration		
61586	Bicoronal, transzygomatic approach and/or Le Fort I osteotomy, with or without internal fixation, without bone graft		

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OPEN SKULL BASE SURGERY CODING

Middle Fossa Codes

Approach		Definitive Procedure	
61590	Infratemporal pre-auricular approach (parapharyngeal space, infratemporal and midline skull base, nasopharynx), with or without disarticulation of the mandible, including parotidectomy, craniotomy, decompression and/or mobilization of the facial nerve and/or petrous carotid artery	61605	Resection or excision of neoplastic, vascular or infectious lesion of infratemporal fossa, parapharyngeal space, petrous apex; extradural
61591	Infratemporal post-auricular approach (internal auditory meatus, petrous apex, tentorium, cavernous sinus, parasellar area, infratemporal fossa) including mastoidectomy, resection of sigmoid sinus, with or without decompression and/or mobilization of contents of auditory canal or petrous carotid artery	61606	intradural, including dural repair, with or without graft
61592	Orbitocranial zygomatic approach (cavernous sinus and carotid artery, clivus, basilar artery or petrous apex) including osteotomy of zygoma, craniotomy, extra- or intradural elevation of temporal lobe	61607	Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; extradural
		61608	**intradural, including dural repair, with or without graft**

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OPEN SKULL BASE SURGERY CODING

Posterior Fossa Codes

Approach		Definitive Procedure	
61595	Transtemporal approach jugular foramen or midline skull base, including mastoidectomy, decompression of sigmoid sinus and/or facial nerve, with or without mobilization	61615	Resection or excision of neoplastic, vascular or infectious lesion of base of posterior cranial fossa, jugular foramen, foramen magnum, or C1-C3 vertebral bodies; extradural
61596	Transcochlear approach, jugular foramen or midline skull base, including labyrinthectomy, decompression, with or without mobilization of facial nerve and/or petrous carotid artery	61616	intradural, including dural repair, with or without graft
61597	Transcondylar (far lateral) approach, jugular foramen or midline skull base, including occipital condylectomy, mastoidectomy, resection of C1-C3 vertebral body(s), decompression of vertebral artery, with or without Mobilization		
61598	Transpetrosal approach, clivus or foramen magnum, including ligation of superior petrosal sinus and/or sigmoid sinus		

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OPEN SKULL BASE SURGERY CODING
OPEN REPAIR AND/OR RECONSTRUCTION CODES

Open Repair and/or Reconstruction Codes—Secondary Procedure (different operative session after skull base surgery code has been performed)

Approach	
61618	Secondary repair of dura for cerebrospinal fluid leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by free tissue graft (eg, pericranium, fascia, tensor fascia lata, adipose tissue, homologous or synthetic grafts)
61619	by local or regionalized vascularized pedicle flap or myocutaneous flap (including galea, temporalis, frontalis or occipitalis muscle)

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OPEN SKULL BASE SURGERY CODING

Posterior Fossa Codes

ALERT: The skull base surgery codes were not intended to be used for aneurysm clipping. Refer to codes 61697-61702 for aneurysm-related procedures.

TIPS:
- Select an approach code first. The approach, as documented, may not describe all the specific structures listed in the code. Select the approach code that most closely resembles the work documented.
- The neurosurgeon resection will almost always be intradural. The approach (removal of bony structures to access skull base) may be extradural. Select the intradural definitive procedure code that best describes the anatomy of the resection.

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OPEN SKULL BASE SURGERY CODING

Methodology for Using Open Skull Base Codes

- **Step I**
  - Determine if it is appropriate to use these codes.
  - Were specific bones removed to access the skull base?
- **Step II**
  - Select an approach code.
- **Step III**
  - Select a definitive procedure code.
- **Step IV**
  - Identify additional codes (as with craniotomy codes).
- **Step V**
  - Determine participation level of other surgeons.

ISSUES WITH SKULL BASE CODES

- Do not use for CP angle tumor resection
- Do not use for aneurysms
- Intended for neoplasm and non neoplasm lesions only!

ENDOSCOPIC ENDONASAL SKULL BASE SURGERY CODING

Endoscopic/Endonasal Skull Base Surgery Example

Diagnosis: Clival intradural lesion with mass effect on the anterior brainstem

Procedure:

1. Endoscopic transnasal resection of clivus
2. Resection of clival intradural lesion
3. Repair of durotomy endoscopically
4. Placement of lumbar drain
5. Use of BrainLAB stereotactic navigation

Surgeon: Dr. Neurosurgeon

Co-Surgeon: Dr. ENT

Note: Many payors do not recognize two surgeons reporting the same code, 64999. Additionally, many payors do not recognize modifier 62 on an unlisted code if each surgeon were to report 64999-62.

The operative note states that the approach was performed by ENT, NS did the resection of the lesion while ENT repaired the spinal fluid leak and closure.

ENDOSCOPIC ENDONASAL SKULL BASE SURGERY CODING

Suggested Coding for the Neurosurgeon:

64999	Unlisted procedure, nervous system (compare to 61601-62)
+61781	Stereotactic navigation, cranial, intradural (assuming the neurosurgeon performed the system set up; if ENT did the set up then ENT will report +61781 instead of the neurosurgeon)
62272-51	Lumbar drain

Suggested Coding for the ENT:

31299	Unlisted procedure, accessory sinus (compare to 61583 and 61601-62)

EXCISION OF A CEREBELLOPONTINE ANGLE TUMOR

The two most common CPT codes used for surgery to remove a cerebellopontine angle (CPA) tumor (e.g., acoustic neuroma, vestibular schwannoma, meningioma) are:

CPT Code	Description
61520	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; cerebellopontine angle tumor
61526	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor;

Image source: https://en.wikipedia.org/wiki/Brain#/media/File:Hearing_mechanics_cropped.jpg

CEREBELLOPONTINE ANGLE TUMOR EXCISION CODES

May separately report code(s) for:

- Placement of ventricular catheter via separate burr hole exposure (e.g., 61210)
- Harvest of graft material via separate skin incision for dural repair such as an abdominal fat graft (15769), fascia lata graft by excision (20922)
- Use of the operating microscope for microdissection (e.g., +69990)
- Placement of a lumbar drain (e.g., 62272)
- Pre-operative stereotactic navigational planning (e.g., +61781)

CEREBELLOPONTINE ANGLE TUMOR EXCISION CODES

Q: Can a skull base codes be used for a CP angle tumor since it is a skull base procedure?

A: No, these codes are specific for CP angle tumors and must be used.

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CRANIOTOMY FOR ANEURYSM CODES

Location		Type	
Carotid	Vertebrobasilar	Complex	Simple
• Anterior communicating artery • Anterior cerebral artery • Posterior communicating artery • Middle cerebral artery	• Vertebral artery • Basilar artery (bifurcation or trunk) • Posterior inferior cerebellar artery • Anterior inferior cerebellar artery • Superior cerebellar artery • Posterior cerebral	• >15mm, or • Calcification of aneurysm neck, or • Incorporation of normal vessels, or • Requiring temporary vessel occlusion, trapping or cardiopulmonary bypass	• Doesn't meet criteria for complex
61697 61700	61698 61702	61697 61698	61700 61702

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CRANIOTOMY FOR ANEURYSM CODES

Coding Tips

- Codes include removal of hematoma associated with a ruptured aneurysm.
- Codes are for clipping of an unruptured or ruptured aneurysm.
- Do not use a separate skull base approach code – the approach is included in all the above codes.
- Do not separately report any code for injection of indocyanine green dye (ICG). This is included in the procedure.

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PITUITARY TUMOR EXCISION

CPT Code	Description
61548	Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic (Do not report code +69990 in addition to code 61548.)
61546	Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach
62165	Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach

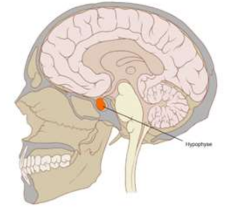
PITUITARY TUMOR EXCISION

2A. DIAGNOSIS:

Cystic endocrine inactive pituitary macroadenoma

PROCEDURE:

1. Endonasal endoscopic removal of cystic macroadenoma
2. Stereotactic navigation
3. Harvesting of abdominal fat graft2A.



https://upload.wikimedia.org/wikipedia/commons/thumb/a/a5/Hypophyse.png/1024px-Hypophyse.png

TRANSNASAL PITUITARY TUMOR EXCISION CASE

Which codes would you report?

A	
61575-22	Transoral approach to skull base for excision of lesion
30520	Septoplasty
31050	Sphenoid sinusotomy
77002-26	Fluoroscopy
+69990	Use of the operating microscope
77002-26	Fluoroscopy
+69990	Use of the operating microscope
61548	Excision of pituitary tumor, transnasal or transeptal approach
62100	Craniotomy for repair of CSF leak
62147	Cranioplasty > 5 cm
15770	Derma-fat-fascia graft
20912	Nasal septal cartilage graft

B	
61548	Excision of pituitary tumor, transnasal or transeptal approach
20922	Fascia lata graft

NEUROENDOVASCULAR PROCEDURE CODING

COMMON CODES

- Diagnostic angiograms
  - Carotid, 36223, 36224
  - Vertebral, 36225, 36226
  - External carotid, 32227
  - Intracranial, 36228
  - Spinal, thoracic 36215, lumbar 36245, and imaging 75705
  - Coding for additional arteries; thyrocervical, costocervical, high cervical
  - **Don't bill with an intervention if you have a prior angiogram that adequately diagnosed the pathology (or CTA for Medicare)**
- 61624 or 61626 embolization, also 75894 guidance angiogram and 75898, follow- up.
  - New applications, embolize feeder vessels for tumors. Embolize feeder vessel for SDH.
  - At risk of bundling!
- 61645 Thrombectomy/thrombolysis. All inclusive code. Includes imaging in same vascular territory.
- 61650 Non thrombolytic infusion. All inclusive code. Includes imaging in same vascular territory

VENOUS PROCEDURES

CPT Code	Description
36012	Selective catheter placement, venous system; second order, or more selective, branch (eg, left adrenal vein, petrosal sinus)
75870	Venography, superior sagittal sinus, radiological supervision and interpretation
64999	Unlisted. Intravenous, endovascular venous stent, and angioplasty. Compare to fee for intracranial arterial angioplasty and stent.

- For Intracranial hypertension
- Pressure measurements are included in the venogram codes.
- Do not use intracranial arterial stent code (61635) or peripheral stent code (37236)

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GUIDELINES: 2023 KEY CHANGES TO INPATIENT & CONSULTATION E/M CODES

Providers Choose Whether Their Documentation will be Based on Medical Decision Making (MDM) or Total Time

- MDM: Based on the three elements: 1) Problems addressed; 2) Data reviewed and analyzed; and 3) Risk
- **Time:** The definition of time is "total time," not typical time, and represents total physician/QHP time on the date of service. The use of date-of-service time builds on the movement over the last several years by Medicare to better recognize the work involved in non-face-to-face services like care coordination. These definitions only apply when code selection is based on time instead of not MDM.

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GUIDELINES: 2023 KEY CHANGES TO INPATIENT & CONSULTATION E/M CODES

Elimination of History and Physical as Elements for Code Selection

While the physician's work in capturing the patient's pertinent history and performing a relevant physical exam contributes to both the time and medical decision making, these elements alone do not determine the appropriate code level for any E/M code beginning in 2023.

- For all E/M codes, the provider should perform and document a *"medically appropriate history and/or examination."*

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2023 E/M MEDICAL DECISION MAKING (MDM) ALL E/M CATEGORIES OF CODE (OUTPATIENT & INPATIENT/OBSERVATION)

Elements of Medical Decision Making

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
Straightforward	Minimal [illegible]	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low [illegible]	Limited [illegible]	Low risk of morbidity from additional diagnostic testing or treatment
Moderate	Moderate [illegible]	Moderate [illegible]	Moderate risk of morbidity from additional diagnostic testing or treatment [illegible]
High	High [illegible]	Extensive [illegible]	High risk of morbidity from additional diagnostic testing or treatment [illegible]

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E/M 2023: HOW IT LOOKS IN 2023

	Code	MDM (2 of 3 Elements)	Element: Problems Addressed	Element: Data Reviewed & Analyzed	Element: Risk of Patient Management	PER CPT - Time Must meet or exceed*
	INITIAL HOSPITAL INPATIENT OR OBSERVATION CARE				**Choose Using MDM OR Time**	
INPATIENT or OBSERVATION	99221	Straightforward or Low	Minimal or Low	Minimal or None or Limited	Minimal Risk or Low Risk	40
	99222	Moderate	Moderate	Moderate	Moderate Risk	55
	99223	High	High	Extensive	High Risk	75
	SUBSEQUENT HOSPITAL INPATIENT OR OBSERVATION CARE				**Choose Using MDM OR Time**	
	99231	Straightforward or Low	Minimal or Low	Minimal or None or Limited	Minimal Risk or Low Risk	25
	99232	Moderate	Moderate	Moderate	Moderate Risk	35
	99233	High	High	Extensive	High Risk	50
CONSULTATION SERVICES	**OFFICE OR OTHER OUTPATIENT CONSULTATION**				**Choose Using MDM OR Time**	
	~~99241~~					
	99242	Straightforward	Minimal	Minimal or None	Minimal Risk	20
	99243	Low	Low	Limited	Low Risk	30
	99244	Moderate	Moderate	Moderate	Moderate Risk	40
	99245	High	High	Extensive	High Risk	55
	INPATIENT OR OBSERVATION CONSULTATION				**Choose Using MDM OR Time**	
	~~99251~~					
	99252	Straightforward	Minimal	Minimal or None	Minimal Risk	35
	99253	Low	Low	Limited	Low Risk	45
	99254	Moderate	Moderate	Moderate	Moderate Risk	60
	99255	High	High	Extensive	High Risk	80
SAME DAY	**OBSERVATION/INPATIENT ADMIT and DISCHARGE SAME DAY**				**Choose Using MDM OR Time**	
	99234	Straightforward or Low	Minimal or Low	Minimal or None or Limited	Minimal Risk or Low Risk	45
	99235	Moderate	Moderate	Moderate	Moderate Risk	70
	99236	High	High	Extensive	High Risk	85
ER SERVICES	**ER SERVICES**		**Choose Using MDM Only**			
	99281	No physician required				Does Not Apply
	99282	Straightforward	Minimal	Minimal or None	Minimal Risk	
	99283	Low	Low	Limited	Low Risk	
	99284	Moderate	Moderate	Moderate	Moderate Risk	
	99285	High	High	Extensive	High Risk	

*Medicare has different time thresholds

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E/M 2023: HOW IT LOOKS IN 2023

Code	MDM	Time Addressed
NEW PATIENT		
99202	Straightforward	15–29
99203	Low	30–44
99204	Moderate	45–59
99205	High	60–74
ESTABLISHED PATIENT		
99211	N/A	N/A
99212	Straightforward	10–19
99213	Low	20–29
99214	Moderate	30–39
99215	High	40–54
OUTPATIENT CONSULTATION		
99242	Straightforward	20
99243	Low	30
99244	Moderate	40
99245	High	55

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USING TIME TO SELECT AN E/M CODE

Using Time to Determine E/M Code Level in a Neurosurgical Practice

The decision to use time as metric to determine a level of E/M should consider the following:

- There is a ceiling on the number of hours that can conceivably be billed. There are only so many hours in a day.
- The new outpatient and inpatient guidelines, as applied to a neurosurgical patient population, can support a relatively high level of E/M code with minimal documentation. **For example, a patient with worsening cervical myelopathy for whom surgery is recommended, supports a level four outpatient visit with documentation of "The patient's pain and imaging had worsened and I'm recommending an ACDF," No detailed history or exam is required. Time? 60 minutes new patient, 40 minutes established.**
- For a patient seen in the ED and admitted for emergency surgery, for example, **"The patient has a subdural hematoma and is going directly to the OR", supports a 99223, the highest level inpatient hospital E/M code**. **Time? 75 minutes.**
- In either of these examples, using time, would likely result in a lower value E/M code.
- The only instance when time might be preferable, is in the infrequent occurrence of a non-operative inpatient, when you and your team are doing several subsequent hospital care visits during a single calendar day. Although only one provider may bill, the cumulative time could potentially support the higher level subsequent hospital care code and a prolonged service code.

GUIDELINES: 2023 KEY CHANGES TO INPATIENT & CONSULTATION E/M CODES

- **Problem: the presenting problem you are evaluating. Document status**
  - Chronic/worsening or acute complicated injury= Moderate (level 4 outpatient, 2 inpatient)
  - Significantly worsening or acute/chronic posing a threat to life or bodily function= high (level 5 outpatient, 3 inpatient)
  - Stable/surveillance= Low (level 3 outpatient, 1 inpatient)
- **Data. Document** what you order or review
  - The information you are ordering/reviewing to determine treatment
  - Imaging you personally review. Automatic moderate level in data element

GUIDELINES: 2023 KEY CHANGES TO INPATIENT & CONSULTATION E/M CODES

- **Risk. The clinical perception the risk of treatment recommendations**
  - Major surgery (spine, cranial endovascular) without co-morbidities = Moderate (level 4 outpatient, level 2 inpatient)
  - Major surgery (spine, cranial endovascular) with co-morbidities = High(level 5 outpatient, 3 inpatient)
  - Emergency surgery major surgery (level 5 inpatient)

E/M EXAMPLES: 9920X & 9921X CODES

Scenario	Problems Addressed	Data	Risk	Code
Established patient who had left L5-S1 microdiscectomy 7 years ago now with increasing low back and bilateral buttock pain. No improvement with caudal injections. MRI ordered at last visit, performed outside, shows paracentral disc herniation lateralized to the right at L4-L5. Recommend L4-L5 microdiscectomy.	Moderate	Moderate	Moderate	**99214**

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E/M EXAMPLES: 9920X & 9921X CODES

Scenario	Problems Addressed	Data	Risk	Code
New patient newly diagnosed with a glioblastoma brings in an outside MRI. You discuss treatment options including surgery. The patient elects to have surgery and the procedure risks are documented in the note.	High	Moderate	High	**99205**

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E/M EXAMPLES: INPATIENT 2023

Scenario	Problems Addressed	Data	Risk	Code
You see a patient with significant cerebral edema in the ED with a traumatic brain injury. After evaluation, and review of the CT, you take the patient to the OR for emergency decompression craniectomy.	High	Moderate	High	**99223**
You are called to the ICU to see a head trauma patient who the intensivist identifies as having increased cerebral pressure and altered mental status. You had seen the patient yesterday in the ED and were monitoring the TBI. You place an ICP as an urgent intervention.	High	N/A	Moderate High?	**99232 or 99233 plus ICP code**

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E/M EXAMPLES: INPATIENT 2023

Scenario	Problems Addressed	Data	Risk	Code
Established patient with known herniated disc on the left at L4-L5 comes without an appointment and has foot drop and is in severe pain. You admit the patient to the hospital today and will do a microdiscectomy tomorrow.	High	None	High	**99223**
You see a patient in the ED with the WHOL. Ruptured aneurysm is diagnosed via CT which you personally interpret. You take the patient emergently to the OR.	High	Moderate	High	**99223**

Note: You need 2/3 elements at the same level. If the two of the highest levels are different, such as a Moderate problem and High risk, Moderate MDM is selected.

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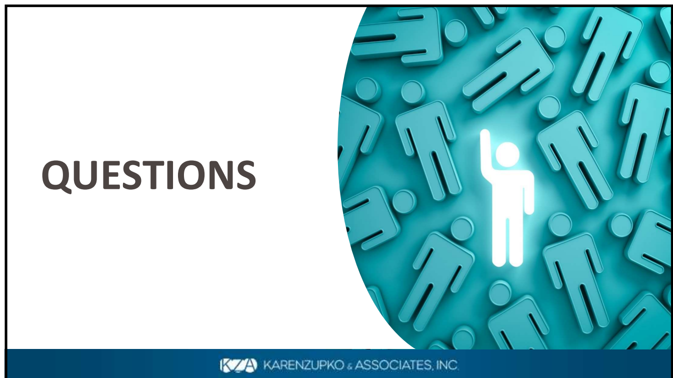

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Thank you
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