OPTUM360®

CODING COMPANION

Neurosurgery/ Neurology

A comprehensive illustrated guide to coding and reimbursement

2022

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Contents

Getting Started with Coding Companion

Coding Companion for Neurology/Neurosurgery 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 Codes

For ease of use, evaluation and management codes related to Neurology/Neurosurgery 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 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 Optum360 *Coding Companion* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

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. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the page following the sample.

Appendix Codes and Descriptions

Some CPT codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

The codes in the appendix are presented in the following order:

- HCPCS
- 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 Edit Updates

The *Coding Companion* series 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 XX.X, the most current version available at press time. The CCI edits are located in a section at the back of the book. Optum360 maintains a website to accompany the Coding Companions series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is http://www.optum360coding.com/ProductUpdates/. The 2022 edition password is: **XXXXXX22**. Log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

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:

69501 Transmastoid antrotomy (simple mastoidectomy)

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

Antrotomy
Transmastoid, 69501

Excision
Mastoid
Simple, 69501

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 xiv 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.

99211-99215

▲ **99211** Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

▲★**99212** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

▲★**99213** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

▲★**99214** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

▲★**99215** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for established 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 excluding the most basic service represented by 99211 that describes an encounter in which the presenting problems are typically minimal and may not require the presence of a physician or other qualified health care professional. For the remainder of codes within this range, 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/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. Report 99212 for a visit that entails straightforward MDM. If time is used for code selection, 10 to 19 minutes of total time is spent on the day of encounter. Report 99213 for a visit requiring a low level of MDM or 20 to 29 minutes of total time; 99214 for a moderate level of MDM or 30 to 39 minutes of total time; and 99215 for a high level of MDM or 40 to 54 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for an established 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 no longer used when determining the level of service. Codes should be selected based upon the CPT revised 2021 Medical Decision Making table. Alternately, 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. Code 99211 does not require the presence of a physician or other qualified health care professional. For office or other outpatient services for a new patient, see 99202-99205. For observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Medicare has identified 99211 as a telehealth/telemedicine service. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes. Services at the origination site are reported with HCPCS Level II code Q3014.

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: **99211** 2020,Sep,14; 2020,Sep,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Mar,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Mar,13; 2014,Jan,11; 2014,Aug,3 **99212** 2020,Sep,14; 2020,Sep,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Oct,5; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99213** 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,3; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99214** 2020,Sep,14; 2020,Sep,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99215** 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,3; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3

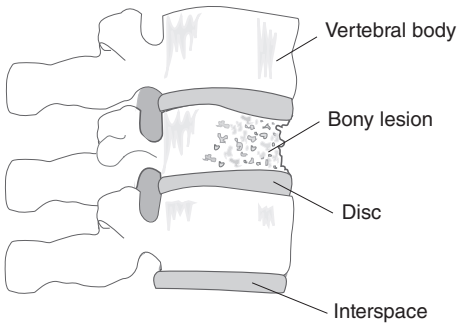
 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

22510-22512

22510 Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic

22511 lumbosacral

\+ **22512** each additional cervicothoracic or lumbosacral vertebral body (List separately in addition to code for primary procedure)



Vertebral defect is repaired percutaneously

Explanation

Percutaneous vertebroplasty is a minimally invasive, image-guided procedure performed by a one- or two-sided injection of a vertebral body. A local anesthetic is administered. A needle is guided into the fractured vertebra under imaging guidance through a small puncture in the patient's skin. Sterile biomaterial such as methyl methacrylate is injected from one or both sides into the damaged vertebral body and acts as a bone cement to reinforce the fractured or collapsed vertebra. The procedure does not restore the original shape to the vertebra, but it does stabilize the bone, preventing further fracture or collapse. Following the procedure, the patient may experience significant, almost immediate pain relief. These codes include a vertebral bone biopsy, if performed, during the same operative session. Report 22510 for percutaneous vertebroplasty of one vertebral body at the cervicothoracic level; 22511 for percutaneous vertebroplasty of one vertebral body at the lumbosacral level; and 22512 for each additional cervicothoracic or lumbosacral vertebral body treated. All imaging guidance is included in these procedures.

Coding Tips

Report 22512 in addition to 22510–22511. Do not report 22510–22512 with 20225, 22310–22315, 22325, or 22327 when they are performed at the same vertebral level. Imaging guidance is included in these procedures and is not reported separately.

ICD-10-CM Diagnostic Codes

M48.061 Spinal stenosis, lumbar region without neurogenic claudication

M48.062 Spinal stenosis, lumbar region with neurogenic claudication

M48.42XA Fatigue fracture of vertebra, cervical region, initial encounter for fracture

M48.43XA Fatigue fracture of vertebra, cervicothoracic region, initial encounter for fracture

M48.44XA Fatigue fracture of vertebra, thoracic region, initial encounter for fracture

M48.45XA Fatigue fracture of vertebra, thoracolumbar region, initial encounter for fracture

M48.46XA Fatigue fracture of vertebra, lumbar region, initial encounter for fracture

M48.47XA Fatigue fracture of vertebra, lumbosacral region, initial encounter for fracture

M48.52XA Collapsed vertebra, not elsewhere classified, cervical region, initial encounter for fracture

M48.53XA Collapsed vertebra, not elsewhere classified, cervicothoracic region, initial encounter for fracture

M48.54XA Collapsed vertebra, not elsewhere classified, thoracic region, initial encounter for fracture

M48.56XA Collapsed vertebra, not elsewhere classified, lumbar region, initial encounter for fracture

M48.57XA Collapsed vertebra, not elsewhere classified, lumbosacral region, initial encounter for fracture

S22.012A Unstable burst fracture of first thoracic vertebra, initial encounter for closed fracture

S22.012B Unstable burst fracture of first thoracic vertebra, initial encounter for open fracture

S22.018A Other fracture of first thoracic vertebra, initial encounter for closed fracture

S22.018B Other fracture of first thoracic vertebra, initial encounter for open fracture

S22.022A Unstable burst fracture of second thoracic vertebra, initial encounter for closed fracture

S22.022B Unstable burst fracture of second thoracic vertebra, initial encounter for open fracture

S22.028A Other fracture of second thoracic vertebra, initial encounter for closed fracture

S22.028B Other fracture of second thoracic vertebra, initial encounter for open fracture

S22.032A Unstable burst fracture of third thoracic vertebra, initial encounter for closed fracture

S22.032B Unstable burst fracture of third thoracic vertebra, initial encounter for open fracture

S22.038A Other fracture of third thoracic vertebra, initial encounter for closed fracture

S22.038B Other fracture of third thoracic vertebra, initial encounter for open fracture

S22.042A Unstable burst fracture of fourth thoracic vertebra, initial encounter for closed fracture

S22.042B Unstable burst fracture of fourth thoracic vertebra, initial encounter for open fracture

S22.048A Other fracture of fourth thoracic vertebra, initial encounter for closed fracture

S22.048B Other fracture of fourth thoracic vertebra, initial encounter for open fracture

S22.052A Unstable burst fracture of T5-T6 vertebra, initial encounter for closed fracture

S22.052B Unstable burst fracture of T5-T6 vertebra, initial encounter for open fracture

S22.058A Other fracture of T5-T6 vertebra, initial encounter for closed fracture

S22.058B Other fracture of T5-T6 vertebra, initial encounter for open fracture

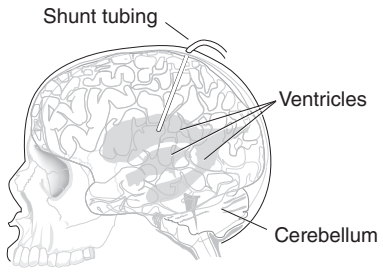
S22.062A Unstable burst fracture of T7-T8 vertebra, initial encounter for closed fracture

S22.062B Unstable burst fracture of T7-T8 vertebra, initial encounter for open fracture

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

61105-61108

61105 Twist drill hole for subdural or ventricular puncture
61107 Twist drill hole(s) for subdural, intracerebral, or ventricular puncture; for implanting ventricular catheter, pressure recording device, or other intracerebral monitoring device
61108 for evacuation and/or drainage of subdural hematoma



Explanation

The physician uses a manually operated twist drill to create an opening in the skull. The physician incises the scalp and peels it away from the area to be drilled. The physician places the drill over the affected area of the skull and twists until the drill pierces the periosteum and the dura is exposed. Fluid may be drawn off from the subdural space or from the ventricles. In 61105, the hole is made to alleviate pressure, and is used for subsequent surgery. In 61107, the hole is used to implant a ventricular drainage catheter, a fluid pressure recording device, or other intracerebral monitoring device. In 61108, the hole is used to access and evacuate or drain a subdural hematoma.

Coding Tips

As "exempt from modifier 51," 61107 has not been designated in CPT as an add-on service/procedure. However, codes identified as exempt from modifier 51 are not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Note that these codes report procedures performed through a twist drill hole. For intracranial neuroendoscopic ventricular catheter placement, see 62160.

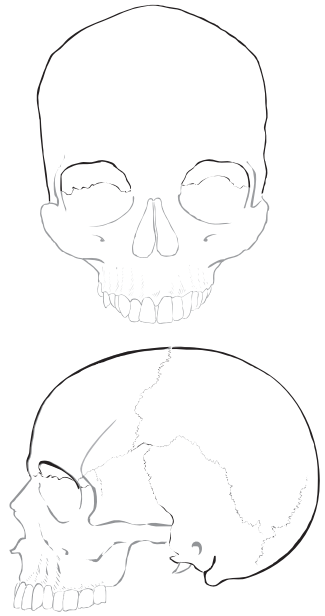
ICD-10-CM Diagnostic Codes

C70.0 Malignant neoplasm of cerebral meninges
C71.1 Malignant neoplasm of frontal lobe
C71.2 Malignant neoplasm of temporal lobe
C71.3 Malignant neoplasm of parietal lobe
C71.4 Malignant neoplasm of occipital lobe
C71.5 Malignant neoplasm of cerebral ventricle
C71.6 Malignant neoplasm of cerebellum
C71.8 Malignant neoplasm of overlapping sites of brain
G06.0 Intracranial abscess and granuloma
G91.0 Communicating hydrocephalus
G91.1 Obstructive hydrocephalus
G93.6 Cerebral edema
I60.01 Nontraumatic subarachnoid hemorrhage from right carotid siphon and bifurcation ☑
I60.02 Nontraumatic subarachnoid hemorrhage from left carotid siphon and bifurcation ☑
I60.11 Nontraumatic subarachnoid hemorrhage from right middle cerebral artery ☑
I60.12 Nontraumatic subarachnoid hemorrhage from left middle cerebral artery ☑
I60.31 Nontraumatic subarachnoid hemorrhage from right posterior communicating artery ☑
I60.32 Nontraumatic subarachnoid hemorrhage from left posterior communicating artery ☑
I60.4 Nontraumatic subarachnoid hemorrhage from basilar artery
I60.6 Nontraumatic subarachnoid hemorrhage from other intracranial arteries
I60.8 Other nontraumatic subarachnoid hemorrhage
I61.0 Nontraumatic intracerebral hemorrhage in hemisphere, subcortical
I61.1 Nontraumatic intracerebral hemorrhage in hemisphere, cortical
I61.4 Nontraumatic intracerebral hemorrhage in cerebellum
I61.5 Nontraumatic intracerebral hemorrhage, intraventricular
I61.6 Nontraumatic intracerebral hemorrhage, multiple localized
I61.8 Other nontraumatic intracerebral hemorrhage
I62.01 Nontraumatic acute subdural hemorrhage
I62.02 Nontraumatic subacute subdural hemorrhage
I62.03 Nontraumatic chronic subdural hemorrhage
I67.1 Cerebral aneurysm, nonruptured
P10.0 Subdural hemorrhage due to birth injury N
P10.1 Cerebral hemorrhage due to birth injury N
P10.4 Tentorial tear due to birth injury N
P10.8 Other intracranial lacerations and hemorrhages due to birth injury N
P11.0 Cerebral edema due to birth injury N
P52.4 Intracerebral (nontraumatic) hemorrhage of newborn N
P52.6 Cerebellar (nontraumatic) and posterior fossa hemorrhage of newborn N
P52.8 Other intracranial (nontraumatic) hemorrhages of newborn N
Q03.0 Malformations of aqueduct of Sylvius
Q03.8 Other congenital hydrocephalus
Q28.2 Arteriovenous malformation of cerebral vessels
S06.1X0A Traumatic cerebral edema without loss of consciousness, initial encounter
S06.1X1A Traumatic cerebral edema with loss of consciousness of 30 minutes or less, initial encounter
S06.1X2A Traumatic cerebral edema with loss of consciousness of 31 minutes to 59 minutes, initial encounter
S06.1X3A Traumatic cerebral edema with loss of consciousness of 1 hour to 5 hours 59 minutes, initial encounter
S06.340A Traumatic hemorrhage of right cerebrum without loss of consciousness, initial encounter ☑
S06.341A Traumatic hemorrhage of right cerebrum with loss of consciousness of 30 minutes or less, initial encounter ☑
S06.342A Traumatic hemorrhage of right cerebrum with loss of consciousness of 31 minutes to 59 minutes, initial encounter ☑
S06.343A Traumatic hemorrhage of right cerebrum with loss of consciousness of 1 hours to 5 hours 59 minutes, initial encounter ☑
S06.350A Traumatic hemorrhage of left cerebrum without loss of consciousness, initial encounter ☑
S06.351A Traumatic hemorrhage of left cerebrum with loss of consciousness of 30 minutes or less, initial encounter ☑

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

61500-61501

61500 Craniectomy; with excision of tumor or other bone lesion of skull
61501 for osteomyelitis



A craniectomy is performed and a lesion of a cranial bone is removed

Explanation

The physician removes a portion of the skull bone invaded by tumor or infection. In 61500, the physician removes a tumor or bony lesion. In 61501, the physician removes infected bone. The physician incises and retracts the scalp and removes bone from the affected area. A bone graft or plastic replacement may be used to reconstruct the skull. The scalp is anastomosed and sutured in layers.

Coding Tips

Note that procedure 61500 reports excision of a bone tumor or bone lesion. For excision of a brain tumor, see 61510–61512 and 61518–61521.

ICD-10-CM Diagnostic Codes

C41.0	Malignant neoplasm of bones of skull and face
D16.4	Benign neoplasm of bones of skull and face
D48.0	Neoplasm of uncertain behavior of bone and articular cartilage
M46.21	Osteomyelitis of vertebra, occipito-atlanto-axial region
M85.2	Hyperostosis of skull
M85.68	Other cyst of bone, other site
M85.69	Other cyst of bone, multiple sites

AMA: **61500** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11; 2014,Jan,9 **61501** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11; 2014,Jan,9

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
61500	19.18	13.22	5.49	37.89
61501	16.35	12.08	4.46	32.89
Facility RVU	**Work**	**PE**	**MP**	**Total**
61500	19.18	13.22	5.49	37.89
61501	16.35	12.08	4.46	32.89

	FUD	Status	MUE	Modifiers				IOM Reference
61500	90	A	1(3)	51	N/A	62*	80	None
61501	90	A	1(3)	51	N/A	62*	80	

* with documentation

Terms To Know

anastomosis. Surgically created connection between ducts, blood vessels, or bowel segments to allow flow from one to the other.

benign. Mild or nonmalignant in nature.

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

hyperostosis. Abnormal overgrowth of bone.

lesion. Area of damaged tissue that has lost continuity or function, due to disease or trauma. Lesions may be located on internal structures such as the brain, nerves, or kidneys, or visible on the skin.

neoplasm. New abnormal growth, tumor.

osteomyelitis. Inflammation of bone that may remain localized or spread to the marrow, cortex, or periosteum, in response to an infecting organism, usually bacterial and pyogenic.

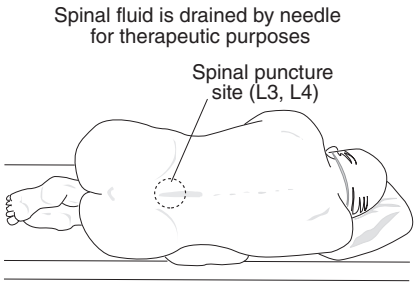
skull. Cranial and facial bones that make up the skeleton of the head. The cranial bones (8) include frontal, parietal (2), temporal (2), occipital, sphenoid, and ethmoid; facial bones (14) include nasal (2), maxillae (2), zygomatic (2), mandible, lacrimal (2), palatine (2), inferior nasal conchae (2), and vomer. Skull base includes the anterior, middle, and posterior fossa; occiput bone; orbital roof; ethmoid and frontal sinus; sphenoid and temporal bones. Skull vault includes the upper, dome-like part of the cranium that includes the frontal and parietal bones.

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

62272 [62329]

62272 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter);

62329 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or CT guidance



Explanation

A therapeutic spinal puncture is performed to lessen cerebrospinal fluid pressure. The patient is placed in a spinal tap position. Using anatomical landmarks (62272) or fluoroscopic or CT guidance (62329), usually the L3 and L4 vertebrae are located and local anesthesia is administered. The lumbar puncture needle is inserted. In some cases, spinal fluid is drawn through the needle as in a lumbar puncture test. In other cases, a catheter is inserted and the fluid empties into a reservoir. Pressure reading is performed with a manometer. When the procedure is completed, the needle is removed and the wound is dressed. In many cases, the patient lies prone to prevent fluid leakage.

Coding Tips

Injection of contrast is included in 62272 and should not be reported separately. Do not report 62272 or 62329 with 77003 or 77012. For spinal puncture, lumbar, diagnostic, see 62270. For ultrasound or MRI guidance, see 76942 and 77021.

ICD-10-CM Diagnostic Codes

G93.2 Benign intracranial hypertension

AMA: **62272** 2020,Jun,10; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11 **62329** 2020,Jun,10; 2020,Jul,15

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
62272	1.58	3.32	0.32	5.22
62329	2.03	6.73	0.43	9.19
Facility RVU	**Work**	**PE**	**MP**	**Total**
62272	1.58	0.64	0.32	2.54
62329	2.03	0.8	0.43	3.26

	FUD	Status	MUE	Modifiers				IOM Reference
62272	0	A	1(3)	51	N/A	N/A	N/A	None
62329	0	A	1(3)	51	N/A	N/A	N/A	

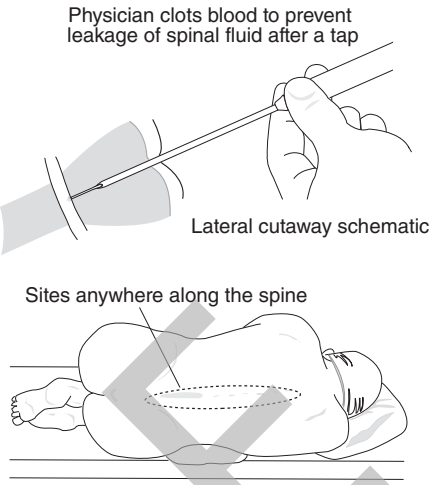
* with documentation

Terms To Know

cerebrospinal fluid. Thin, clear fluid circulating in the cranial cavity and spinal column that bathes the brain and spinal cord.

62273

62273 Injection, epidural, of blood or clot patch



Explanation

This procedure is performed following a spinal puncture to prevent spinal fluid leakage. The patient remains in a spinal tap position. The patient's blood is injected outside the dura to clot and plug the wound, preventing spinal fluid leakage. The wound is dressed and monitored.

Coding Tips

This procedure is sometimes performed after delivery when an epidural anesthesia was used to treat headache caused by leakage of spinal fluid. Injection of contrast is included in 62273 and should not be reported separately. For fluoroscopic guidance and localization, see 77003. For injection of diagnostic or therapeutic substance(s), see 62320–62327. 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

G97.0 Cerebrospinal fluid leak from spinal puncture

G97.1 Other reaction to spinal and lumbar puncture

G97.51 Postprocedural hemorrhage of a nervous system organ or structure following a nervous system procedure

G97.82 Other postprocedural complications and disorders of nervous system

AMA: **62273** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
62273	2.15	2.56	0.19	4.9
Facility RVU	**Work**	**PE**	**MP**	**Total**
62273	2.15	0.92	0.19	3.26

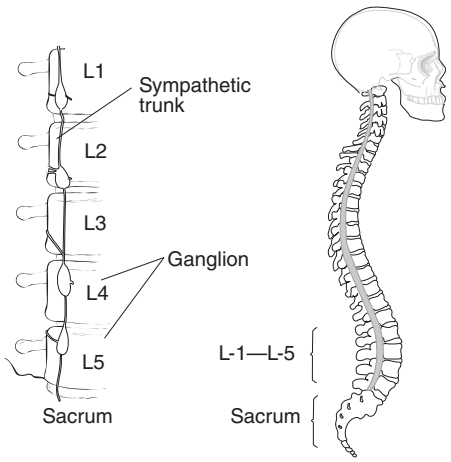
	FUD	Status	MUE	Modifiers				IOM Reference
62273	0	A	2(3)	51	N/A	N/A	N/A	100-03,10.5

* with documentation

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

64818

64818 Sympathectomy, lumbar



The sympathetic nerves of the paravertebral area are both motor and sensory

Explanation

The physician performs a sympathectomy on the lumbar sympathetic nerves. The physician makes a lateral incision through the lumbar area to reach the sympathetic ganglia, which lie on the lateral border of the vertebral column. The physician determines at which level to remove the ganglia, and dissects to the vertebral bodies. The sympathetic plexus is located and resected. The wound is sutured in layers.

Coding Tips

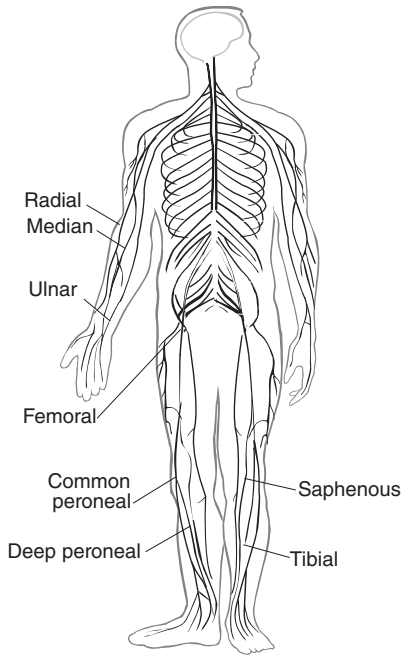
This is a unilateral procedure. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). To report a thoracolumbar sympathectomy, see 64809.

ICD-10-CM Diagnostic Codes

G57.71 Causalgia of right lower limb ☑
G57.72 Causalgia of left lower limb ☑
G90.521 Complex regional pain syndrome I of right lower limb ☑
G90.522 Complex regional pain syndrome I of left lower limb ☑
G90.523 Complex regional pain syndrome I of lower limb, bilateral ☑
G90.59 Complex regional pain syndrome I of other specified site
I70.211 Atherosclerosis of native arteries of extremities with intermittent claudication, right leg A ☑
I70.212 Atherosclerosis of native arteries of extremities with intermittent claudication, left leg A ☑
I70.213 Atherosclerosis of native arteries of extremities with intermittent claudication, bilateral legs A ☑
I70.218 Atherosclerosis of native arteries of extremities with intermittent claudication, other extremity A
I70.221 Atherosclerosis of native arteries of extremities with rest pain, right leg A ☑
I70.222 Atherosclerosis of native arteries of extremities with rest pain, left leg A ☑
I70.223 Atherosclerosis of native arteries of extremities with rest pain, bilateral legs A ☑
I70.231 Atherosclerosis of native arteries of right leg with ulceration of thigh A ☑
I70.232 Atherosclerosis of native arteries of right leg with ulceration of calf A ☑
I70.233 Atherosclerosis of native arteries of right leg with ulceration of ankle A ☑
I70.234 Atherosclerosis of native arteries of right leg with ulceration of heel and midfoot A ☑
I70.235 Atherosclerosis of native arteries of right leg with ulceration of other part of foot A ☑
I70.238 Atherosclerosis of native arteries of right leg with ulceration of other part of lower leg A ☑
I70.241 Atherosclerosis of native arteries of left leg with ulceration of thigh A ☑
I70.242 Atherosclerosis of native arteries of left leg with ulceration of calf A ☑
I70.243 Atherosclerosis of native arteries of left leg with ulceration of ankle A ☑
I70.244 Atherosclerosis of native arteries of left leg with ulceration of heel and midfoot A ☑
I70.245 Atherosclerosis of native arteries of left leg with ulceration of other part of foot A ☑
I70.248 Atherosclerosis of native arteries of left leg with ulceration of other part of lower leg A ☑
I70.25 Atherosclerosis of native arteries of other extremities with ulceration A
I70.291 Other atherosclerosis of native arteries of extremities, right leg A ☑
I70.292 Other atherosclerosis of native arteries of extremities, left leg A ☑
I70.293 Other atherosclerosis of native arteries of extremities, bilateral legs A ☑
I70.298 Other atherosclerosis of native arteries of extremities, other extremity A
I73.00 Raynaud's syndrome without gangrene
I73.01 Raynaud's syndrome with gangrene
I73.1 Thromboangiitis obliterans [Buerger's disease]
L74.513 Primary focal hyperhidrosis, soles
L74.52 Secondary focal hyperhidrosis
M79.604 Pain in right leg ☑
M79.605 Pain in left leg ☑
M79.651 Pain in right thigh ☑
M79.652 Pain in left thigh ☑
M79.661 Pain in right lower leg ☑
M79.662 Pain in left lower leg ☑
M79.671 Pain in right foot ☑
M79.672 Pain in left foot ☑
S77.01XA Crushing injury of right hip, initial encounter ☑
S77.02XA Crushing injury of left hip, initial encounter ☑
S77.11XA Crushing injury of right thigh, initial encounter ☑
S77.12XA Crushing injury of left thigh, initial encounter ☑
S77.21XA Crushing injury of right hip with thigh, initial encounter ☑
S77.22XA Crushing injury of left hip with thigh, initial encounter ☑

95905

95905 Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes F-wave study when performed, with interpretation and report



Select peripheral nerves

Explanation

Nerve testing uses sensors to measure and record nerve functions including conduction, amplitude, and latency/velocity. Nerves are stimulated with electric shocks along the course of the muscle. The time required to initiate contraction is measured and recorded. Measurements of distal latency (the time required to traverse the segment nearest the muscle) and conduction velocity (the time required for an impulse to travel a measured length of nerve) are also recorded. Code 95905 reports motor and/or sensory nerve conduction tests performed using preconfigured electrode arrays. It includes F-wave study, when performed, as well as interpretation and report. Report 95905 only once for each limb studied.

Coding Tips

These procedures have both technical and professional components. To claim only the professional component, append modifier 26. To claim only the technical component, append modifier TC. To claim the complete procedure (i.e., both the professional and technical components), submit without a modifier. For needle EMG of the anal and urethral sphincters, see 51785. For sacral reflex testing, see 51792. Do not report 95905 at the same session as 95885, 95886, or 95907–95913.

ICD-10-CM Diagnostic Codes

G12.21 Amyotrophic lateral sclerosis A
G12.23 Primary lateral sclerosis
G12.24 Familial motor neuron disease
G12.25 Progressive spinal muscle atrophy
G12.29 Other motor neuron disease
G12.8 Other spinal muscular atrophies and related syndromes
G35 Multiple sclerosis
G36.0 Neuromyelitis optica [Devic]
G36.8 Other specified acute disseminated demyelination
G56.01 Carpal tunnel syndrome, right upper limb ☑
G56.02 Carpal tunnel syndrome, left upper limb ☑
G56.11 Other lesions of median nerve, right upper limb ☑
G56.12 Other lesions of median nerve, left upper limb ☑
G56.21 Lesion of ulnar nerve, right upper limb ☑
G56.22 Lesion of ulnar nerve, left upper limb ☑
G56.31 Lesion of radial nerve, right upper limb ☑
G56.32 Lesion of radial nerve, left upper limb ☑
G57.01 Lesion of sciatic nerve, right lower limb ☑
G57.02 Lesion of sciatic nerve, left lower limb ☑
G57.21 Lesion of femoral nerve, right lower limb ☑
G57.22 Lesion of femoral nerve, left lower limb ☑
G57.31 Lesion of lateral popliteal nerve, right lower limb ☑
G57.32 Lesion of lateral popliteal nerve, left lower limb ☑
G57.41 Lesion of medial popliteal nerve, right lower limb ☑
G57.42 Lesion of medial popliteal nerve, left lower limb ☑
G57.51 Tarsal tunnel syndrome, right lower limb ☑
G57.52 Tarsal tunnel syndrome, left lower limb ☑
G57.61 Lesion of plantar nerve, right lower limb ☑
G57.62 Lesion of plantar nerve, left lower limb ☑
G61.0 Guillain-Barre syndrome
G61.82 Multifocal motor neuropathy
G62.89 Other specified polyneuropathies
G81.01 Flaccid hemiplegia affecting right dominant side ☑
G81.02 Flaccid hemiplegia affecting left dominant side ☑
G81.03 Flaccid hemiplegia affecting right nondominant side ☑
G81.04 Flaccid hemiplegia affecting left nondominant side ☑
G82.21 Paraplegia, complete
G82.22 Paraplegia, incomplete
G82.51 Quadriplegia, C1-C4 complete
G82.52 Quadriplegia, C1-C4 incomplete
G82.53 Quadriplegia, C5-C7 complete
G82.54 Quadriplegia, C5-C7 incomplete
G83.0 Diplegia of upper limbs
G83.5 Locked-in state
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
M47.16 Other spondylosis with myelopathy, lumbar region
M47.22 Other spondylosis with radiculopathy, cervical region
M47.23 Other spondylosis with radiculopathy, cervicothoracic region
M47.24 Other spondylosis with radiculopathy, thoracic region
M47.25 Other spondylosis with radiculopathy, thoracolumbar region
M47.26 Other spondylosis with radiculopathy, lumbar region
M48.32 Traumatic spondylopathy, cervical region
M48.33 Traumatic spondylopathy, cervicothoracic region

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

G0453

G0453 Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)

Explanation

Continuous intraoperative neurophysiology monitoring (IONM) is performed by a qualified health care provider other than the surgeon or anesthesiologist involved in the surgical procedure. IONM may include various electrophysiologic modalities, such as electroencephalography (EEG), electromyography (EMG), and evoked potentials. The provider must be solely dedicated to monitoring the neurophysiological tests and available to intervene if necessary.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0453	0.6	0.29	0.05	0.94
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0453	0.6	0.29	0.05	0.94

70240

70240 Radiologic examination, sella turcica

Explanation

Films are taken of the sella turcica, the depression within the sphenoid bone that houses the pituitary gland. The patient is placed in the prone semioblique position and the x-ray beam is directed to a spot slightly anterior and superior to the external auditory meatus while the patient's head is maintained in a lateral position.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
70240	0.19	0.73	0.02	0.94
Facility RVU	**Work**	**PE**	**MP**	**Total**
70240	0.19	0.73	0.02	0.94

70250-70260

70250 X-ray of skull, fewer than 4 views
70260 complete, minimum of 4 views

Explanation

Films are taken of the skull bones. In 70250, three or less views are taken, and in 70260, a complete exam with a four view minimum is performed. The most common projections for routine skull series are AP axial (front to back), lateral, and PA axial (back to front). X-rays may be taken with the patient placed erect, prone, or supine and either code may include stereoradiography, which is a technique that produces three-dimensional images.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
70250	0.18	0.8	0.02	1.0
70260	0.28	0.94	0.02	1.24
Facility RVU	**Work**	**PE**	**MP**	**Total**
70250	0.18	0.8	0.02	1.0
70260	0.28	0.94	0.02	1.24

70360

70360 Radiologic examination; neck, soft tissue

Explanation

The technologist uses x-rays to obtain soft tissue images of the patient's neck rather than bone. The radiologist obtains two views, typically front to back (AP), and side to side (lateral). This procedure is performed to visualize abnormal air patterns or suspected foreign bodies or obstructions within the throat or neck.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
70360	0.18	0.66	0.02	0.86
Facility RVU	**Work**	**PE**	**MP**	**Total**
70360	0.18	0.66	0.02	0.86

72020

72020 Radiologic examination, spine, single view, specify level

Explanation

One film is taken of the spine that requires specification of the level examined.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
72020	0.16	0.5	0.02	0.68
Facility RVU	**Work**	**PE**	**MP**	**Total**
72020	0.16	0.5	0.02	0.68

72040-72052

72040 Radiologic examination, spine, cervical; 2 or 3 views
72050 4 or 5 views
72052 6 or more views

Explanation

A radiologic examination of the cervical spine is performed. Report 72040 for two or three views, 72050 for four or five views, and 72052 for a complete study (six or more views). The complete study includes films taken in oblique (angled) positions and in flexion and/or extension positioning.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
72040	0.22	0.83	0.02	1.07
72050	0.27	1.13	0.02	1.42
72052	0.3	1.35	0.02	1.67
Facility RVU	**Work**	**PE**	**MP**	**Total**
72040	0.22	0.83	0.02	1.07
72050	0.27	1.13	0.02	1.42
72052	0.3	1.35	0.02	1.67

72070-72074

72070 Radiologic examination, spine; thoracic, 2 views
72072 thoracic, 3 views
72074 thoracic, minimum of 4 views

CPT Index

A

● New ▲ Revised + Add On AMA: CPT Assist[Resequenced]