



“Back” to Basics...Coding Spinal Procedures

Mary Chelucci, RHIA, CCS
Sarah Reed, RHIT, CCS



Disclaimer

Every reasonable effort has been taken to ensure that the educational information provided in this presentation is accurate and useful. Applying best practice solutions and achieving results will vary in each hospital/facility situation. A thorough individual review of the information is recommended and to establish individual facility guidelines.

MRA does not guarantee the contents of this material and denies any implied guarantee of appropriateness of this material for any specific purpose. MRA is not liable or responsible for any loss or damage caused by the information presented in this material including but not limited to any loss of revenue, interruption of service, loss of business, or indirect damages resulting from the use of this presentation.

Furthermore, MRA does not guarantee that the content of this material will restrict disputes or differences of opinions with third party payers (Medicare or otherwise) as to the specific dollar amount that is to be paid to the service provider. Copying, distributing, recreating or any other unauthorized use of the content in these slides without the express written consent of Medical Record Associates is strictly prohibited.



Presenter's Bio

Mary Chelucci, RHIA, CCS, has been in HIM for over 35 years. Mary is currently working as a Project Manager and Auditor for MRA. Prior to MRA, she has worked as a Coder, Trauma Registrar, Medical Records Supervisor and Medical Records Coordinator for acute care hospitals and one outpatient clinic.



Co-Author Bio

Sarah Reed, RHIT, CCS works with MRA as an Outpatient Coding Auditor and Trainer. She has over 10 years of experience working in HIM and specializes in SDS Coding. Prior to joining MRA, her past positions included Surgery Coding Specialist, Senior Coding Compliance Auditor and Revenue Integrity Failed Claims Specialist.



Learning Objectives

- **Define Specific Spinal Procedures Including:**
 - Laminectomies
 - Discectomies
 - Vertebroplasties/Kyphoplasties
 - Spinal Fusions
- **Review Official Coding Guidelines and coding conventions of ICD 10 PCS and CPT.**
- **Review Coding Clinic and CPT Assistant references**



Laminectomy



What is a Laminectomy?

- A laminectomy is a procedure where a portion of the vertebra is removed. This is done to decompress the spinal nerve root or the spinal cord.
- This procedure may be performed as an Open, Percutaneous or Percutaneous Endoscopic approach in ICD 10 PCS coding.



Why a Laminectomy?

- To decompress the spinal nerve root
- To excise a synovial cyst
- To excise a spinal cord lesion
- To inspect the spinal cord
- Often a laminectomy is the approach to a procedure (such as a spinal fusion) and is not coded separately in PCS.



Coding Clinic

- **Decompressive laminectomy - clarification**
 - ICD-10-CM/PCS Coding Clinic, **Second Quarter ICD-10 2015** Page: 34
Effective with discharges: July 6, 2015
- A question was asked regarding decompression laminectomies. Are these considered Excision or Release as the Root Operation?



Coding Clinic (cont.)

- The answer is that this would be considered “Release” as the Root Operation since it is done to release the spinal nerve root.



Coding Clinic

- **Decompressive laminectomy (release of spinal cord versus release of spinal meninges)**
 - ICD-10-CM/PCS Coding Clinic, **Third Quarter ICD-10 2018** Page: 30
Effective with discharges: September 24, 2018
- A question was asked regarding the decompression of the thecal sac. Also documented as release of the thecal sac. The question is regarding the Body Part in this case.



Coding Clinic (cont.)

- The answer is Body Part of spinal cord in this case.



CPT Decompressive Laminectomy

- **CPT 63017** – Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (e.g. spinal stenosis), more than two vertebral segments; lumbar
- **CPT definition:** A *vertebral segment* describes the basic constituent part into which the spine may be divided. It represents a single complete vertebral bone with its associated articular processes and laminae



Excision of Synovial Cyst



What is a Synovial Cyst?

- An abnormal fluid filled sac in the spinal joint. These cysts are benign.



Why do a Synovial Cystectomy?

- Synovial cysts can cause spinal stenosis, or the spinal nerves may become pinched. This can cause weakness, numbness or pain.



Coding Clinic

- **Excision of synovial cyst**
 - ICD-10-CM/PCS Coding Clinic, **Second Quarter ICD-10 2018** Pages: 22-23 Effective with discharges: June 6, 2018
 - Related Information
- A question was asked regarding removal of a synovial cyst with a L4-L5 laminectomy. How is the synovial cyst removal coded?



Coding Clinic (cont.)

- The answer is 01NB0ZZ. (Release Lumbar nerve, Open Approach)
This would be a release of the nerve root since the synovial cyst is causing pressure on the nerve.



CPT Excision of Synovial Cyst

- **CPT 63267** – Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; lumbar
 - **Tip:** CPT 63267 includes the decompression and partial facetectomy and isn't coded separately when performed at the same level.



Discectomy



What is a Discectomy?

- When an intervertebral disc is partially or totally removed.
- This procedure may be performed as an Open, Percutaneous or Percutaneous Endoscopic (arthroscopic) approach in ICD 10 PCS coding.



Why a Discectomy?

- A discectomy is performed to remove the disc or disc material that is compressing the spinal nerve root or spinal cord.



Coding Clinic

- **Decompressive laminectomy/foraminotomy and lumbar discectomy**
 - ICD-10-CM/PCS Coding Clinic, **Second Quarter ICD-10 2016** Page: 16
Effective with discharges: May 27, 2016
- A question was asked regarding a patient with both a disc herniation and foraminal stenosis. Both a discectomy was performed, and laminectomy done to decompress the nerve roots. Can both the laminectomy and the discectomy be coded?



Coding Clinic (cont.)

- The answer is that both can be coded in this case. The discectomy was done to treat the disc herniation and the laminectomy was done to treat the foraminal stenosis.
- Root operations: Excision and Release



CPT Decompressive Laminectomy, Foraminotomy and Lumbar Discectomy

- **CPT 63030** – Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
- **CPT +63035** – each additional interspace
- **CPT definition:** A *vertebral interspace* is the non-bony compartment between two adjacent vertebral bodies, which contains the intervertebral disc, and includes the nucleus pulposus, annulus fibrosus and two cartilaginous endplates.



Vertebroplasty/Kyphoplasty



What is a Vertebroplasty/ Kyphoplasty?

Surgical procedures used for vertebral compression fractures. The collapsed vertebra is surgically corrected by using a filler (usually bone cement). This relieves pressure on the nerve which causes pain. These are similar procedures. A vertebroplasty is performed by injecting cement into the bone fracture. Kyphoplasty is performed by inserting a balloon to correct the collapsed vertebral height first before injecting the cement.

- Procedures are performed as a Percutaneous approach in ICD 10 PCS coding.
- If a vertebral biopsy is performed during this procedure, it would also be coded.



Why a Vertebroplasty/Kyphoplasty?

- To relieve the pain from the fracture
- To stabilize the fracture
- To reduce the deformity
- To correct the vertebral height which was lost after fracture



The ICD-10-CM and ICD-10-PCS Coding Handbook

23. Diseases of the Musculoskeletal System and Connective Tissue

Vertebroplasty and Kyphoplasty

- Percutaneous vertebroplasty is a technique used to treat vertebral compression fractures. The procedure involves the insertion of cement glue-like material (polymethylmethacrylate) into the vertebral body to stabilize and strengthen collapsed or crushed bone. ICD-10-PCS classifies this procedure to the root operation "Supplement," with "synthetic substitute" for the device value. For example, percutaneous lumbar vertebroplasty is coded to **0QU03JZ, Supplement lumbar vertebra with synthetic substitute, percutaneous approach.**
- The ARCUATE™ XP procedure is a variation of a percutaneous vertebroplasty in which an osteotome is used to cut arcs in the cancellous bone within the vertebral body. The arcs created with the osteotome allow for dispersion of bone cement material when it is subsequently injected into the vertebral body. No bone or bone marrow is removed from, or compacted within, the vertebral body. The ARCUATE™ XP procedure is also coded to the root operation "Supplement."



The ICD-10-CM and ICD-10-PCS Coding Handbook

23. Diseases of the Musculoskeletal System and Connective Tissue

- Percutaneous vertebral augmentation is a procedure using an inflatable balloon that is expanded to reestablish vertebral height in compression fractures. After the balloon is removed, the cavity is filled with polymethylmethacrylate, which hardens to further stabilize the bone. Coding of percutaneous vertebral augmentation requires two codes, one for the root operation "Reposition" and another for the root operation "Supplement." Other similar procedures coded in the same manner include arcuoplasty, kyphoplasty, skyphoplasty, and spineoplasty. For example, percutaneous kyphoplasty of the lumbar spine should be coded to **0QS03ZZ, Reposition lumbar vertebra, percutaneous approach**, and **0QU03JZ, Supplement lumbar vertebra with synthetic substitute, percutaneous approach**.
- While these procedures are similar, there is no balloon involved in the vertebroplasty, and no attempt is made to restore vertebral height to reduce the compression fractures of the vertebra; therefore, only the root operation "Supplement" is coded for vertebroplasty and not "Reposition."
- If a vertebral biopsy is performed during a kyphoplasty of the lumbar vertebra, assign codes **0QS03ZZ, Reposition lumbar vertebra, percutaneous approach**; **0QU03JZ, Supplement lumbar vertebra with synthetic substitute, percutaneous approach**; and **0QB03ZX, Excision of lumbar vertebra, percutaneous approach, diagnostic**. The biopsy is not an inherent part of the kyphoplasty and should be coded separately if performed.



Coding Clinic

- **Percutaneous vertebroplasty using cement**
 - ICD-10-CM/PCS Coding Clinic, **Second Quarter ICD-10 2014** Pages: 12-13 Effective with discharges: May 26, 2014
- A question was asked whether the cement used in a vertebroplasty is a Device in PCS?



Coding Clinic (cont.)

- The answer is yes this is considered a device. It would be a synthetic substitute.
- According to the ICD-10-PCS Reference Manual, Appendix B, page 120, "Material that is classified as a PCS device is distinguished from material classified as a PCS substance by the fact that it has a specific location. A device is intended to maintain a fixed location at the procedure site where it was put, whereas a substance is intended to disperse or be absorbed in the body."
- "Material that is classified as a PCS device is also distinguishable by the fact that it is removable. Although it may not be practical to remove some types of devices once they become established at the site, it is physically possible to remove a device for some time after the procedure.



Coding Clinic (cont.)

- Kiva kyphoplasty
- ICD-10-CM/PCS Coding Clinic Second Quarter ICD-10 2019 Page 35
- Effective with discharges June 21, 2019

Question:

- How do you code a Kiva kyphoplasty at L5? This is treatment utilizing an implant instead of the usual balloon technique. The Kiva implant is deployed followed by an injection of cement.



Coding Clinic (cont.)

Answer:

- 0QU30JZ Supplement lumbar vertebra with synthetic substitute, percutaneous approach
- Since the Kiva implant is designed to support the vertebral body and there is a reservoir for the bone cement, no separate code is assigned.



CPT Percutaneous Vertebroplasty

- **CPT 22510-22512** Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance;
 - Select code by location (cervicothoracic, lumbosacral)
 - Biopsy included, imaging included, unilateral or bilateral
- **Vertebroplasty** - injection of cement into the vertebral body to reinforce the structure of the vertebral body.
 - Treatment of osteoporotic or neoplastic compression fractures with intractable pain



CPT Percutaneous Augmentation (Kyphoplasty)

- **CPT 22513-22515** Vertebral Augmentation (thoracic or lumbar)
 - Cavity creation followed by injection of bone cement
 - Fracture reduction and bone biopsy included
 - Unilateral or bilateral, per vertebral body
 - For cervical vertebral augmentation use unlisted code **22899**
 - *(CPT Assistant, January 2015, Volume 25, Issue 1, page 8)*
- **CPT 0200T-0201T** Sacral Augmentation
 - Injection of bone cement with or without cavity creation
 - Sacral procedures are reported once per encounter
 - **0200T** unilateral injection(s), one or more needles
 - **0201T** bilateral injections, 2 or more needles



Spinal Fusion



What is a Spinal Fusion?

- When the vertebrae are fused together to prevent movement between them.
- This may be performed anteriorly (from the front) or posteriorly (from the back).
- May be with an interbody fusion device or bone graft.
- May be performed as Open, Percutaneous or Percutaneous Endoscopic (arthroscopic) approach in ICD 10 PCS coding.



Why a Spinal Fusion?

- To stabilize the spine when the spine is weak
- To correct a deformity such as scoliosis
- For disc degeneration or for spondylolisthesis



PCS Coding Guidelines

Fusion Procedures of the Spine

- B3.10a The body part coded for a spinal vertebral joint(s) rendered immobile by a spinal fusion procedure is classified by the level of the spine (e.g. thoracic). There are distinct body part values for a single vertebral joint and for multiple vertebral joints at each spinal level. Example: Body part values specify Lumbar Vertebral Joint, Lumbar Vertebral Joints, 2 or More and Lumbosacral Vertebral Joint.
- B3.10b If multiple vertebral joints are fused, a separate procedure is coded for each vertebral joint that uses a different device and/or qualifier. Example: Fusion of lumbar vertebral joint, posterior approach, anterior column and fusion of lumbar vertebral joint, posterior approach, posterior column are coded separately.
- B3.10c Combinations of devices and materials are often used on a vertebral joint to render the joint immobile. When combinations of devices are used on the same vertebral joint, the device value coded for the procedure is as follows:
 - If an interbody fusion device is used to render the joint immobile (containing bone graft or bone graft substitute), the procedure is coded with the device value Interbody Fusion Device
 - If bone graft is the only device used to render the joint immobile, the procedure is coded with the device value Nonautologous Tissue Substitute or Autologous Tissue Substitute
 - If a mixture of autologous and nonautologous bone graft (with or without biological or synthetic extenders or binders) is used to render the joint immobile, code the procedure with the device value Autologous Tissue Substitute

Examples: Fusion of a vertebral joint using a cage style interbody fusion device containing morselized bone graft is coded to the device Interbody Fusion Device. Fusion of a vertebral joint using a bone dowel interbody fusion device made of cadaver bone and packed with a mixture of local morselized bone and demineralized bone matrix is coded to the device Interbody Fusion Device. Fusion of a vertebral joint using both autologous bone graft and bone bank bone graft is coded to the device Autologous Tissue Substitute



Coding Guidelines (cont.)

No additional code is assigned for the insertion of fixation devices such as rods, plates, and screws. They are components of the root operation "Fusion."

Occasionally, instrumentation called interbody fusion devices are used to stabilize and fuse degenerative disc spaces and to provide an immediately stable segment for fusion and relief of symptoms. These devices are also known as interbody fusion cage, BAK cage, ray-threaded fusion cage, synthetic cage, spacer, or bone dowels. Combinations of devices and materials are often used on a vertebral joint to render the joint immobile. When combinations of devices are used on the same vertebral joint, the device value for the procedure is coded using the following guidelines:

If a mixture of autologous and nonautologous bone graft (with or without biological or synthetic extenders or binders) is used to render the joint immobile, code the procedure with the device value Autologous Tissue Substitute. Examples: Fusion of a vertebral joint using a cage style interbody fusion device containing morselized bone graft is coded to the device Interbody Fusion Device. Fusion of a vertebral joint using a bone dowel interbody fusion device made of cadaver bone and packed with a mixture of local morselized bone and demineralized bone matrix is coded to the device Interbody Fusion Device. Fusion of a vertebral joint using both autologous bone graft and bone bank bone graft is coded to the device Autologous Tissue Substitute.



Coding Guidelines (cont.)

Coding of Diseases of the Skin and Diseases of the Musculoskeletal System

23 Diseases of the Musculoskeletal System and Connective Tissue

- Spinal fusion is a surgical procedure whereby two or more vertebrae are fused to correct problems with the vertebrae. The vertebrae can be fused using bone grafting, genetically engineered bone substitute, and interbody fusion devices containing bone graft material. The goal of spinal fusion surgery is pain relief after conservative treatments have failed. The procedure is indicated for spinal vertebrae injuries such as protrusion and degeneration of the cushion between vertebrae, curvature of the spine, or weak spine caused by injections or tumors.
- Traditionally, three basic approaches have been used for spinal fusion or spinal refusion: anterior, posterior, and lateral transverse. The classic anterior approach requires an incision in the neck or the abdomen, and the fusion is carried out from the front of the vertebrae through the anterior annulus. In the classic posterior approach, the incision is made in the patient's back directly over the vertebrae. In the lateral transverse approach, an incision is made on the patient's side and the vertebrae are approached through the lamina.



Coding Guidelines (cont.)

- During an anterior column fusion, the body (corpus) of adjacent vertebrae are fused (interbody fusion). The anterior column can be fused using an anterior, lateral, or posterior technique. For the posterior column fusion, posterior structures of adjacent vertebrae are fused (pedicle, lamina, facet, transverse process, or "gutter" fusion). A posterior column fusion can be performed using a posterior, posterolateral, or lateral transverse technique.
- Spinal fusion and refusion procedures are coded to the root operation "Fusion"--joining together portions of an articular body part rendering the articular body part immobile. The body part coded for a spinal vertebral joint(s) rendered immobile by a spinal fusion procedure is classified by the level of the spine, namely, cervical, thoracic, lumbar, lumbosacral, or sacrococcygeal. There are distinct body part values for a single vertebral joint and for multiple vertebral joints at each spinal level. For example, body part values specify "lumbar vertebral joint," "lumbar vertebral joints, 2 or more," and "lumbosacral joint."
- If multiple vertebral joints are fused, a separate procedure is coded for each vertebral joint that uses a different device and/or qualifier. For example, **Open fusion of lumbar vertebral joint with synthetic substitute, posterior approach, anterior column (OSG00JJ)**, and **Open fusion of lumbar vertebral joint with synthetic substitute, posterior approach, posterior column (OSG00J1)**, are coded separately because the procedures involve different portions of the column (anterior column versus posterior column).



Coding Guidelines (cont.)

Interbody Fusion Devices (IBFD):

Interbody fusion device used alone, refers to spacers or dowel that are made of bone and used without a cage or other IBFD to fuse the joint.

Instrumentation alone (e.g., cage, spacer, IBFD) without any type of bone graft material to join the vertebral joints is not considered a Fusion, but an Insertion.

Spinal Instrumentation:

When assigning PCS codes for procedures using spinal instrumentation (e.g., pedicle screws, rods, spinal instrumentation, stabilization devices, or internal fixation devices), code the procedure based on what was done, rather than the device used. These devices are NOT separately coded when a spinal fusion is performed. However, if there was no documentation of bone graft or a bone graft substitute being utilized (Fusion), then code Insertion of instrumentation into the vertebral bone or Insertion of spinal motion preservation device into the vertebral joints.

The DTRAX Spinal System is a set of instruments intended and indicated for access and preparation of a spinal joint to aid in a cervical posterior fusion of the facet joints.

NuVasive VersaTie (posterior tethering system)

When fixation instrumentation or posterior tethering devices (e.g., VersaTie) are placed synchronously with a spinal fusion, the instrumentation is considered integral to the fusion procedure and no additional code is assigned.

Source: 3M Encoder Nosology



Spinal Fusion Acronyms

- **ALIF:** The anterior lumbar interbody fusion (ALIF) is an interbody fusion of the anterior and middle columns of the spine through an anterior incision, either transperitoneal or retroperitoneal. It can also be done laparoscopically.
- **AxiaLIF:** The axial lumbar interbody fusion (AxiaLIF®) is a percutaneous fusion of the anterior column at L5-S1. An AxiaLIF® 360° refers to the combination of an AxiaLIF® procedure of the anterior column performed along with a posterior column fusion, which may include the use of pedicle screws or facet screws. The AxiaLIF® 360° is described as providing a percutaneous 360° fusion.
- **DLIF:** The direct lateral lumbar interbody fusion (DLIF) is a minimally invasive alternative to conventional spinal fusion. The DLIF is performed through a lateral approach, which allows for limited soft-tissue disruption. The procedure can only be performed at L4-L5 or at higher levels and requires dissection through the psoas muscle.
- **PLIF:** The posterior lumbar interbody fusion (PLIF) involves an anterior and middle column fusion through a posterior approach.
- **TLIF:** The transforaminal lumbar interbody fusion (TLIF) involves a transverse lateral interbody fusion through a posterior approach.
- **XLIF:** The extreme lateral interbody fusion (XLIF®) is a less invasive spinal surgery of the anterior column. The fusion may be accomplished either percutaneously or via a circular tube retractor through a lateral approach.

Spinal fusion Qualifiers



TABLE 23.2 Common Fusion and Refusion ICD-10-PCS Qualifiers

Fusion Procedure	Approach and Column	ICD-10-PCS Qualifier (Seventh Character)
ALIF	Anterior approach, anterior column	0
AxialIF	Posterior approach, anterior column	J
DLIF	Anterior approach, anterior column	0
PLIF	Posterior approach, anterior column	J
TLIF	Posterior approach, anterior column	J
XLIF	Anterior approach, anterior column	0

Source: Coders' Desk Reference for ICD-10-PCS Procedures by Optum



Example of coding fusion in PCS

1. Anterior Approach, Anterior Column (e.g., ALIF, DLIF, retroperitoneal, XLIF)
2. Posterior Approach, Anterior Column (e.g., AxiaLIF, PLIF, TLIF)
3. Posterior Approach, Posterior Column (posterolateral, transpedicular, transverse process)

Source: 3M Encoder



Fusion, Spinal, Interbody Fusion Device

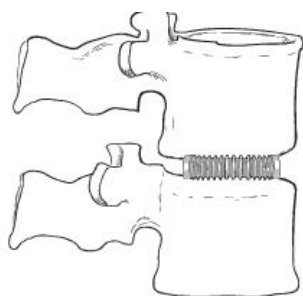
Spinal fusion, also known as spinal arthrodesis, fuses together one or more vertebral joints. To facilitate the fusion, graft material, sometimes on its own but often within an implanted device, must be inserted. A graft-filled implant, referred to as Interbody Fusion Device in ICD-10-PCS, is specifically used for fusions of the anterior spinal column; it is not an option for posterior column fusions. Documentation may include metal or titanium cage (BAK, Ray threaded), polyetheretherketone (PEEK) cage, polymer (Bengal[®]), threaded bone dowel, radiolucent porous (COALESCE[®], COHERE[®]), nanotextured surface (nanoLOCK[™] or Titan Endoskeleton[™]).

Although interbody fusion devices are used only for anterior column fusions, access to the anterior column can be gained through various approaches—anterior, lateral, or posterior. The seventh-character qualifier value is used to identify the anatomical access used to place the device in the anterior column. The following list provides terminology commonly used in documentation and the anatomical access or approach with which it is associated.

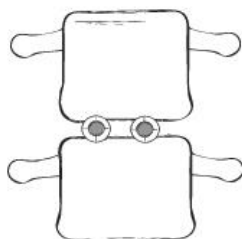
- Anterior approach:
 - Anterior lumbar interbody fusion (ALIF)
 - Direct lateral interbody fusion (DLIF)
 - Extreme lateral interbody fusion (XLIF)
 - Transpsoas interbody fusion
- Posterior approach:
 - Posterior lumbar interbody fusion (PLIF)
 - Transforaminal lumbar interbody fusion (TLIF)
 - Axial lumbar interbody fusion (AxiaLIF)



Fusion, Spinal, Interbody Fusion Device

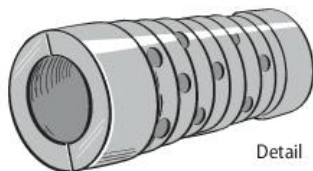


Metal cages support spine until fusion occurs



Anterior view

Spinal fusion with metal cages



Detail

Under general anesthesia, the patient is positioned on the table based on the vertebral level being fused and the anatomical access point required to reach the anterior column. Using an Open approach, an incision is made, muscles and other structures are retracted carefully to one side, and retractors are placed. Bone and degenerated or herniated intervertebral disc material are removed at the levels to be decompressed using rongeurs or curettes. Distractor instruments are used to restore the normal height of the disc space, and the appropriate size of implant is determined. An interbody fusion device is inserted into the disc space, and a bone graft is placed into and sometimes in front of the device. Fluoroscopic x-rays are used to confirm that the device is in the correct position. Additional fixation of the device may be performed by inserting screws. After the spine is stabilized, the wound area is irrigated with a sterile solution containing antibiotics. The retractors are removed, restoring the retracted tissues to normal anatomic position, and the incision is closed in layers with sutures. The skin is closed with sutures or staples. Temporary drains may be inserted in the surgical wound to prevent fluid buildup. A sterile bandage is applied.

Source: Coder's Desk Reference for ICD-10-PCS Procedures by Optum



CPT Arthrodesis

- Code selection can be per level *or* per interspace.
- Lots of good instructional notes available!
 - Specific instructions for insertion, removal and revision of spinal instrumentation.
- Assign additional codes for
 - Instrumentation (22840-22855, 22859) & Graft(s) (20930-20939)
- Category III code deleted, FY 2023
 - Total disc arthroplasty each additional interspace, lumbar; previously 0163T now located 22860
- Removal/Revision total disc arthroplasty
 - See codes 095T, 0098T
- Posterior intra-facet implant placement
 - See codes 0219T-0222T



CPT Arthrodesis

Anterior or Anterolateral Approach (e.g., ALIF, DLIF, Retroperitoneal, XLIF)

- See CPT 22548-22558, +22585

➤ **Tip:** “The XLIF and DLIF approaches utilize an incision in the lateral trunk/flank with the dissection through the retroperitoneal space, rather than a posterior incision with dissection through the lateral paraspinal space as in a LECA. Due to this, the XLIF and DLIF are considered an anterior lumbar approach (ALIF)” (*Lateral Extracavitary Approaches to the Lumbar Spine, CPT Assistant October 2009, Volume 19, Issue 10, page 9*)



CPT Arthrodesis

Posterior, Posterolateral or Lateral Transverse (e.g., PLIF, TLIF)

- See CPT 22590-22634, 22800-22812
- **Tip:** “From a CPT coding perspective, posterolateral fusion and posterior interbody fusion are two distinct procedures. Beginning January 1, 2012, performing both posterior or posterolateral fusion and posterior interbody fusion at the same vertebral level in the lumbar region (eg, L4-5), should be reported by one combined code to represent both procedures with code 22633” (CPT Assistant December 2011, Volume 21, Issue 12, page 14)



CPT: C3-C6 Laminectomy with Decompression of Spinal Cord and Posterior Instrument Fusion

- **CPT 22600**, Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment (code 1 unit to capture C3)
- **+22614**, each additional *vertebral segment* (code 3 units to capture C4, C5, C6)
- **+22842**, Posterior segmental instrumentation; 3-6 vertebral segments
- **CPT 63015**, Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy, or discectomy, more than 2 vertebral segments; cervical



Coding Clinic

- **Spinal Fusion Procedures without Bone Graft Clarification**
- ICD-10-CM/PCS Coding Clinic, **First Quarter ICD-10 2018** Pages: 22-23 Effective with discharges: February 18, 2018
- Question was regarding whether a spinal fusion procedure without bone graft can be coded to “fusion”. This conflicts with the fusion definition which states that fusion is when the body part is joined together by a fixation device, bone graft, or other means.



Coding Clinic (cont.)

- Answer is that spinal fusions have their own guideline that goes beyond the basic “Fusion” definition. Spinal fusion guidelines state that a bone graft is required.



Coding Clinic

- **Decompression of Spinal Cord and Placement of Instrumentation**
- ICD-10-CM/PCS Coding Clinic, **Second Quarter ICD-10 2017** Pages: 23-24 Effective with discharges: May 17, 2017, Related Information
- A question was asked regarding a C3-C7 laminectomy with decompression of spinal cord and placement of posterior instrumentation and spinal fusion. Lateral mass screws were placed in C3-C6 with connecting rods after decompression laminectomy. What device value is assigned for spinal fusion and would the decompression of the spinal cord be coded separately?



Coding Clinic (cont.)

Answer:

- 0RH104Z Insertion of internal fixation device into cervical vertebral joint, Open Approach
 - 00NW0ZZ Release of cervical spinal cord, Open approach
- This is not a spinal fusion. There was no bone graft or bone graft substitute used. The insertion of rods and screws does not alone constitute a spinal fusion.



CPT Assistant

- Two new codes were created in 2022 to report decompression with laminectomy when performed in conjunction with **lumbar interbody fusion**. These codes are to be used with CPT codes 22630-22634.
 - + **63052** Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [e.g., spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)
 - + **63053**; each additional segment
- These codes represent decompression performed on the same interspace[s] and vertebral segment[s] as posterior interbody fusion that includes laminectomy, removal of facets, and/or opening/widening of the foramen for decompression of nerves or spinal components, such as spinal cord, cauda equina, or nerve roots.
 - *CPT Assistant, March 2022, Volume 32, Issue 3, page 3*



PCS Coding Tips

For Laminectomies:

- 1) Do not code separately if used for surgical approach (as in spinal fusions).
- 2) If there is a distinct surgical objective, decompression laminectomy may be coded separately from discectomy or fusion.

For Discectomies:

- 1) Root Operation of Excision unless documented as “Total discectomy”. Total discectomy is a Root Operation of Resection.



PCS Coding Tips Continued

For Kyphoplasties and Vertebroplasties:

1. Kyphoplasty is a Root Operation of Reposition.
2. Vertebroplasty is a Root Operation of Supplement.
3. If a vertebral biopsy is performed during a Kyphoplasty/Vertebroplasty, it should be coded separately.



PCS Coding Tips Continued

For Spinal Fusions:

- 1) Code discectomies separately.
- 2) Add a code for bone marrow or bone harvested at a separate site.
- 3) BMP can be coded, if desired. Reporting is optional. Check with your facility.
- 4) Fixation devices such as rods, screws, or plates do not require a code in spinal fusions.
- 5) A spinal fusion is performed with bone graft or bone graft substitute. These can be done with or without instrumentation



CPT Coding Tips

- 1) Determine the approach (i.e., anterior, posterior, interbody, etc.)
- 2) Pay attention to full CPT code descriptors and instructional notes.
- 3) Use add-on codes when needed (i.e., instrumentation, grafts, additional level or segment)
- 4) Resources are available: CPT Code Book, CPT Assistant, Coding Clinic for HCPCS, Anatomy charts.
- 5) Research device types and methods to help you better understand the procedure being performed.
- 6) Query when documentation is conflicting, or clarification is needed



References

- <https://www.mayoclinic.org/tests-procedures/laminectomy/about/pac-20394533>
- <http://www.kidport.com/RefLib/Science/HumanBody/SkeletalSystem/Spine.htm>
- <http://www.uscspine.com/spine-health-education/spinal-anatomy.cfm>
- <http://www.thepainreliefcentertx.com/patient-education/spine/lumbar-discectomy-pain-management>
- <https://www.epainassist.com/back-pain/synovial-cyst>
- <https://www.spineuniverse.com/treatments/surgery/kyphoplasty-vertebroplasty-vertebral-augmentation-implant-treatments-spinal>
- <http://www.am-spine.com/spineprocedures/kyphoplasty-and-vertebroplasty/>
- <https://www.orthogate.org/patient-education/lumbar-spine/posterior-lumbar-interbody-fusion>
- <https://www.drgrunch.com/procedure-info/2017/8/14/anterior-lumbar-interbody-fusion-alif>
- <https://www.neurosurgery.columbia.edu/patient-care/conditions/synovial-cyst>
- https://www.google.com/search?q=images+of+fusion+using+bone+graft&rlz=1C1GCEA_enUS791US791&source=lnms&tbm=isch&sa=&ved=0ahUKEwic-eCwltDgAhVMXKwKHfZ-ARwQ_AUIDigB&biw=1216&bih=563#imgrc=QdJbeg4278D6XM
- 3M Coding and Reimbursement
- CPT Assistant
- AHA Coding Clinic
- Coders' Desk Reference for ICD-10-PCS Procedures by Optum



Thank You!