Optum

Coding Companion

Neurosurgery/ Neurology

A comprehensive illustrated guide to coding and reimbursement

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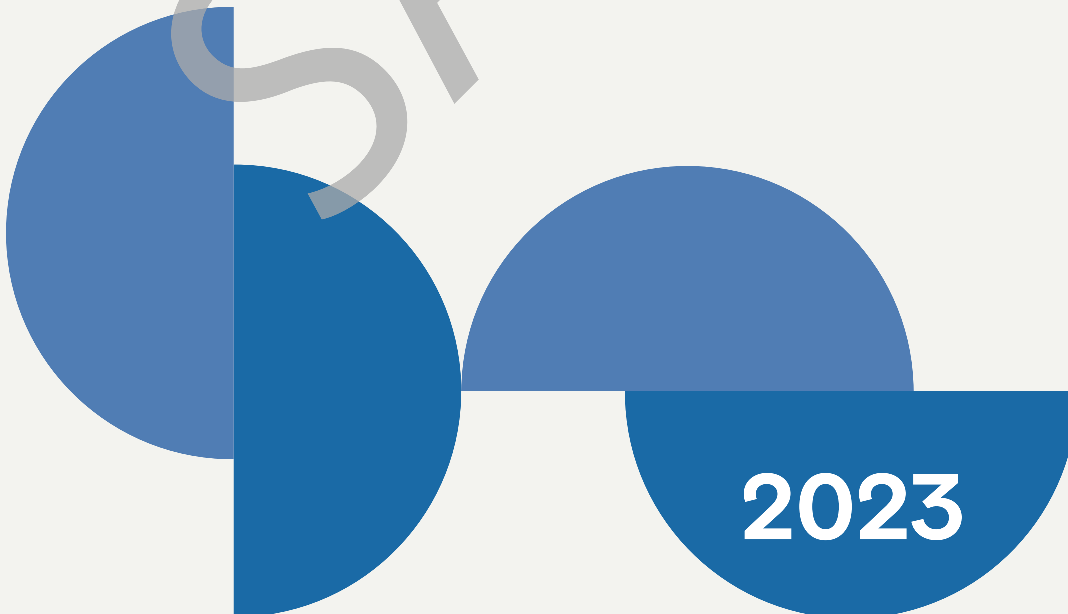

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Correct Coding Initiative Update 627

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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, in the 10th revision of the ICD-10-CM codes, conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. Features include icons to identify newborn, pediatric, adult, male only, female only, and laterality. 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. 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 Edits 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 XX.X, 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 CCI edits are located in a section at the back of the book. As other CPT (including COVID-related vaccine and administration codes) and ICD-10-CM codes relevant to your specialty are released, updates will be posted to the Optum360 website. The website address is http://www.optum360coding.com/ProductUpdates/. The 2023 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:

61635 Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed

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

Arteriovenous Malformation
  Cranial
    Intravascular Stent(s), 61635

OR

Catheter
  Placement
    Stent, 61635

OR

Cerebral Vessel(s)
  Stent Placement, 61635

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.

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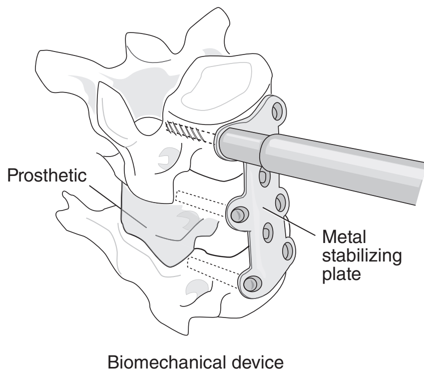
22853-22854

1

+ **22853** Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)
+ **22854** Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)

2



Biomechanical device

Explanation

3

The physician replaces an intervertebral disc or a partial or complete vertebral body is resected due to destruction by disease, trauma, or other processes. Once the disc or body has been removed by a separately identifiable procedure, a hole is cored out of the vertebral bodies above and below the removed vertebrae to secure a biomechanical device (synthetic cage or mesh) into the resulting intervertebral disc space. The physician selects the biomechanical device best suited to the location and type of deformity being corrected. Screws, wires, or plates may be used to secure the device. Muscles are allowed to fall back into place and the wound is closed over a drain with layered sutures. Report 22853 for replacement of an intervertebral disc. Report 22854 for replacement of a partial or complete vertebral body.

Coding Tips

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Report 22853 or 22854 in addition to 22100–22102, 22110–22114, 22206–22207, 22210–22214, 22220–22224, 22310–22327, 22532, 22533, 22548–22558, 22590–22612, 22630, 22633, 22634, 22800–22812, 63001–63030, 63040–63042, 63045–63047, 63050–63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170–63290, and 63300–63307. Report 22853 or 22854 for each noncontiguous defect. Application of an intervertebral bone device/graft is reported separately, see 20930–20938. Report separately treatment of a fracture/dislocation (22325–22328) and arthrodesis (22548–22812). It is inappropriate to append modifier 62 to spinal instrumentation codes.

5

ICD-10-CM Diagnostic Codes

This/these CPT code(s) are add-on code(s). See the primary procedure code that this code is performed with for your ICD-10-CM code selections.

6

Associated HCPCS Codes

C1831 Personalized, anterior and lateral interbody cage (implantable)

7

AMA: **22853** 2020,May,13; 2018,Sep,7; 2018,Jul,14; 2018,Jan,8; 2017,Aug,9 **22854** 2020,May,13; 2018,Sep,7; 2018,Jan,8; 2017,Mar,7

8

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
22853	4.25	2.1	1.25	7.6
22854	5.5	2.71	1.63	9.84
Facility RVU	**Work**	**PE**	**MP**	**Total**
22853	4.25	2.1	1.25	7.6
22854	5.5	2.71	1.63	9.84

	FUD	Status	MUE	Modifiers				IOM Reference
22853	N/A	A	4(3)	N/A	N/A	62	80	None
22854	N/A	A	4(3)	N/A	N/A	62	80	

* with documentation

Terms To Know

9

arthrodesis. Surgical fixation or fusion of a joint to reduce pain and improve stability, performed openly or arthroscopically.

corpectomy. Removal of the body of a bone, such as a vertebra.

stabilization. Fixed, firm state that is resistant to change.

SAMPLE

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1. CPT Codes and Descriptions

This edition of *Coding Companion* is updated with CPT codes for year 2022.

The following icons are used in *Coding Companion:*

● This CPT code is new for 2022.

▲ This CPT code description is revised for 2022.

✚ 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 telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. 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 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.

[ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

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 Optum360 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 or left) 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 2022.

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, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs when the technical (modifier TC) or professional (modifier26) component of a procedure is provided.

SAMPLE

Evaluation and Management Guidelines Common to All E/M Services

Information unique to this section is defined or identified below.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital 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 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 the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians and other qualified health care professionals. The definitions in the E/M section are provided solely for the basis of code selection.

Some definitions are common to all categories of services, and others are specific to one or more categories only.

New and Established Patient

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 E/M services with a specific CPT® code or codes. A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/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/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See the decision tree on the following page.

When a physician/qualified health care professional is on call or covering for another physician/qualified health care professional, the patient's encounter is classified as it would have been by the physician/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 exact same subspecialties 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 on the following page is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the **other** E/M services when counseling and/or coordination of care dominates the service.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Face-to-face time (outpatient consultations [99241, 99242, 99243, 99244, 99245], domiciliary, rest home, or custodial services [99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337], home services [99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350], cognitive assessment and care plan services [99483]): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient.

SAMPLE

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 time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**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 time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**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 time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**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 time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

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, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 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 no longer used when determining the level of service. Codes should be selected based upon the current CPT 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. For office or other outpatient services for an established patient, see 99211-99215. For observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. 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: **99202** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2020,Dec,11; 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,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99203** 2020,Sep,3; 2020,Sep,14; 2020,Oct,14; 2020,Nov,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,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 **99204** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,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,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3 **99205** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,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,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.1	0.09	2.12
99203	1.6	1.51	0.15	3.26
99204	2.6	2.04	0.23	4.87
99205	3.5	2.62	0.31	6.43
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.15	2.42
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*	None
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*	

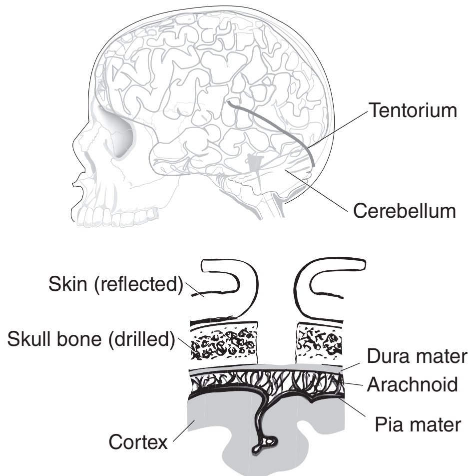
* with documentation

SAMPLE

61250-61253

61250 Burr hole(s) or trephine, supratentorial, exploratory, not followed by other surgery

61253 Burr hole(s) or trephine, infratentorial, unilateral or bilateral



A burr hole or trephine core is made into the skull

Explanation

The physician drills a burr hole or trephine. In 61250 the hole is made to access the supratentorial area of the brain. In 61253, the infratentorial, unilateral, or bilateral area of the brain is accessed. The physician makes an incision in the scalp over the area to be drilled, and uses a burr hole drill or a trephine to create an opening to the brain. The physician explores the area and closes the wound. No other procedures are reported at this time.

Coding Tips

Note that 61250 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). Code 61253 is a unilateral or bilateral code and as such is reported once even if the procedure is performed on both sides. Codes 61250 and 61253 should be reported only when no other surgical procedure is performed during the same surgical session. If burr holes or trephine are followed by a craniotomy, do not use 61250 or 61253; see 61304–61321.

ICD-10-CM Diagnostic Codes

G09 Sequelae of inflammatory diseases of central nervous system
G93.5 Compression of brain
P10.4 Tentorial tear due to birth injury N
Q28.2 Arteriovenous malformation of cerebral vessels
Q28.3 Other malformations of cerebral vessels

AMA: **61253** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
61250	11.49	9.9	4.27	25.66
61253	13.49	10.87	4.99	29.35
Facility RVU	**Work**	**PE**	**MP**	**Total**
61250	11.49	9.9	4.27	25.66
61253	13.49	10.87	4.99	29.35

	FUD	Status	MUE	Modifiers				IOM Reference
61250	90	A	1(3)	51	50	62*	80	None
61253	90	A	1(3)	51	N/A	N/A	80	

* with documentation

Terms To Know

burr. Specialized surgical drill used to shape or make holes in bones or gain access into the cranium.

infratentorial. Located below or beneath the tentorium of the cerebellum, which is the dura mater supporting the occipital lobes and covering the cerebellum.

supratentorial. Located above the tentorium. The tentorium is the covering of dura mater in the brain supporting the occipital lobes and covering the cerebellum.

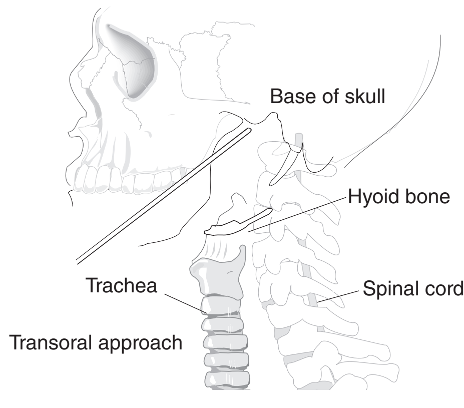
trephine (bone). Specialized round saw for cutting circular holes in bone, especially the skull.

SAMPLE

Skull/Brain

61575-61576

61575 Transoral approach to skull base, brain stem or upper spinal cord for biopsy, decompression or excision of lesion;
61576 requiring splitting of tongue and/or mandible (including tracheostomy)



Explanation

The physician approaches the skull base, brain stem, or upper spinal cord and obtains a biopsy, decompresses the brain stem or spinal cord, or excises a lesion. In 61575, the physician access the affected area through the patient's mouth. In 61576, the physician performs a tracheostomy and cuts through the mandible and tongue to reach an extensive defect. The physician places a gag retractor in the patient's mouth and makes a posterior pharyngeal wall incision. The mucosa is retracted to the deep muscle layers which are dissected to reach the skull base or superior spinal cord. The bone is removed to expose the area of interest. A lesion may be biopsied or excised. Decompression is accomplished by removing bone from around the structure. If incised, the dura is closed, then the posterior pharyngeal wall is reapproximated and sutured in layers.

Coding Tips

Arthrodesis is reported separately; see 22548.

ICD-10-CM Diagnostic Codes

C71.7 Malignant neoplasm of brain stem
C72.0 Malignant neoplasm of spinal cord
C72.1 Malignant neoplasm of cauda equina
C79.31 Secondary malignant neoplasm of brain
D16.4 Benign neoplasm of bones of skull and face
D16.6 Benign neoplasm of vertebral column
D32.0 Benign neoplasm of cerebral meninges
D33.0 Benign neoplasm of brain, supratentorial
D33.1 Benign neoplasm of brain, infratentorial
D33.4 Benign neoplasm of spinal cord
D33.7 Benign neoplasm of other specified parts of central nervous system
D43.0 Neoplasm of uncertain behavior of brain, supratentorial
D43.1 Neoplasm of uncertain behavior of brain, infratentorial
D43.4 Neoplasm of uncertain behavior of spinal cord
D49.6 Neoplasm of unspecified behavior of brain
G95.11 Acute infarction of spinal cord (embolic) (nonembolic)
G95.29 Other cord compression
M06.08 Rheumatoid arthritis without rheumatoid factor, vertebrae
M06.88 Other specified rheumatoid arthritis, vertebrae
M47.011 Anterior spinal artery compression syndromes, occipito-atlanto-axial region
M47.012 Anterior spinal artery compression syndromes, cervical region
M47.021 Vertebral artery compression syndromes, occipito-atlanto-axial region
M47.022 Vertebral artery compression syndromes, cervical region
M47.11 Other spondylosis with myelopathy, occipito-atlanto-axial region
M47.12 Other spondylosis with myelopathy, cervical region
M47.21 Other spondylosis with radiculopathy, occipito-atlanto-axial region
M47.22 Other spondylosis with radiculopathy, cervical region
M47.811 Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region
M47.812 Spondylosis without myelopathy or radiculopathy, cervical region
M47.891 Other spondylosis, occipito-atlanto-axial region
M47.892 Other spondylosis, cervical region
M50.01 Cervical disc disorder with myelopathy, high cervical region
M50.11 Cervical disc disorder with radiculopathy, high cervical region

AMA: **61575** 2014,Jan,11 **61576** 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
61575	36.56	23.66	13.56	73.78
61576	55.31	48.56	20.52	124.39
Facility RVU	**Work**	**PE**	**MP**	**Total**
61575	36.56	23.66	13.56	73.78
61576	55.31	48.56	20.52	124.39

	FUD	Status	MUE	Modifiers				IOM Reference
61575	90	A	1(2)	51	N/A	62*	80	None
61576	90	A	1(2)	51	N/A	62*	80	

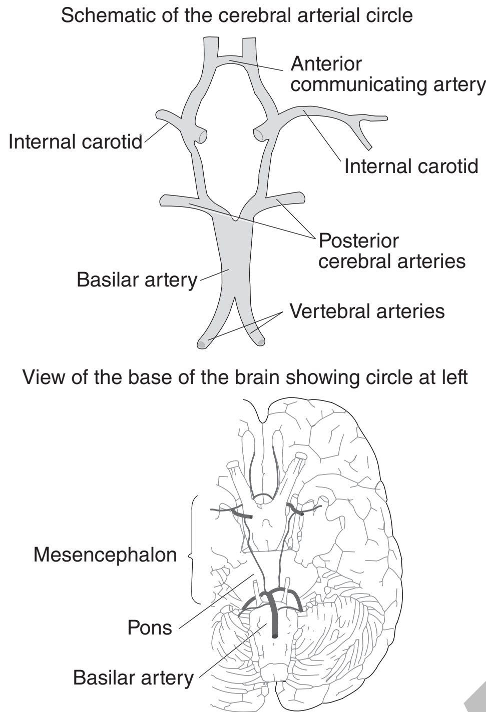
* with documentation

Skull/Brain

SAMPLE

61702

61702 Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation



Explanation

The physician resects a simple vertebrobasilar aneurysm. Simple aneurysms include those that are 15 millimeters or less in size and contain no anatomical features that will complicate the surgery such as calcifications or critical perforating vessels at the aneurysm neck. After using angiography to locate the aneurysm, the physician uses a posterior cranial fossa approach for access. The aneurysm is located and clipped under direct visualization. After making sure the clip is secure and there is no bleeding, the physician closes the dura. The bone flap is repositioned and secured and the scalp is sutured in layers.

Coding Tips

This code includes a craniotomy when performed.

ICD-10-CM Diagnostic Codes

I67.1	Cerebral aneurysm, nonruptured
Q28.2	Arteriovenous malformation of cerebral vessels
Q28.3	Other malformations of cerebral vessels

AMA: 61702 2014,Jan,11

Relative Value Units/Medicare Edits

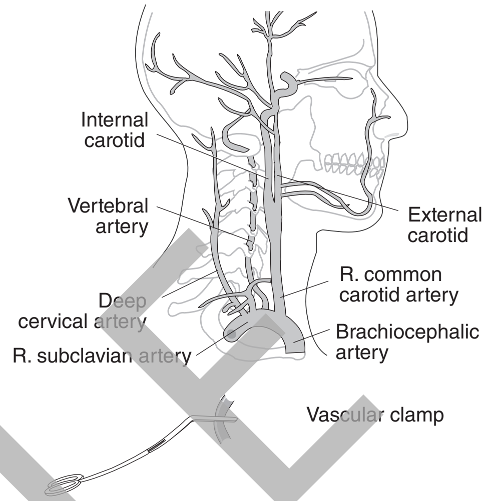
Non-Facility RVU	Work	PE	MP	Total
61702	60.04	35.9	22.3	118.24
Facility RVU	**Work**	**PE**	**MP**	**Total**
61702	60.04	35.9	22.3	118.24

	FUD	Status	MUE	Modifiers				IOM Reference
61702	90	A	1(3)	51	N/A	62*	80	None

* with documentation

61703

61703 Surgery of intracranial aneurysm, cervical approach by application of occluding clamp to cervical carotid artery (Selverstone-Crutchfield type)



Explanation

The physician resects an aneurysm after clamping the carotid artery to control bleeding. The physician makes a high neck incision and locates the ipsilateral carotid artery. Next, the physician performs a craniotomy to access the intracranial aneurysm. When the aneurysm is located, the carotid artery is occluded with a clamp. The physician places a clip on the aneurysm under direct visualization. Once the aneurysm has been clipped and bleeding is controlled, the carotid clamp is released. The aneurysm site is reexamined for bleeding. The physician closes the dura. The bone flap is repositioned and secured; the scalp is reanastomosed and sutured in layers. The neck incision is sutured in layers.

Coding Tips

For an intracranial approach to the carotid artery, see 61700. For a cervical approach for direct ligation of the carotid artery, see 37600–37606.

ICD-10-CM Diagnostic Codes

I67.1	Cerebral aneurysm, nonruptured
Q28.2	Arteriovenous malformation of cerebral vessels
Q28.3	Other malformations of cerebral vessels

AMA: 61703 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
61703	18.8	14.35	6.97	40.12
Facility RVU	**Work**	**PE**	**MP**	**Total**
61703	18.8	14.35	6.97	40.12

	FUD	Status	MUE	Modifiers				IOM Reference
61703	90	A	1(3)	51	N/A	62*	80	None

* with documentation

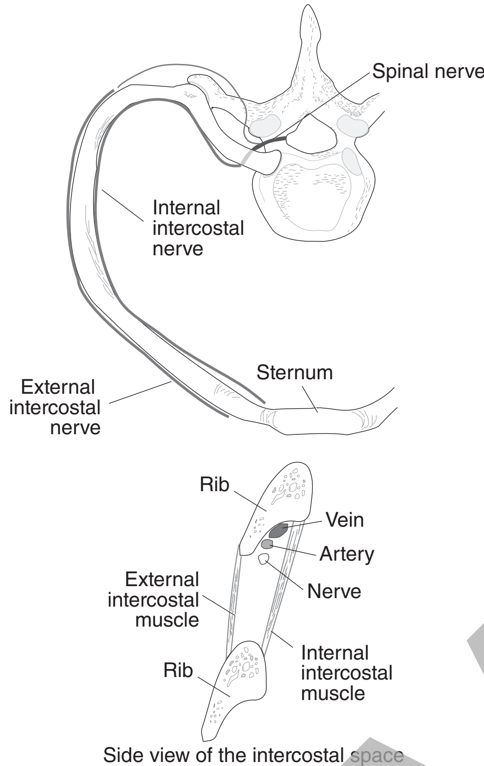
Skull/Brain

SAMPLE

64420-64421

64420 Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level

\+ **64421** intercostal nerve, each additional level (List separately in addition to code for primary procedure)



Side view of the intercostal space

Explanation

The physician injects one or more anesthetic agents and/or steroids near the intercostal nerves, which are located underneath the ribs, to alleviate pain and inflammation often caused by a herpes zoster infection (shingles) or a surgical incision. In 64420, a single level is injected. Report 64421 for each additional level injected.

Coding Tips

If destruction of the nerve is performed on the same date of service, do not report 64420 or 64421 separately. Report 64421 in addition to 64420. Code 64421 should be reported twice when performed bilaterally. Do not report with modifier 50 per CPT guidelines. Medicare may still require the use of modifier 50. For destruction of an intercostal nerve by a neurolytic agent, see 64620.

ICD-10-CM Diagnostic Codes

B02.23	Postherpetic polyneuropathy
B02.29	Other postherpetic nervous system involvement
B02.9	Zoster without complications
G58.0	Intercostal neuropathy
R07.1	Chest pain on breathing
R07.81	Pleurodynia
R07.82	Intercostal pain
R07.89	Other chest pain
S20.211A	Contusion of right front wall of thorax, initial encounter
S20.213A	Contusion of bilateral front wall of thorax, initial encounter
S20.214A	Contusion of middle front wall of thorax, initial encounter
S20.223A	Contusion of bilateral back wall of thorax, initial encounter
S20.224A	Contusion of middle back wall of thorax, initial encounter
S22.22XA	Fracture of body of sternum, initial encounter for closed fracture
S22.22XB	Fracture of body of sternum, initial encounter for open fracture
S22.31XA	Fracture of one rib, right side, initial encounter for closed fracture ☑
S22.31XB	Fracture of one rib, right side, initial encounter for open fracture ☑
S22.41XA	Multiple fractures of ribs, right side, initial encounter for closed fracture ☑
S22.41XB	Multiple fractures of ribs, right side, initial encounter for open fracture ☑

AMA: **64420** 2018,Jan,8; 2017,Jan,8; 2016,Jan,9; 2016,Jan,13; 2015,Jun,3; 2015,Jan,16 **64421** 2018,Jan,8; 2017,Jan,8; 2016,Jan,9; 2016,Jan,13; 2015,Jun,3; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
64420	1.08	1.75	0.11	2.94
64421	0.5	0.44	0.05	0.99

Facility RVU	Work	PE	MP	Total
64420	1.08	0.54	0.11	1.73
64421	0.5	0.18	0.05	0.73

	FUD	Status	MUE	Modifiers				IOM Reference
64420	0	A	2(2)	51	50	N/A	N/A	None
64421	N/A	A	3(3)	N/A	50	N/A	N/A	

* with documentation

Terms To Know

injection. Forcing a liquid substance into a body part such as a joint or muscle.

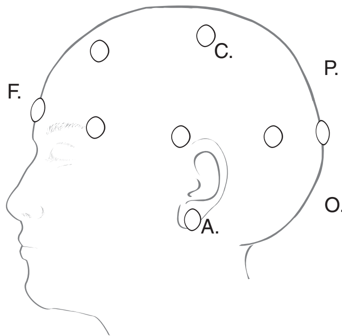
intercostal nerve. Thoracic nerve.

regional anesthesia. Anesthesia administered to a nerve or nerve plexus to provide a loss of sensation in a particular region, without inducing unconsciousness. Sometimes sedative agents are administered, such as Valium, prior to administration of the regional anesthesia.

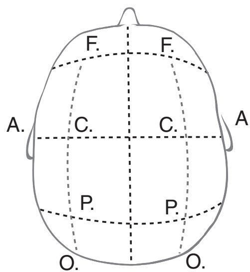
SAMPLE

95816-95819

95816 Electroencephalogram (EEG); including recording awake and drowsy
95819 including recording awake and asleep



Typical locations for (EEG) leads.
A. ear lobe, C. central, P. parietal,
F. frontal, O. occipital



Explanation

Sensors are placed on a patient's head in an electroencephalogram (EEG) to measure and record the brain's electrical activity. Brain waves are captured on paper or electronic medium for study. Code 95816 applies to a patient awake and drowsy during the EEG. Code 95819 applies to a patient intermittently awake and then asleep during the EEG.

Coding Tips

These codes include hyperventilation and/or photic stimulation when appropriate. Procedures 95816 and 95819 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. If EEG monitoring is extended, see 95812 and 95813. If the EEG is analyzed digitally, see 95957. Do not report 95816–95819 with 95700–95726. For a long-term EEG greater than two hours, see 95700–95726.

ICD-10-CM Diagnostic Codes

G31.81	Alpers disease
G31.82	Leigh's disease
G31.83	Dementia with Lewy bodies
G31.84	Mild cognitive impairment, so stated
G31.85	Corticobasal degeneration
G31.89	Other specified degenerative diseases of nervous system
G40.009	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, not intractable, without status epilepticus
G40.019	Localization-related (focal) (partial) idiopathic epilepsy and epileptic syndromes with seizures of localized onset, intractable, without status epilepticus
G40.109	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, not intractable, without status epilepticus
G40.119	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with simple partial seizures, intractable, without status epilepticus
G40.209	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, not intractable, without status epilepticus
G40.219	Localization-related (focal) (partial) symptomatic epilepsy and epileptic syndromes with complex partial seizures, intractable, without status epilepticus
G40.309	Generalized idiopathic epilepsy and epileptic syndromes, not intractable, without status epilepticus
G40.319	Generalized idiopathic epilepsy and epileptic syndromes, intractable, without status epilepticus
G40.42	Cyclin-Dependent Kinase-Like 5 Deficiency Disorder
G40.822	Epileptic spasms, not intractable, without status epilepticus
G40.824	Epileptic spasms, intractable, without status epilepticus
G40.834	Dravet syndrome, intractable, without status epilepticus
G40.89	Other seizures
G40.A09	Absence epileptic syndrome, not intractable, without status epilepticus
G40.A19	Absence epileptic syndrome, intractable, without status epilepticus
G40.B09	Juvenile myoclonic epilepsy, not intractable, without status epilepticus
G40.B19	Juvenile myoclonic epilepsy, intractable, without status epilepticus
G65.0	Sequelae of Guillain-Barre syndrome
G80.0	Spastic quadriplegic cerebral palsy
G80.1	Spastic diplegic cerebral palsy
G80.2	Spastic hemiplegic cerebral palsy
G80.3	Athetoid cerebral palsy
G80.4	Ataxic cerebral palsy
G80.8	Other cerebral palsy
G92.00	Immune effector cell-associated neurotoxicity syndrome, grade unspecified
G92.01	Immune effector cell-associated neurotoxicity syndrome, grade 1
G92.02	Immune effector cell-associated neurotoxicity syndrome, grade 2
G92.03	Immune effector cell-associated neurotoxicity syndrome, grade 3
G92.04	Immune effector cell-associated neurotoxicity syndrome, grade 4
G92.05	Immune effector cell-associated neurotoxicity syndrome, grade 5
G92.8	Other toxic encephalopathy
G93.1	Anoxic brain damage, not elsewhere classified
G93.2	Benign intracranial hypertension
G93.40	Encephalopathy, unspecified
G93.41	Metabolic encephalopathy

SAMPLE

Correct Coding Initiative Update

❖Indicates Mutually Exclusive Edit

0075T 01924-01926, 0213T, 0216T, 34713-34716, 34812-34820, 34833-34834, 35201-35206, 35226, 35261-35266, 35286, 36000, 36100, 36140, 36200, 36215-36217, 36410, 36591-36592, 36620-36625, 36831-36833, 36860-36861, 37236, 37246-37247, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 69990, 75600, 75605, 76000, 76380, 76942, 76998, 77001-77002, 77012, 77021, 93050, 96360, 96365, 96372, 96374-96377, 96523, 99446-99449, 99451-99452

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