SpineSearch

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CORE
Medical Revenue
Cycle Management

Five Pearls Of Coding

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Disclosure Slide

- CEO of SpineSearch and Core Medical RCM
- No other disclosures

Founder SpineSearch

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Founded 2008

H/R and Training

Healthcare Recruitment

Core Medical Revenue Cycle Management

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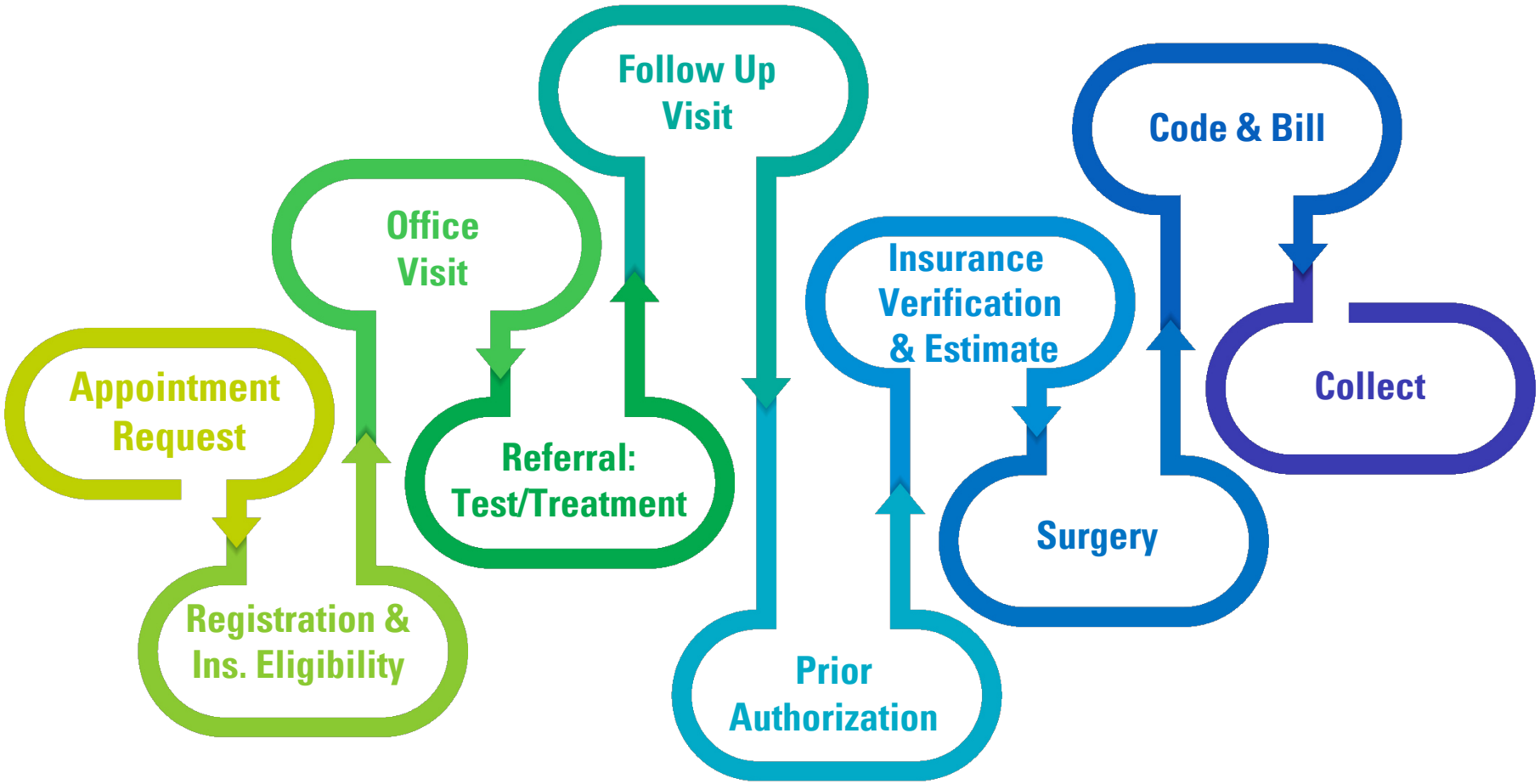
Founded 2018

Revenue Cycle Management
Billing
Coding
Consulting

RCM Process



Pearl #1

Check for CPT & ICD-10 code changes each year.

CPT changes effective January 1st each year.

- New Code
- Revised Code
- Revised Text

ICD-10 changes effective October 1st each year.

ICD-10 – CM (Clinical Modification)

ICD-10- PCS (International Classification of Diseases, 10th Edition, Procedure Coding System) Hospital

What's New: CPT

2024:

- 22836-22838 Anterior thoracic vertebral body tethering
- 27278 Percutaneous SI fusion with intra-articular implants without a transfixing device.
- 64596-64598 Percutaneous peripheral integrated neurostimulator

2025:

- No changes to SPINE surgery codes.
- 61715 (MRgFUS)
- 64446-64474 New fascial plane block codes

Pearl #2

New Telehealth Codes Effective January 1, 2025

CPT	Description
98000-98003	Synchronous audio-video visit – new patient
98004-98007	Synchronous audio-video visit – estab. patient
98008-98011	Synchronous audio-only visit – new patient
98012-98015	Synchronous audio-only visit – estab. patient
98016	Brief communication technology-based service (eg, virtual check-in) – established patient

- 99441-99443 – Telephone E&M Service are DELETED.

Pearl #2

New Telehealth Codes Effective January 1, 2025

- Medicare extended their telehealth flexibilities through 09/30/25.
  - No site restrictions for patient
  - Continue to use the office visit E&M codes 99202-99215
  - POS 10 – patient's home
  - POS 02 – other than patient's home
  - Modifier 93 *if audio only* due to patient inability to do audio and video (e.g. no internet access)
  - 98000-98015 currently not covered by Medicare
- Check payer websites for coding and coverage updates

What's New: ICD-10

October 1, 2024:

M51.36 Lumbar DDD (no longer valid)

M51.360 Lumbar DDD with discogenic backpain only
M51.361 Lumbar DDD with lower extremity pain only
M51.362 Lumbar DDD with discogenic back pain and lower extremity pain
M51.369 Lumbar DDD without mention of lumbar back pain or lower extremity pain

M51.37 Lumbosacral DDD (no longer valid)

M51.370 Lumbosacral DDD with discogenic backpain only
M51.371 Lumbosacral DDD with lower extremity pain only
M51.372 Lumbosacral DDD with discogenic back pain and lower extremity pain
M51.379 Lumbosacral DDD without mention of lumbar back pain or lower extremity pain

Evaluation and Management

- In 2021 New and Established Office Visit coding changed.
  - Old: History, Exam, Medical Decision Making
  - New: Medical Decision Making or Time
- In 2023 Hospital Visit, SNF Visit, and Consult coding changed.
  - Old: History, Exam, Medical Decision Making
  - New: Medical Decision Making or Time
- Changes apply to all payors.
- Reminder: E/M may comprise up to 20% of surgical specialty revenue.

Pearl #3

Update your office visit templates.

- History: medically appropriate.
  - ROS, Past, Family, Social History?
- Exam: medically appropriate.
  - Skin exam?
  - Lymph node exam?
  - Neurological Exam on Spine Patients?
- Focus on Medical Decision Making
  - Problem
  - Data
  - Risk

Evaluation and Management

1. Number and Complexity of **Problems** Addressed at the Encounter
2. Amount and/or Complexity of **Data** to be Reviewed and Analyzed
3. **Risk** of Complications and/or Morbidity or Mortality of Patient Management

Evaluation and Management

Medical Decision Making

✓3 Components

✓2 of the 3 components must support the level of Medical Decision Making.

New Patient Visit	Established Patient Visit	Medical Decision Making
99201 (Deleted)	99211	
99202	99212	Straightforward
99203	99213	Low
99204	99214	Moderate
99205	99215	High

Level of Medical Decision Making (MDM)

Revisions effective January 1, 2023 are noted in red text

	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making: Number and Complexity of Problems Addressed	Elements of Medical Decision Making: 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.*	Elements of Medical Decision Making: Risk of Complications and/or Morbidity or Mortality of Patient Management
	N/A	N/A	N/A	N/A
	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury or • 1 stable acute illness; or • acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited *(Must meet the requirements of at least 1 of the 2 categories)* Category 1: Tests and documents • Any combination of 2 from the following: • Review of prior external note(s) from each unique source*; • review of the result(s) of each unique test*; • ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Low risk of morbidity from additional diagnostic testing or treatment
	Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate *(Must meet the requirements of at least 1 out of 3 categories)* Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)	Moderate risk of morbidity from additional diagnostic testing or treatment *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health
	High	High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	Extensive *(Must meet the requirements of at least 2 out of 3 categories)* Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	High risk of morbidity from additional diagnostic testing or treatment *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Evaluation and Management

Level 4 Example

- Patient has low back pain for the past year, now worsening with numbness in the foot.
- Independent Interpretation of MRI films.
- Ordered PT

Problem: Moderate (Chronic problem with exacerbation)
Data: Moderate (Independent Interpretation)
Risk: Low (PT)

Evaluation and Management

Level 3 Example

- Patient has known stenosis and spondylosis causing low back pain for past 6 months, now worsening with numbness in the foot.
- Ordered an MRI and X-rays.
- Ordered PT.

Problem: Moderate (Chronic problem with exacerbation)
Data: Low (2 tests ordered)
Risk: Low (PT)

Evaluation and Management

Level 2 Example

- Patient returns after 6 weeks of PT for low back pain. Significantly improved.
- No tests ordered or reviewed.
- Return PRN.

Problem: Low (stable acute illness)

Data: None (1 test ordered would be Minimal)

Risk: Straightforward (PRN)

Evaluation and Management

Time

Provider Time ONLY – On the Date of Service

- Preparing to see patient (e.g., review of tests, images, records)
- Obtaining history
- Performing exam
- Counseling/educating patient and/or caregiver
- Ordering tests, medications, procedures
- Referring and communicating with other providers
- Documenting in the EMR
- Interpreting tests and communicating to patient
- Care Coordination

Evaluation and Management

Time

Provider Time ONLY – On the Date of Service

New Patient Visits		Office/Outpatient Consultation		Established Patient Visits	
99202	15-29 minutes	99242	20-29 minutes	99212	10-19 minutes
99203	30-44 minutes	99243	30-39 minutes	99213	20-29 minutes
99204	45-59 minutes	99244	40-54 minutes	99214	30-39 minutes
99205	60-74 minutes	99245	55-69 minutes	99215	40-54 minutes

Evaluation and Management

New Patient

- Not seen by a physician of the same specialty and subspecialty in the same practice within the past 3 years, regardless of diagnosis.
- Hospital Consults and Visits count towards the 3-year rule.
- Any face-to-face service is included in the 3-year rule.
- NPs or PAs are treated as having the same specialty as their physician.

Operative Note

1. Patient Demographics
2. Date of Service
3. Co-surgeon/Assistant
4. Pre-/Post-op Diagnoses
5. Summary of Procedure
6. Indications Paragraph
7. Findings Paragraph
8. Main Body of Report
9. Medical Necessity of Assistant
10. Teaching Physician Attestation

Operative Note

ASSISTANT:

Physician Assistant services utilized for this procedure.

PRELIMINARY DIAGNOSIS:
1. C5-6 DEGENERATIVE DISK DISEASE WITH SPINAL STENOSIS AND SEVERE FORAMINAL STENOSIS.
2. C4-5 CERVICAL SPONDYLOSIS WITH SEVERE LEFT FACET ARTHROSIS.
3. CERVICAL RADICULOPATHY.

POSTOPERATIVE DIAGNOSIS:
1. C5-6 DEGENERATIVE DISK DISEASE WITH SPINAL STENOSIS AND SEVERE FORAMINAL STENOSIS.
2. C4-5 CERVICAL SPONDYLOSIS WITH SEVERE LEFT FACET ARTHROSIS.
3. CERVICAL RADICULOPATHY.

NAME OF OPERATION:
1. ANTERIOR CERVICAL DECOMPRESSION AND FUSION WITH ALLOGRAFT, CAGE AND PLATE NUVASIVE C4-5, C5-6.

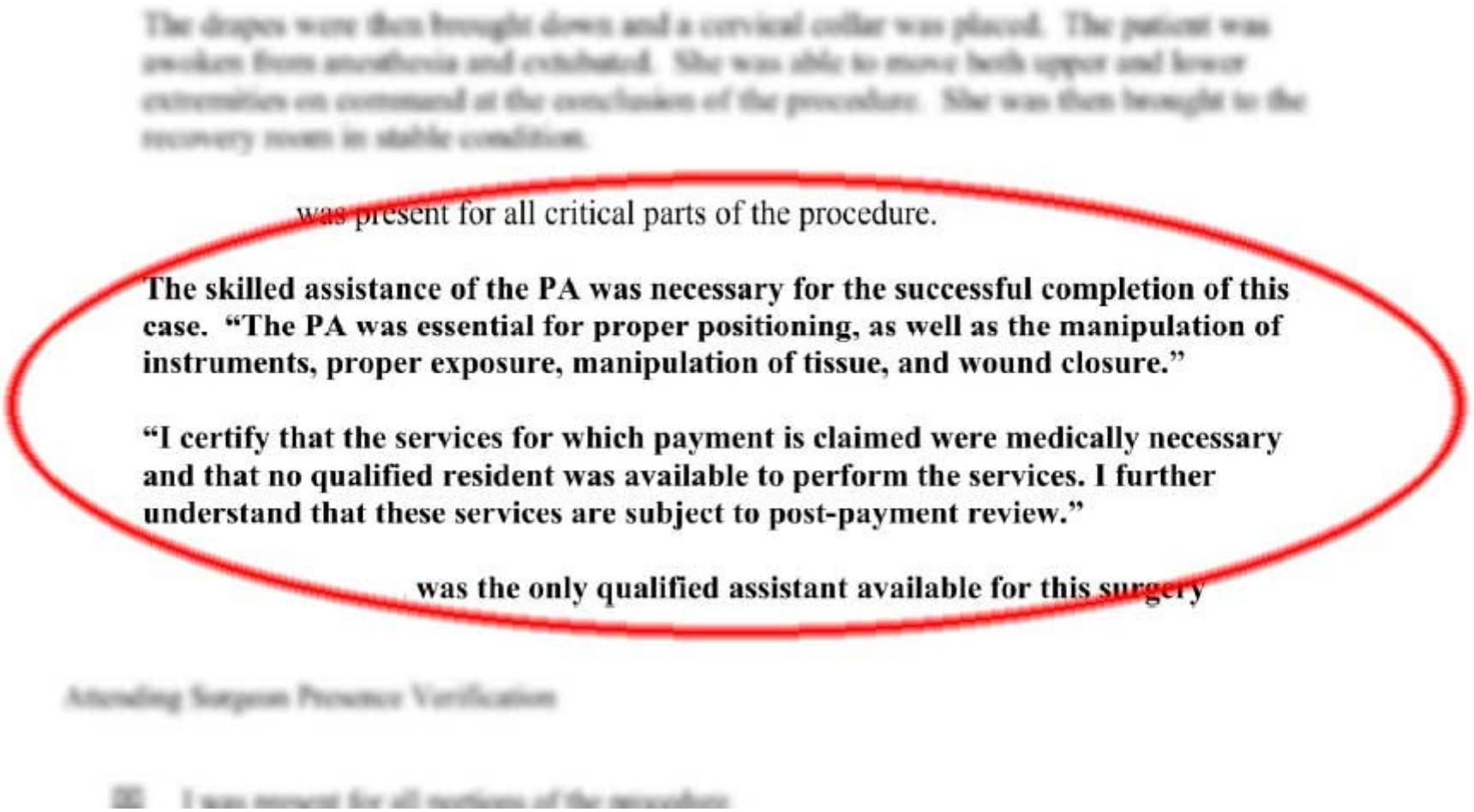
Pearl #4

Create an ICD-10 Cheat Sheet

ICD10	Cervical
M50.21	Disc Displacement, C2-C3, C3-C4
M50.221	Disc Displacement, C4-C5
M50.222	Disc Displacement, C5-C6
M50.223	Disc Displacement, C6-C7
M50.23	Disc Displacement, C7-T1
M50.11	Disc Disorder w/Radic, C2-C3, C3-C4
M50.121	Disc Disorder w/Radic, C4-C5
M50.122	Disc Disorder w/Radic, C5-C6
M50.123	Disc Disorder w/Radic, C6-C7
M50.13	Disc Disorder w/Radic, C7-T1
M50.01	Disc Disorder w/Myelo, C2-C3, C3-C4
M50.021	Disc Disorder w/Myelo, C4-C5
M50.022	Disc Disorder w/Myelo, C5-C6
M50.023	Disc Disorder w/Myelo, C6-C7
M50.03	Disc Disorder w/Myelo, C7-T1

- Levels
- Laterality
- Radiculopathy or Myelopathy
- Stenosis – Neurogenic Claudication Present
- Fractures – Type, Open or Closed, Cord Injury
- Pathologic Fracture – Osteoporosis or Other Cause

Operative Note



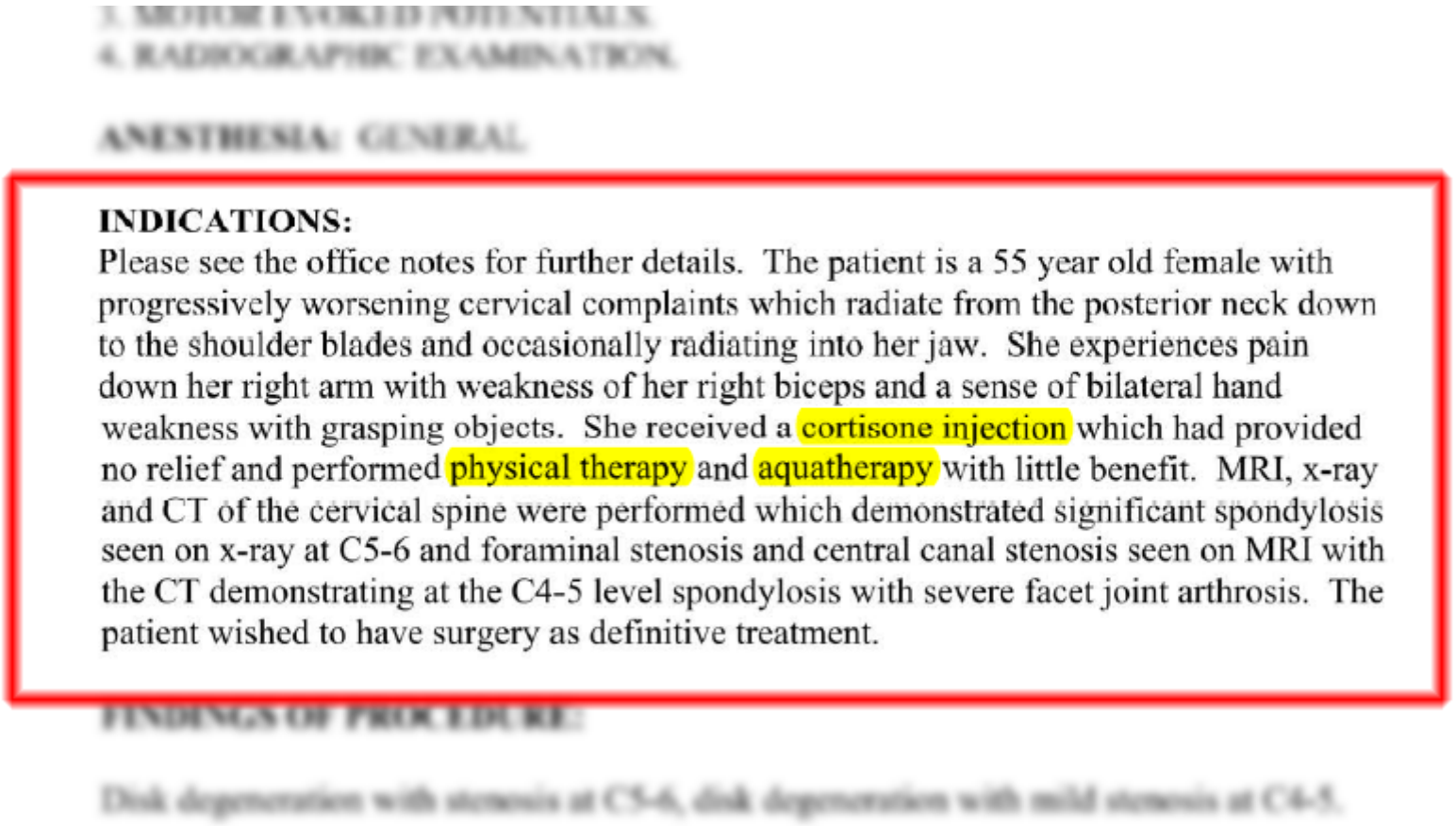
was present for all critical parts of the procedure.

The skilled assistance of the PA was necessary for the successful completion of this case. "The PA was essential for proper positioning, as well as the manipulation of instruments, proper exposure, manipulation of tissue, and wound closure."

"I certify that the services for which payment is claimed were medically necessary and that no qualified resident was available to perform the services. I further understand that these services are subject to post-payment review."

was the only qualified assistant available for this surgery

Operative Note



INDICATIONS:
Please see the office notes for further details. The patient is a 55 year old female with progressively worsening cervical complaints which radiate from the posterior neck down to the shoulder blades and occasionally radiating into her jaw. She experiences pain down her right arm with weakness of her right biceps and a sense of bilateral hand weakness with grasping objects. She received a cortisone injection which had provided no relief and performed physical therapy and aquatherapy with little benefit. MRI, x-ray and CT of the cervical spine were performed which demonstrated significant spondylosis seen on x-ray at C5-6 and foraminal stenosis and central canal stenosis seen on MRI with the CT demonstrating at the C4-5 level spondylosis with severe facet joint arthrosis. The patient wished to have surgery as definitive treatment.

Operative Note

Name of Operation

1. Decompression
2. Fusion
3. Instrumentation
4. Microdissection
5. Stereotactic Navigation
6. Grafts
7. Bone Marrow Aspirate
8. Moderate Sedation

Operative Note

2. C4-5 CERVICAL SPONDYLOSIS WITH SEVERE LEFT FACET ARTHROSIS.
3. CERVICAL RADICULOPATHY.

NAME OF OPERATION:
1. ANTERIOR CERVICAL DECOMPRESSION AND FUSION WITH ALLOGRAFT, CAGE AND PLATE (Specify Brand/Type) C4-5, C5-6.
2. PLACEMENT AND REMOVAL OF GARDNER WELLS TONGS.
3. MOTOR EVOKED POTENTIALS.
4. RADIOGRAPHIC EXAMINATION.

ANESTHESIA: GENERAL

INDICATIONS:
Please see the office notes for further details. The patient is a 55 year old female with

Modifiers

Modifier	Description	Typical %
80	Assistant Surgeon	16%
82	Assistant Surgeon (qualified resident not available)	16%
AS	NP or PA Assistant at Surgery	13.6%
62	Co-surgeon	62.5%
50	Bilateral Procedure	150%
51	Multiple Procedure	50%
59	Distinct Procedural Service	Varies
22	Increased Procedural Services	Varies

Pearl #5

Use Modifier 59 for a Plate separate from a Cage.

- CCI Edit bundles CPT 22845, anterior instrumentation (plate), with CPT 22853, interbody biomechanical device (PEEK cage).
- IF the plate is completely separate from the cage (i.e. can be used with any other cage or structural allograft), then add modifier 59 to 22845 to appropriately bypass the CCI edit.
- IF the plate is not separate, it is considered an *integrated device*, and only 22853 should be coded.

Modifiers

Global Period Modifiers

Modifier	Description	Typical %
58	Staged or Related Procedure During Post-op Period	100%
78	Unplanned Return to the OR (complication) During Post-op Period	@75%
79	Unrelated Procedure During the Post-op Period	100%

Modifiers

What is the 101 on CCI edits and bundling?

- NCCI = National Correct Coding Initiative
- Published and updated by CMS quarterly
- Goal is to promote correct coding and reduce improper coding and payments of Medicare Part B and Medicaid claims.
- Majority of private payers also use CCI edits when processing claims.
- 2 types of CCI edits:
  - Procedure to Procedure (PTP) Edits – "bundling edits"
  - Medically Unlikely Edits (MUE) – maximum number of units

Modifiers

Case Example

2 Level ACDF, PEEK Cages, separate Anterior Plate, Morselized Allograft

22551
22552
22845-59
22853 x 2
20936

What happens if modifier 59 is not billed with 22845? *Denial*

Modifier 62: Two Surgeons (aka Co-Surgery)

- CPT says: Two surgeons performing different parts of a single CPT code
- Medicare and many payors say: Two *different specialty* surgeons performed different parts of a single CPT code. Payors do not recognize fellowship subspecialties.
- Classic example: CPT 22558 (*Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar*)

Vascular Surgery	*Orthopedic Spine Surgery*
• Approach • Closure	• Discectomy • Endplate preparation/decortication • Placement of bone graft
Both surgeons report 22558-62 because neither surgeon performed all elements of the same single CPT code	

Modifier 62: Two Surgeons (aka Co-Surgery)

NOT co-surgery: Ortho Spine Surgery does the fusion and instrumentation while Neurosurgery does the decompression

Why? A single CPT code is not being "shared". Each surgeon reports his/her own codes (OSS: fusion, instrumentation) (NS: decompression). This is "collegial" co-surgery – not "coding" co-surgery.

Gray area: OSS and NS doing an entire case together (e.g., OSS does left side while NS does right side)

- CPT says no modifier 62 on instrumentation and bone graft codes. That leaves the fusion and decompression codes available for modifier 62.
  - Of which CPT code are the two surgeons doing different parts???
- Payors say "why are two surgeons with the same expertise required"? Modifier 62 costs payors more money (125% for co-surgery vs 116% for assistant surgery).

Modifier 62: Two Surgeons (aka Co-Surgery)

To determine if CPT modifier 62 is applicable to a particular surgical CPT code:

1. Refer to the Medicare Physician Fee Schedule database (MPFSDB) and select Payment Policy Indicators.
2. Check the Medicare Physician Fee Schedule for an indicator next to the procedure code (0, 1, or 2).
3. If the code carries a co-surgery indicator of "1," you must supply documentation to establish medical necessity for two surgeons. If it's a "2," you may append modifier 62 as long as each of the operating surgeons is of a different specialty.

	A	B	C	D	E	U	V	W
1			2025 National Physician Fee Schedule Relative Value File Ja					
2			CPT codes and descriptions only are copyright 2024 American Medical Association. All Rig					
3			Dental codes (D codes) are copyright 2025/26 American Dental Association. All Rights Rese					
4								
5			RELEASED 12/23/2024					
6								
7					NOT USED			
8					FOR			
9				STATUS	MEDICARE	ASST	CO-	TEAM
10	HCPCS	MOD	DESCRIPTION	CODE	PAYMENT	SURG	SURG	SURG
381	22632		Arthrd pst tq 1ntrspc lm ea	A		2	2	0
382	22633		Arthrd cmbn 1ntrspc lumbar	A		2	2	0
383	22634		Arthrd cmbn 1ntrspc ea addl	A		2	2	0

Modifier 22:
Increased Procedural Services

CPT says: “When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient’s condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.”

Note: The whole point of using modifier 22 is to be paid more $$.

Modifier 22: Increased Procedural Services

Question How often is Medicare's modifier 22 used in common surgical procedures and is its use associated with increased compensation?

Findings In this cross-sectional study evaluating 10 high-volume surgical procedures (N = 625 316), modifier 22 was appended to a relatively small number of cases; associated charges were somewhat higher, but payment increases were small. Further, because modifier 22 claims were more likely to be denied, the net financial impact was negligible.

Meaning The findings suggest that alternative mechanisms are needed for surgeons to be able to accurately convey increased work and to create incentives for providing equitable care to patients with the most complex cases.

https://jamanetwork.com/journals/jamasurgery/fullarticle/2816728

Modifier 22:
Increased Procedural Services

Medicare and payors say:

- Time – compare actual procedure time to CMS physician work time assigned to each CPT code

	A	B	C	D	E	F
1	cpt_code	Pre_Evaluation_Time	Pre_Positioning_time	Pre_Service_Scrub_Dress_Wait_tim	Median_Intra_Service_Time	Immediate_post_Service_time
091	22630	40	20	15	150	30
092	22632	0	0	0	60	0
093	22633	40	20	15	180	30
094	22634	0	0	0	65	0

Modifier 22: Increased Procedural Services

CPT	*Brief Description*	*CMS Intra-Service Time*	*Surgeon Documented Time*
22633	Combined PL and PLIF / TLIF	180 min	
+63052	Decompression at same level as 1st PL/PLIF/TLIF	45 min	20-30 min
+22840	Instrumentation	60 min	
+61783	Spinal navigation	30 min	20-30 min
+22853	Cage	45 min	
+20937	Iliac crest graft harvest	40 min	
		Total 400 min (almost 7 hours)	

Are these statements necessary?

"....nerve root decompression above and beyond what required for TLIF requiring an additional 20-30 minutes of surgical time"

"....requiring additional 20-30 minutes of time for preoperative planning for navigation assistance"

Modifier 22: Increased Procedural Services

CPT	*Brief Description*	*CMS Intra-Service Time*	*Surgeon Documented Time*
22633	Combined PL and PLIF / TLIF	180 min	
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+22840	Instrumentation	60 min	
+61783	Spinal navigation	30 min	20-30 min
+22853	Cage	45 min	
+20937	Iliac crest graft harvest	40 min	
	Total	400 min (almost 7 hours)	

What beyond time can we use to support modifier 22? How often to use 22?

S-I Joint Fusion:
Code is on the Payor Radar Screen

27280 (*Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed*)

Code includes placement of instrumentation across the joint (cannot separately report +22848, pelvic instrumentation) and harvest/use of bone graft (cannot separately report +20930, +20931, +20936, +20937, +20938) even if using bone graft for other fusion procedures.

In short, 27280 requires documentation of:

- Opening the sacro-iliac joint
- Decortication of the joint
- Placement of bone graft into the joint

27280 is NOT merely placement of S2-alar screws or other pelvic instrumentation – that is add-on code +22848 (*Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure*)

Back to Osteotomies: An Area of Documentation Improvement

	Posterior "Decompression" (63xxx)	*Posterior Osteotomy (2221x)*
Includes:	• Laminectomy, partial/total facetectomy, foraminotomy, nerve root decompression	• Same work involved in decompression code (meaning do not report 63xxx code with 2221x code for procedures at same spinal level)
Diagnosis:	• Examples: disc disease, spondylosis, spondylolisthesis	• Deformity (eg, scoliosis, kyphosis)
Documentation:	• Removal of spinous processes, lamina(e), partial/full facetectomy, foraminotomy, nerve decompression	• Must say more than "osteotomies were performed" • Removal of wedge of bone including lamina, resect posterior ligament, pars interarticularis, and entire facet joint (adjacent inferior and superior articular processes); resulting gap was closed which resulted in realignment of the spine (eg, "to achieve xx-xx degrees of lordosis")
Time:	• 63045 (C) = 120 min (2 hrs) • 63046 (T) = 120 min • 63047 (L) = 90 min (1 hr)	• 22210 (C) = 180 min (3 hrs) • 22212 (T) = 210 min • 22214 (L) = 200 min (3+ hrs)

Review of the 5 Pearls

1. Check for CPT & ICD-10 code changes each year.
2. New Telehealth Codes Effective January 1, 2025
3. Update your office visit templates.
4. Create an ICD-10 Cheat Sheet
5. Use Modifier 59 for a Plate separate from a Cage.

5 Take Aways

1. Change in Telehealth
2. Additional DDD ICD 10 Coding
3. Op Note Documentation Tips
4. Modifiers 62/22
5. Resources

Resources

- The AMA owns CPT: New Codes 1/1
- WHO owns and publishes ICD 10: Annually 10/1
- New codes can be found here: cms.gov
- CMS owns HCPCS
- NASS
  Annual coding course
- AANS
  Annual coding course
- AAPC
  Multiple Courses
  Codify

THANK YOU!

NERVES
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