Optum

Coding Companion

Orthopaedics: Upper - Spine & Above

A comprehensive illustrated guide to coding and reimbursement

2025

optumcoding.com

Contents

Getting Started with Coding Companion

Coding Companion for Orthopaedics — Upper: Spine and Above is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to orthopaedics — upper: spine and above are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT/HCPCS code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum *Coding Companion* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features.

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT/HCPCS code description, followed by an easy-to-understand explanation.

The codes in the appendix are presented in the following order

- HCPCS
- E/M
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 29.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2025 edition password is: **XXXXXX.** Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

24138 Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process

could be found in the index under the following main terms:

Abscess
Excision
Olecranon Process, 24138

or **Excision**
Abscess
Olecranon Process, 24138

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

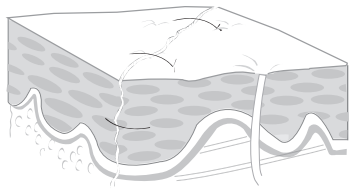
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

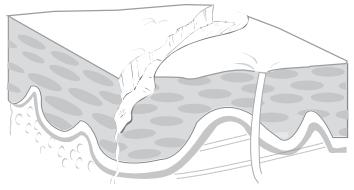
The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

12020-12021

12020 Treatment of superficial wound dehiscence; simple closure
12021 with packing



Example of a simple closure involving only one skin layer



Example of a wound left open with packing due to infection

Explanation

There has been a breakdown of the healing skin either before or after suture removal. The skin margins have opened. The physician cleanses the wound with irrigation and antimicrobial solutions. The skin margins may be trimmed to initiate bleeding surfaces. Report 12020 if the wound is sutured in a single layer. Report 12021 if the wound is left open and packed with gauze strips due to the presence of infection. This allows infection to drain from the wound and the skin closure will be delayed until the infection is resolved.

Coding Tips

For extensive or complicated secondary closure of surgical wound or dehiscence, see 13160. Medicare and some other payers may require G0168 be reported for wound closure by tissue adhesives only. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

T81.31XA Disruption of external operation (surgical) wound, not elsewhere classified, initial encounter

T81.32XA Disruption of internal operation (surgical) wound, not elsewhere classified, initial encounter

T81.33XA Disruption of traumatic injury wound repair, initial encounter

Associated HCPCS Codes

G0168 Wound closure utilizing tissue adhesive(s) only

AMA: **12020** 2022,Aug; 2022,Feb; 2021,Aug; 2019,Nov **12021** 2022,Aug; 2022,Feb; 2021,Aug; 2019,Nov

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
12020	2.67	5.93	0.43	9.03
12021	1.89	3.13	0.3	5.32
Facility RVU	**Work**	**PE**	**MP**	**Total**
12020	2.67	2.52	0.43	5.62
12021	1.89	2.02	0.3	4.21

	FUD	Status	MUE	Modifiers				IOM Reference
12020	10	A	2(3)	51	N/A	N/A	N/A	None
12021	10	A	3(3)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

dehiscence. Complication of healing in which the surgical wound ruptures or bursts open, superficially or through multiple layers.

infection. Presence of microorganisms in body tissues that may result in cellular damage.

irrigation. To wash out or cleanse a body cavity, wound, or tissue with water or other fluid.

packing. Material placed into a cavity or wound, such as gels, gauze, pads, and sponges.

subcutaneous tissue. Sheet or wide band of adipose (fat) and areolar connective tissue in two layers attached to the dermis.

superficial. On the skin surface or near the surface of any involved structure or field of interest.

suture. Numerous stitching techniques employed in wound closure.

buried suture. Continuous or interrupted suture placed under the skin for a layered closure.

continuous suture. Running stitch with tension evenly distributed across a single strand to provide a leakproof closure line.

interrupted suture. Series of single stitches with tension isolated at each stitch, in which all stitches are not affected if one becomes loose, and the isolated sutures cannot act as a wick to transport an infection.

purse-string suture. Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen.

retention suture. Secondary stitching that bridges the primary suture, providing support for the primary repair; a plastic or rubber bolster may be placed over the primary repair and under the retention sutures.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2024.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- ✚ This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified services that may be performed via telehealth. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 93 or 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services, when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
97802	97803	97804	99406	99407	99408	99409
99497	99498					

2. Illustrations

The illustrations that accompany the *Coding Companion* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most pages will have an illustration, there will be some pages that do not.

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes the most common method of performing each procedure.

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2023.

The 2024 Medicare edits were not available at the time this book went to press. Updated 2024 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2025 edition password is **XXXXXX**.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices,

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

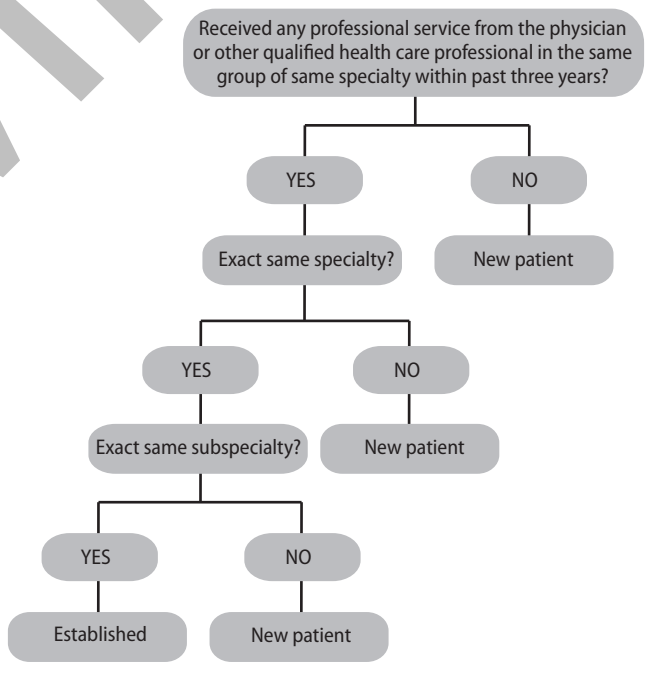
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or

AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

▶ ◀ = Contains new or revised text

99202-99205

▲★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

▲★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

▲★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

▲★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, a total time of 15 minutes must be met or exceeded on the day of the encounter. Report 99203 for a visit requiring a low level of MDM or meeting or exceeding 30 minutes of total time; 99204 for a visit requiring a moderate level of MDM or meeting or exceeding 45 minutes of total time; and 99205 for a visit requiring a high level of MDM or meeting or exceeding 60 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternatively, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. Medicare and the CPT codebook have identified these codes as telehealth/telemedicine services. Telemedicine services may be reported by the performing provider by adding modifier 95 to the procedure code and/or using the appropriate place of service (POS) indicator; POS 02 for telehealth when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211-99215.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99203** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99204** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99205** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun

Relative Value Units/Medicare Edits

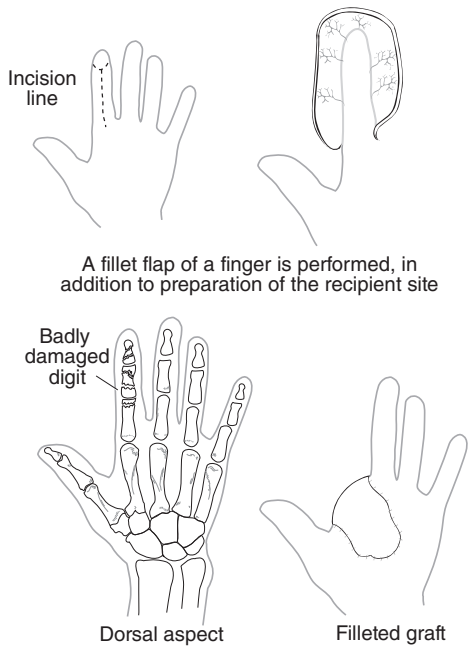
Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.14	0.08	2.15
99203	1.6	1.56	0.17	3.33
99204	2.6	2.11	0.23	4.94
99205	3.5	2.71	0.31	6.52
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.08	1.42
99203	1.6	0.68	0.17	2.45
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	100-04,11,40.1.3; 100-04,12,30.6.4; 100-04,12,30.6.10; 100-04,12,190.7; 100-04,12,230; 100-04,12,230.1; 100-04,18,80.2; 100-04,32,12.1
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

14350

14350 Filleted finger or toe flap, including preparation of recipient site



Explanation

The physician creates a filleted finger to repair a large deficit on the hand. The physician makes a bilateral longitudinal incision and dissects the tissue away from the donor site, protecting vascular integrity. The recipient site is prepared and the flap is rotated into place. Excess tissue is excised and the wound is sutured in layers.

Coding Tips

When this code is used to report repair of traumatic wounds, the procedure must have been previously planned and developed by the physician to effect the repair. This code does not apply when direct closure or rearrangement of traumatized tissue incidentally results in these configurations. Preparation of the recipient site is included and should not be reported separately. Any skin grafting required to close the secondary defect is reported separately. Some payers may require the use of HCPCS Level II modifiers FA–F9 to identify the specific finger involved. For an intralesional injection to limit scarring, see 11900. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

S62.511B Displaced fracture of proximal phalanx of right thumb, initial encounter for open fracture ☑

S62.521B Displaced fracture of distal phalanx of right thumb, initial encounter for open fracture ☑

S62.610B Displaced fracture of proximal phalanx of right index finger, initial encounter for open fracture ☑

S62.612B Displaced fracture of proximal phalanx of right middle finger, initial encounter for open fracture ☑

S62.614B Displaced fracture of proximal phalanx of right ring finger, initial encounter for open fracture ☑

S62.616B Displaced fracture of proximal phalanx of right little finger, initial encounter for open fracture ☑

S62.618B Displaced fracture of proximal phalanx of other finger, initial encounter for open fracture

S62.620B Displaced fracture of middle phalanx of right index finger, initial encounter for open fracture ☑

S62.622B Displaced fracture of middle phalanx of right middle finger, initial encounter for open fracture ☑

S62.624B Displaced fracture of middle phalanx of right ring finger, initial encounter for open fracture ☑

S62.626B Displaced fracture of middle phalanx of right little finger, initial encounter for open fracture ☑

S62.628B Displaced fracture of middle phalanx of other finger, initial encounter for open fracture

S62.630B Displaced fracture of distal phalanx of right index finger, initial encounter for open fracture ☑

S62.632B Displaced fracture of distal phalanx of right middle finger, initial encounter for open fracture ☑

S62.634B Displaced fracture of distal phalanx of right ring finger, initial encounter for open fracture ☑

S62.636B Displaced fracture of distal phalanx of right little finger, initial encounter for open fracture ☑

S62.638B Displaced fracture of distal phalanx of other finger, initial encounter for open fracture

AMA: **14350** 2023,Apr; 2022,Nov; 2022,Feb; 2021,Aug; 2021,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
14350	11.05	7.94	1.11	20.1
Facility RVU	**Work**	**PE**	**MP**	**Total**
14350	11.05	7.94	1.11	20.1

	FUD	Status	MUE	Modifiers				IOM Reference
14350	90	A	2(3)	51	N/A	N/A	80*	None

* with documentation

Terms To Know

dissection. Separating by cutting tissue or body structures apart.

flap. Mass of flesh and skin partially excised from its location but retaining its blood supply that is moved to another site to repair adjacent or distant defects.

suture. Numerous stitching techniques employed in wound closure.

buried suture. Continuous or interrupted suture placed under the skin for a layered closure.

continuous suture. Running stitch with tension evenly distributed across a single strand to provide a leakproof closure line.

interrupted suture. Series of single stitches with tension isolated at each stitch, in which all stitches are not affected if one becomes loose, and the isolated sutures cannot act as a wick to transport an infection.

purse-string suture. Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen.

retention suture. Secondary stitching that bridges the primary suture, providing support for the primary repair; a plastic or rubber bolster may be placed over the primary repair and under the retention sutures.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

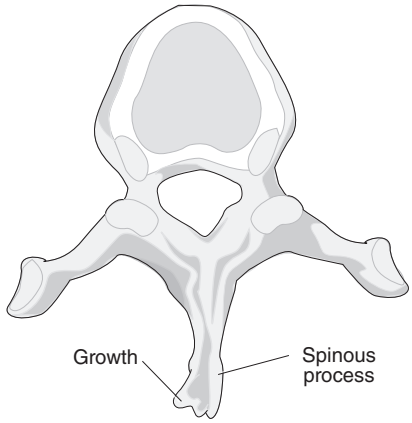
22100-22103

22100 Partial excision of posterior vertebral component (eg, spinous process, lamina or facet) for intrinsic bony lesion, single vertebral segment; cervical

22101 thoracic

22102 lumbar

\+ **22103** each additional segment (List separately in addition to code for primary procedure)



Physician removes growths from the spinous process

Explanation

The physician removes spurs, other growths, or bone disease by partial resection of a posterior vertebral component such as the spinous process, lamina, or facet. The patient is placed prone and an incision is made overlying the affected vertebra and taken down to the level of the fascia. The fascia is incised and the paravertebral muscles are retracted. The physician removes the affected part of the spinous process, lamina, or facet. Paravertebral muscles are repositioned and the tissue and skin is closed with layered sutures. Report 22100 for a cervical vertebral segment; 22101 for a thoracic vertebral segment; and 22102 for a lumbar vertebral segment. Report 22103 for each additional segment in conjunction with the code for the primary procedure.

Coding Tips

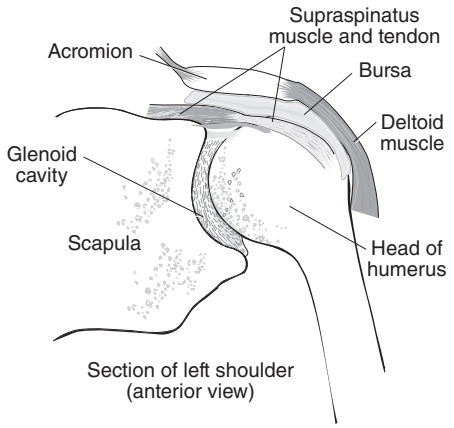
An excisional biopsy is not reported separately if a therapeutic excision is performed during the same surgical session. Report 22103 in addition to 22100–22102. For partial excision of vertebral body, for intrinsic bony lesion, without decompression of the spinal cord and/or nerve root, see 22110–22116. For complete or near complete resection of the vertebral body, see vertebral corpectomy codes 63081–63091. For insertion of posterior spinous process distraction devices, see 22867–22870.

ICD-10-CM Diagnostic Codes

C41.2 Malignant neoplasm of vertebral column
C79.51 Secondary malignant neoplasm of bone
D16.6 Benign neoplasm of vertebral column
D48.0 Neoplasm of uncertain behavior of bone and articular cartilage
D49.2 Neoplasm of unspecified behavior of bone, soft tissue, and skin
M25.78 Osteophyte, vertebrae
M46.21 Osteomyelitis of vertebra, occipito-atlanto-axial region
M46.22 Osteomyelitis of vertebra, cervical region
M46.23 Osteomyelitis of vertebra, cervicothoracic region
M46.24 Osteomyelitis of vertebra, thoracic region
M46.25 Osteomyelitis of vertebra, thoracolumbar region
M46.26 Osteomyelitis of vertebra, lumbar region
M46.27 Osteomyelitis of vertebra, lumbosacral region
M46.51 Other infective spondylopathies, occipito-atlanto-axial region
M46.52 Other infective spondylopathies, cervical region
M46.53 Other infective spondylopathies, cervicothoracic region
M46.54 Other infective spondylopathies, thoracic region
M46.55 Other infective spondylopathies, thoracolumbar region
M46.56 Other infective spondylopathies, lumbar region
M46.57 Other infective spondylopathies, lumbosacral region
M47.11 Other spondylosis with myelopathy, occipito-atlanto-axial region
M47.12 Other spondylosis with myelopathy, cervical region
M47.13 Other spondylosis with myelopathy, cervicothoracic region
M47.14 Other spondylosis with myelopathy, thoracic region
M47.15 Other spondylosis with myelopathy, thoracolumbar region
M48.061 Spinal stenosis, lumbar region without neurogenic claudication
M48.062 Spinal stenosis, lumbar region with neurogenic claudication
M48.11 Ankylosing hyperostosis [Forestier], occipito-atlanto-axial region
M48.12 Ankylosing hyperostosis [Forestier], cervical region
M48.13 Ankylosing hyperostosis [Forestier], cervicothoracic region
M48.21 Kissing spine, occipito-atlanto-axial region
M48.22 Kissing spine, cervical region
M48.23 Kissing spine, cervicothoracic region
M48.24 Kissing spine, thoracic region
M48.25 Kissing spine, thoracolumbar region
M48.26 Kissing spine, lumbar region
M48.27 Kissing spine, lumbosacral region
M48.31 Traumatic spondylopathy, occipito-atlanto-axial region
M48.32 Traumatic spondylopathy, cervical region
M48.33 Traumatic spondylopathy, cervicothoracic region
M48.34 Traumatic spondylopathy, thoracic region
M48.35 Traumatic spondylopathy, thoracolumbar region
M48.36 Traumatic spondylopathy, lumbar region
M48.37 Traumatic spondylopathy, lumbosacral region
M48.8X1 Other specified spondylopathies, occipito-atlanto-axial region
M48.8X2 Other specified spondylopathies, cervical region
M48.8X3 Other specified spondylopathies, cervicothoracic region
M48.8X4 Other specified spondylopathies, thoracic region
M48.8X5 Other specified spondylopathies, thoracolumbar region
M48.8X6 Other specified spondylopathies, lumbar region
M48.8X7 Other specified spondylopathies, lumbosacral region
M54.11 Radiculopathy, occipito-atlanto-axial region
M54.12 Radiculopathy, cervical region
M54.13 Radiculopathy, cervicothoracic region
M54.14 Radiculopathy, thoracic region
M54.15 Radiculopathy, thoracolumbar region
M54.16 Radiculopathy, lumbar region
M54.17 Radiculopathy, lumbosacral region
M85.48 Solitary bone cyst, other site
M85.58 Aneurysmal bone cyst, other site
M85.68 Other cyst of bone, other site
M86.38 Chronic multifocal osteomyelitis, other site
M86.48 Chronic osteomyelitis with draining sinus, other site

23000

23000 Removal of subdeltoid calcareous deposits, open



Inflammatory cells from wear and tear cause calcareous (calcium) deposits to form in the supraspinatus tendon and deltoid muscle. The deposits are removed from sites under the tendon or from beneath the deltoid in the shoulder

Explanation

The physician removes subdeltoid calcareous deposits by making a small incision over the deltoid muscle to expose the rotator cuff tendons. The raised area over the calcium deposits is incised in line with the axis of the fibers and the calcareous deposits are removed. A large cavity is made in the tendon with a curette to remove all damaged tissue. The opening is closed with side-to-side sutures. Once the tendon is repaired, the skin incision is closed and a soft dressing is applied.

Coding Tips

When the physician cannot complete the procedure through the arthroscope and an open procedure is performed, list the open procedure first, code the arthroscope as diagnostic, and append modifier 51. Medicare and some other third party payers do not allow a scope procedure when performed in conjunction with a related open procedure. Check with individual payers regarding their specific coding guidelines. For excisional biopsy of soft tissue of the shoulder, superficial, see 23065; deep, see 23066. For needle biopsy of muscle, see 20206.

ICD-10-CM Diagnostic Codes

M11.011 Hydroxyapatite deposition disease, right shoulder ☑
M11.012 Hydroxyapatite deposition disease, left shoulder ☑
M11.111 Familial chondrocalcinosis, right shoulder ☑
M11.112 Familial chondrocalcinosis, left shoulder ☑
M11.211 Other chondrocalcinosis, right shoulder ☑
M11.212 Other chondrocalcinosis, left shoulder ☑
M11.811 Other specified crystal arthropathies, right shoulder ☑
M11.812 Other specified crystal arthropathies, left shoulder ☑
M25.711 Osteophyte, right shoulder ☑
M25.712 Osteophyte, left shoulder ☑
M25.811 Other specified joint disorders, right shoulder ☑
M25.812 Other specified joint disorders, left shoulder ☑
M61.011 Myositis ossificans traumatica, right shoulder ☑
M61.012 Myositis ossificans traumatica, left shoulder ☑
M61.021 Myositis ossificans traumatica, right upper arm ☑
M61.022 Myositis ossificans traumatica, left upper arm ☑
M61.111 Myositis ossificans progressiva, right shoulder ☑
M61.112 Myositis ossificans progressiva, left shoulder ☑
M61.121 Myositis ossificans progressiva, right upper arm ☑
M61.122 Myositis ossificans progressiva, left upper arm ☑
M61.311 Calcification and ossification of muscles associated with burns, right shoulder ☑
M61.312 Calcification and ossification of muscles associated with burns, left shoulder ☑
M61.321 Calcification and ossification of muscles associated with burns, right upper arm ☑
M61.322 Calcification and ossification of muscles associated with burns, left upper arm ☑
M61.411 Other calcification of muscle, right shoulder ☑
M61.412 Other calcification of muscle, left shoulder ☑
M61.421 Other calcification of muscle, right upper arm ☑
M61.422 Other calcification of muscle, left upper arm ☑
M65.221 Calcific tendinitis, right upper arm ☑
M65.222 Calcific tendinitis, left upper arm ☑
M75.31 Calcific tendinitis of right shoulder ☑
M75.32 Calcific tendinitis of left shoulder ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
23000	4.48	11.34	0.75	16.57
Facility RVU	**Work**	**PE**	**MP**	**Total**
23000	4.48	5.51	0.75	10.74

	FUD	Status	MUE	Modifiers				IOM Reference
23000	90	A	1(2)	51	50	62*	80	None

* with documentation

Terms To Know

bursa. Cavity or sac containing fluid that occurs between articulating surfaces and serves to reduce friction from moving parts. An anatomical structure frequently referenced in orthopedic notes as it may become diseased or need removal.

calcifying tendinitis. Inflammation and hardening of tissue due to calcium salt deposits, occurring in the tendons and areas of tendonomuscular attachment.

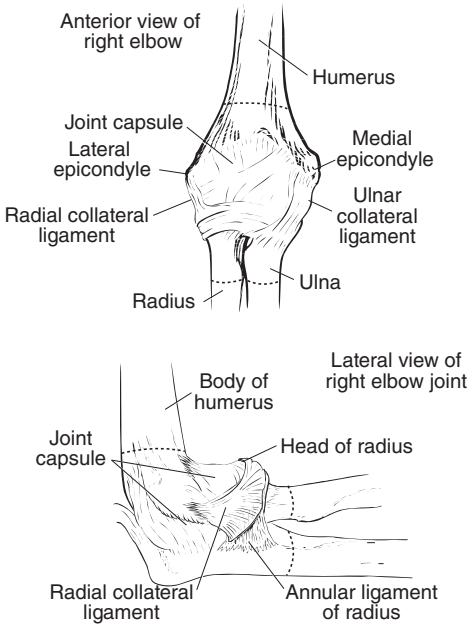
myositis ossificans. Inflammatory disease of muscles due to bony deposits or conversion of muscle tissue to bony tissue.

ossification. Formation of bony growth or hardening into bone-like substance.

tendon. Fibrous tissue that connects muscle to bone, consisting primarily of collagen and containing little vasculature.

24155

24155 Resection of elbow joint (arthrectomy)



Explanation

An elbow joint arthrectomy is performed to remove the joint by resection of the distal humerus and the proximal radius and ulna. The physician makes a longitudinal incision along the lateral elbow. Dissection is carried down through the joint capsule to expose the distal humerus and the proximal radius and ulna. The physician selects the level at which the bones are to be resected. The physician uses a bone saw to divide the bones at the appropriate level. The physician preserves the surrounding muscle attachments to maintain some support and function for moving the elbow. However, gross instability of the elbow is present. The incision is repaired in layers using staples, sutures, and/or Steri-strips.

Coding Tips

According to CPT guidelines, the application and removal of the first cast, splint, or traction device are included in the codes that appear in the Musculoskeletal System section of CPT. Supplies may be reported separately. Modifier 56 should not be reported for preoperative management of a fracture. Removal of a cast by a provider, other than the provider who applied the cast, can be reported with cast removal codes 29700, 29705, and 29710. Cast, splint, or strapping (29000-29750) and/or traction device (20690, 20692) replacement during or after the global period of a procedure may be reported separately.

ICD-10-CM Diagnostic Codes

M19.021 Primary osteoarthritis, right elbow ☑

M19.121 Post-traumatic osteoarthritis, right elbow ☑

S52.121A Displaced fracture of head of right radius, initial encounter for closed fracture ☑

S52.121B Displaced fracture of head of right radius, initial encounter for open fracture type I or II ☑

S52.121C Displaced fracture of head of right radius, initial encounter for open fracture type IIIA, IIIB, or IIIC ☑

S52.124A Nondisplaced fracture of head of right radius, initial encounter for closed fracture ☑

S52.124B Nondisplaced fracture of head of right radius, initial encounter for open fracture type I or II ☑

S52.124C Nondisplaced fracture of head of right radius, initial encounter for open fracture type IIIA, IIIB, or IIIC ☑

S53.011A Anterior subluxation of right radial head, initial encounter ☑

S53.014A Anterior dislocation of right radial head, initial encounter ☑

S53.021A Posterior subluxation of right radial head, initial encounter ☑

S53.024A Posterior dislocation of right radial head, initial encounter ☑

S53.111A Anterior subluxation of right ulnohumeral joint, initial encounter ☑

S53.114A Anterior dislocation of right ulnohumeral joint, initial encounter ☑

S53.121A Posterior subluxation of right ulnohumeral joint, initial encounter ☑

S53.124A Posterior dislocation of right ulnohumeral joint, initial encounter ☑

S57.01XA Crushing injury of right elbow, initial encounter ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
24155	12.09	11.11	2.44	25.64
Facility RVU	**Work**	**PE**	**MP**	**Total**
24155	12.09	11.11	2.44	25.64

	FUD	Status	MUE	Modifiers				IOM Reference
24155	90	A	1(2)	51	50	62*	80	None

* with documentation

Terms To Know

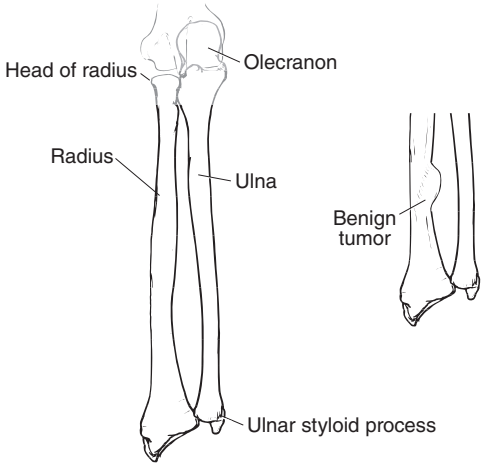
arthrectomy. Surgical excision or resection of a joint.

osteoarthritis. Most common form of a noninflammatory degenerative joint disease with degenerating articular cartilage, bone enlargement, and synovial membrane changes.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

25120-25126

25120 Excision or curettage of bone cyst or benign tumor of radius or ulna (excluding head or neck of radius and olecranon process);
25125 with autograft (includes obtaining graft)
25126 with allograft



Explanation

A bone cyst or benign tumor of the radius or ulna, excluding the head, neck, or olecranon process, is removed. The physician makes an incision in the forearm overlying the cyst or tumor. The skin and underlying soft tissues are reflected to expose the periosteum, which is separated from the bone. Curettes or osteotomes are used to scrape or cut the lesion from the bone. Once the benign tumor or cyst is removed and healthy bone tissue is present, the periosteum is repositioned and the incision is repaired in layers. If the bone defect created requires a graft for repair, the physician obtains the necessary size bone graft from a separate donor site on the patient and packs it into the site where the tumor or bone cyst was removed or uses a bone bank allograft. Report 25125 if the procedure is done with an autograft and 25126 if an allograft is used.

Coding Tips

In 25125, any bone graft harvest is not reported separately. According to CPT guidelines, the application and removal of the first cast, splint, or traction device are included in the codes that appear in the Musculoskeletal System section of CPT. Supplies may be reported separately. Modifier 56 should not be reported for preoperative management of a fracture. Removal of a cast by a provider, other than the provider who applied the cast, can be reported with cast removal codes 29700, 29705, and 29710. Cast, splint, or strapping (29000-29750) and/or traction device (20690, 20692) replacement during or after the global period of a procedure may be reported separately. For excision or curettage of a bone cyst or benign tumor of head or neck of radius or olecranon process, see 24120–24126.

ICD-10-CM Diagnostic Codes

D16.01 Benign neoplasm of scapula and long bones of right upper limb ☑
D16.02 Benign neoplasm of scapula and long bones of left upper limb ☑
M85.031 Fibrous dysplasia (monostotic), right forearm ☑
M85.032 Fibrous dysplasia (monostotic), left forearm ☑
M85.431 Solitary bone cyst, right ulna and radius ☑
M85.432 Solitary bone cyst, left ulna and radius ☑
M85.531 Aneurysmal bone cyst, right forearm ☑
M85.532 Aneurysmal bone cyst, left forearm ☑
M85.631 Other cyst of bone, right forearm ☑
M85.632 Other cyst of bone, left forearm ☑

AMA: **25120** 2021,Dec **25125** 2021,Dec **25126** 2021,Dec; 2019,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
25120	6.27	7.78	1.18	15.23
25125	7.67	8.82	1.55	18.04
25126	7.74	8.86	1.56	18.16
Facility RVU	**Work**	**PE**	**MP**	**Total**
25120	6.27	7.78	1.18	15.23
25125	7.67	8.82	1.55	18.04
25126	7.74	8.86	1.56	18.16

	FUD	Status	MUE	Modifiers				IOM Reference
25120	90	A	1(3)	51	50	62*	80*	None
25125	90	A	1(3)	51	50	N/A	80*	
25126	90	A	1(3)	51	50	N/A	80	

* with documentation

Terms To Know

allograft. Graft from one individual to another of the same species.

aneurysmal bone cyst. Solitary bone lesion that bulges into the periosteum, marked by a calcified rim.

autograft. Tissue harvested from the same individual at one anatomical site and grafted to another separate anatomical site.

benign. Mild or nonmalignant in nature.

cyst. Elevated encapsulated mass containing fluid, semisolid, or solid material with a membranous lining.

exostosis. Abnormal formation of a benign bony growth.

fascia. Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.

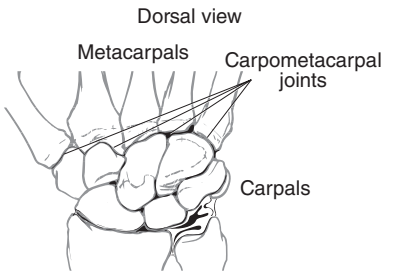
neoplasm. New abnormal growth, tumor.

tumor. Pathological swelling or enlargement; a neoplastic growth of uncontrolled, abnormal multiplication of cells.

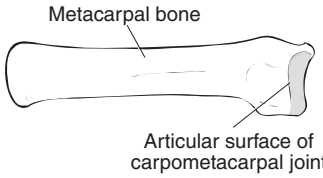
 N Newborn: 0 **P Pediatric: 0-17** **M Maternity: 9-64** **A Adult: 15-124** ♂ **Male Only** ♀ **Female Only**

26130

26130 Synovectomy, carpometacarpal joint



Articular spaces of the wrist. Synovial membranes line these surfaces and synovial fluid lubricates the joint actions



The synovial membrane is surgically removed from a carpometacarpal (knuckle) joint

Explanation

The physician removes the synovial membrane from the carpometacarpal joint. The physician incises the skin overlying the affected joint. The joint capsule is exposed by dissecting down through the soft tissues and freeing and reflecting the muscles. The joint capsule is incised to expose the synovium, the inner membrane of the articular capsule that lines the joint cavity. The inflamed or enlarged synovium is dissected away from the capsule and the bones and removed. A drain tube may be placed and the incision is repaired in layers with sutures, staples, and/or Steri-strips. A splint may be applied to limit movement.

Coding Tips

This code should be reported for each joint involved. When multiple joints are involved, report one joint synovectomy as the primary procedure and append modifier 51 to subsequent procedures. Local anesthesia is included in this service. However, this procedure may be performed under general anesthesia, depending on the age and/or condition of the patient. For synovectomy, metacarpophalangeal joint, see 26135.

ICD-10-CM Diagnostic Codes

M00.041 Staphylococcal arthritis, right hand ☑
M00.042 Staphylococcal arthritis, left hand ☑
M00.141 Pneumococcal arthritis, right hand ☑
M00.142 Pneumococcal arthritis, left hand ☑
M00.241 Other streptococcal arthritis, right hand ☑
M00.242 Other streptococcal arthritis, left hand ☑
M00.841 Arthritis due to other bacteria, right hand ☑
M00.842 Arthritis due to other bacteria, left hand ☑
M05.741 Rheumatoid arthritis with rheumatoid factor of right hand without organ or systems involvement ☑
M05.742 Rheumatoid arthritis with rheumatoid factor of left hand without organ or systems involvement ☑
M06.041 Rheumatoid arthritis without rheumatoid factor, right hand ☑
M06.042 Rheumatoid arthritis without rheumatoid factor, left hand ☑
M06.341 Rheumatoid nodule, right hand ☑
M06.342 Rheumatoid nodule, left hand ☑
M12.541 Traumatic arthropathy, right hand ☑
M12.542 Traumatic arthropathy, left hand ☑
M18.0 Bilateral primary osteoarthritis of first carpometacarpal joints
M18.11 Unilateral primary osteoarthritis of first carpometacarpal joint, right hand ☑
M18.12 Unilateral primary osteoarthritis of first carpometacarpal joint, left hand ☑
M18.2 Bilateral post-traumatic osteoarthritis of first carpometacarpal joints
M18.31 Unilateral post-traumatic osteoarthritis of first carpometacarpal joint, right hand ☑
M18.32 Unilateral post-traumatic osteoarthritis of first carpometacarpal joint, left hand ☑
M19.041 Primary osteoarthritis, right hand ☑
M19.042 Primary osteoarthritis, left hand ☑
M19.141 Post-traumatic osteoarthritis, right hand ☑
M19.142 Post-traumatic osteoarthritis, left hand ☑
M65.841 Other synovitis and tenosynovitis, right hand ☑
M65.842 Other synovitis and tenosynovitis, left hand ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
26130	5.59	7.54	1.13	14.26
Facility RVU	**Work**	**PE**	**MP**	**Total**
26130	5.59	7.54	1.13	14.26

	FUD	Status	MUE	Modifiers				IOM Reference
26130	90	A	1(3)	51	50	N/A	N/A	None

* with documentation

Terms To Know

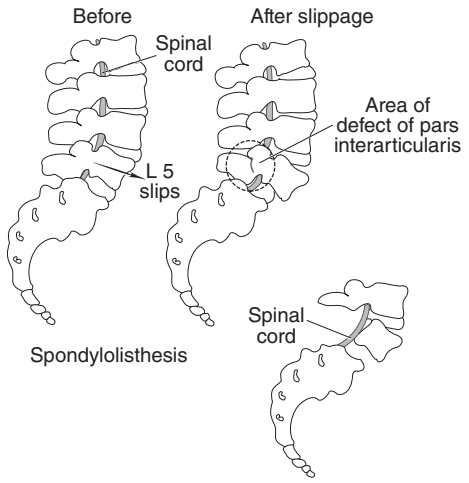
osteoarthritis. Most common form of a noninflammatory degenerative joint disease with degenerating articular cartilage, bone enlargement, and synovial membrane changes.

villonodular synovitis. Inflammation of the synovial membrane due to excessive synovial tissue formation, especially in the knee.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

63012

63012 Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)



Physician corrects spondylolisthesis, or slippage of the bottom lumbar vertebra forward, using the Gill procedure

Explanation

The physician performs the laminectomy to correct spondylolisthesis, the slipping of the lumbar vertebrae forward where they join the sacral vertebrae. The physician makes a midline incision overlying the lumbar vertebrae to facilitate repair of the spondylolisthesis. The fascia are incised and the paravertebral muscles are retracted. The physician resects the spinous processes of all three vertebrae and the middle part of the loose fifth lumbar neural arch. The ligamentum flavum is freed or excised at various levels of vertebrae. The fifth lumbar nerve root is retracted. Decompression is carried out to include the facets as well as other bony or soft tissue structures that may be applying pressure to the spinal cord, nerve roots, or cauda equina. The procedure is repeated on the opposite side. The incision is closed with layered sutures.

Coding Tips

Arthrodesis is reported separately; see 22590–22614. Report 63012 only when a laminectomy is performed for lumbar spondylolisthesis. For laminectomy one or two vertebral segments for spinal stenosis, lumbar, see 63005. For partial excision of the lamina (laminotomy, hemilaminectomy), with facetectomy, foraminotomy, and/or excision of the herniated intervertebral disc, see 63030–63035. For re-exploration laminotomy (hemilaminectomy), with partial facetectomy, foraminotomy, and/or excision of the herniated intervertebral disc, see 63042. For laminectomy (complete excision of the lamina), unilateral or bilateral, with facetectomy and foraminotomy, see 63047–63048.

ICD-10-CM Diagnostic Codes

G83.4	Cauda equina syndrome
M43.05	Spondylolysis, thoracolumbar region
M43.06	Spondylolysis, lumbar region
M43.07	Spondylolysis, lumbosacral region
M43.15	Spondylolisthesis, thoracolumbar region
M43.16	Spondylolisthesis, lumbar region
M43.17	Spondylolisthesis, lumbosacral region
M43.18	Spondylolisthesis, sacral and sacrococcygeal region
Q06.3	Other congenital cauda equina malformations
Q76.2	Congenital spondylolisthesis
S34.3XXA	Injury of cauda equina, initial encounter

AMA: **63012** 2019,Dec; 2018,May; 2017,Mar; 2017,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
63012	16.85	13.55	5.66	36.06
Facility RVU	**Work**	**PE**	**MP**	**Total**
63012	16.85	13.55	5.66	36.06

	FUD	Status	MUE	Modifiers				IOM Reference
63012	90	A	1(2)	51	N/A	62	80	None

* with documentation

Terms To Know

cauda equina. Spinal roots occupying the lower end of the vertebral canal and descending from the distal end of the spinal cord, named for their appearance resembling that of the tail of a horse.

congenital. Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.

laminectomy. Removal or excision of the posterior arch of a vertebra to provide additional space for the nerves and widen the spinal canal.

spondylolisthesis. Forward displacement of one vertebra slipping over another, usually in the fourth or fifth lumbar area.

vertebra. Any one of the 33 bones composing the spinal column, generally having a disc-shaped body, two transverse processes, and a spinal process centered posteriorly. Vertebrae are connected by the laminae between them and are attached to the body by pedicles, forming an enclosed, protective ring around the vertebral foramen through which the spinal cord runs.

 N Newborn: 0 **P Pediatric: 0-17** **M Maternity: 9-64** **A Adult: 15-124** ♂ **Male Only** ♀ **Female Only**

Correct Coding Initiative Update 29.3

❖Indicates Mutually Exclusive Edit

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