

Neurosurgery/ Neurology

A comprehensive illustrated guide to
coding and reimbursement

SAMPLE

2025

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Getting Started with Coding Companion

Coding Companion for Neurosurgery/Neurology 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 neurosurgery/neurology 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
- Pathology and Laboratory
- E/M
- Medicine Services
- Surgery
- Category III
- Radiology

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:

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 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.

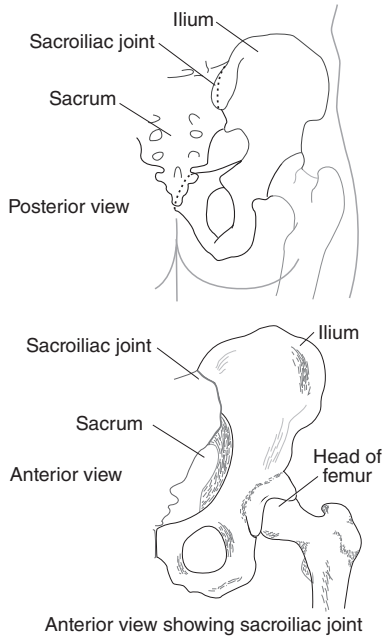
Sample Page and Key

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

27096

1

27096 Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed



2

Explanation

The physician injects the sacroiliac joint, the articulation between the sacrum and the ilium in the pelvis. The physician draws contrast, an anesthetic, and/or steroid into a syringe. Through a posterior approach, a needle (syringe attached) is inserted into the sacroiliac joint. Arthrography, CT, or fluoroscopic guidance may be used to guide the needle placement. The physician pushes on the syringe to deliver its content into the joint. The needle is withdrawn.

Coding Tips

This code is to be used only with imaging confirmation of intra-articular needle positioning. 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). For the injection procedure without CT or fluoroscopic imaging guidance, see 20552.

ICD-10-CM Diagnostic Codes

- M45.8 Ankylosing spondylitis sacral and sacrococcygeal region
- M46.08 Spinal enthesopathy, sacral and sacrococcygeal region
- M46.1 Sacroiliitis, not elsewhere classified
- M46.28 Osteomyelitis of vertebra, sacral and sacrococcygeal region
- M46.38 Infection of intervertebral disc (pyogenic), sacral and sacrococcygeal region
- M46.58 Other infective spondylopathies, sacral and sacrococcygeal region
- M46.88 Other specified inflammatory spondylopathies, sacral and sacrococcygeal region
- M53.88 Other specified dorsopathies, sacral and sacrococcygeal region
- M54.31 Sciatica, right side
- M54.32 Sciatica, left side

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- M54.41 Lumbago with sciatica, right side
- M54.42 Lumbago with sciatica, left side
- M54.51 Vertebrogenic low back pain
- M54.59 Other low back pain
- M99.14 Subluxation complex (vertebral) of sacral region
- S33.2XXA Dislocation of sacroiliac and sacrococcygeal joint, initial encounter
- S33.6XXA Sprain of sacroiliac joint, initial encounter

Associated HCPCS Codes

- G0260 Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

AMA: 27096 2023, Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
27096	1.48	3.25	0.14	4.87
Facility RVU	Work	PE	MP	Total
27096	1.48	0.83	0.14	2.45
FUD	Status	MUE	Modifiers	IOM Reference
27096	0	A	1(2) 51 50 N/A N/A	None

Terms To Know

- arthrography.** Radiographic study of a joint and its internal structures. Air or contrast medium is injected into the joint just before the images are taken.
- CT.** Computed tomography.
- fluoroscopy.** Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.

9

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:

- ▢ Newborn: 0
- ▣ Pediatric: 0-17
- ▤ Maternity: 9-64
- ▥ 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 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, 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

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.

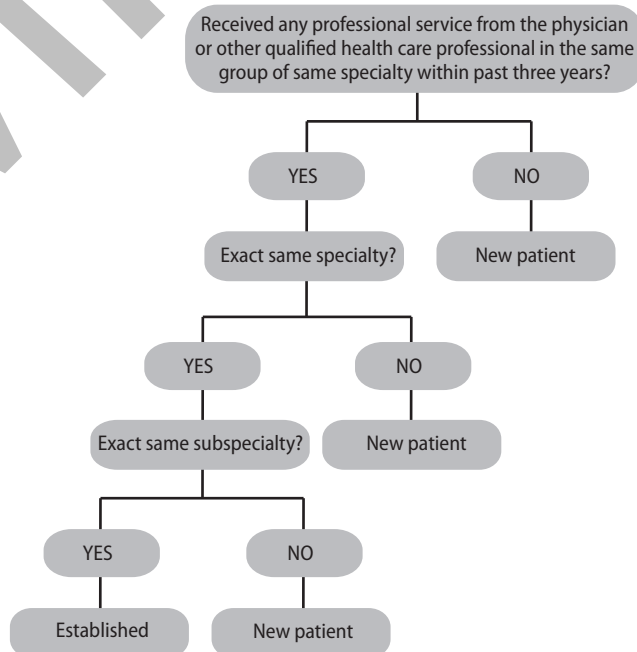
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the 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.

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,Sept; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sept; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sept; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sept; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,May; 2019,Jan; 2018,Oct; 2018,Sept; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99203** 2023,Nov; 2023,Oct; 2023,Sept; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sept; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sept; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sept; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,May; 2019,Jan; 2018,Oct; 2018,Sept; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99204** 2023,Nov; 2023,Oct; 2023,Sept; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sept; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sept; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sept; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,May; 2019,Jan; 2018,Oct; 2018,Sept; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99205** 2023,Nov; 2023,Oct; 2023,Sept; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sept; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sept; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sept; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,May; 2019,Jan; 2018,Oct; 2018,Sept; 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;
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	100-04,12,30.6.4;
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	100-04,12,30.6.10;
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	100-04,12,190.7;
								100-04,12,230;
								100-04,12,230.1;
								100-04,18,80.2;
								100-04,32,12.1

* with documentation

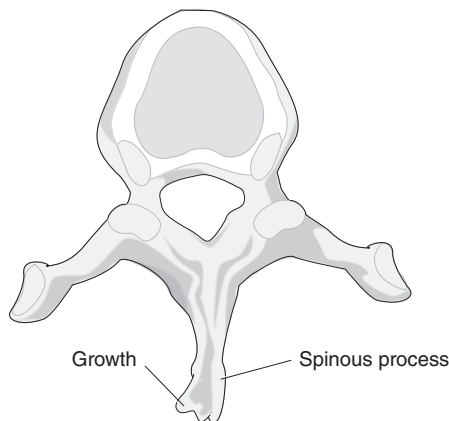
22100-22103

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)



Example of cervical vertebra

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 the vertebral body, for intrinsic bony lesion, without decompression of spinal cord and/or nerve root, see 22110–22116. For complete or near complete resection of the vertebral body, use vertebral corpectomy codes 63081–63091. For insertion of posterior spinous process distraction devices, see 22867–22870.

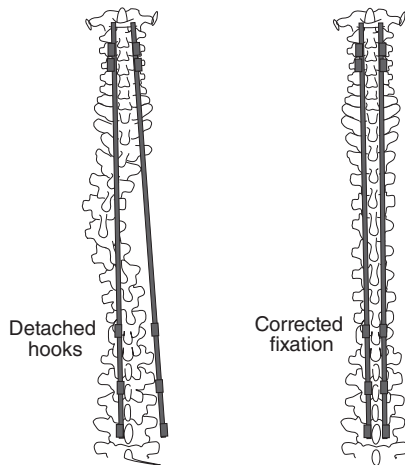
ICD-10-CM Diagnostic Codes

- 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
- M86.58 Other chronic hematogenous osteomyelitis, other site

22849

22849 Reinsertion of spinal fixation device



The physician reinserts spinal fixation device following correction failure or reappearance of the deformity

Explanation

This code describes the procedures used following failure of devices such as wires, screws, cables, plates, or rods used in spinal fixation. The patient is placed in the position dictated by the failure. The physician makes a midline incision overlying the damaged section. The fascia, paravertebral muscles, and ligaments are retracted. A number of reparative techniques may be used, depending on the device and point of failure. In most cases, the device must be replaced. The physician closes the muscles, fascia, and skin with layered sutures.

Coding Tips

Report exploration of spinal fusion separately; see 22830. Removal of instrumentation (22850, 22852, 22855) is not reported separately when performed with reinsertion of a spinal fixation device at the same spine levels.

ICD-10-CM Diagnostic Codes

- T84.216A Breakdown (mechanical) of internal fixation device of vertebrae, initial encounter
- T84.226A Displacement of internal fixation device of vertebrae, initial encounter
- T84.296A Other mechanical complication of internal fixation device of vertebrae, initial encounter
- T84.418A Breakdown (mechanical) of other internal orthopedic devices, implants and grafts, initial encounter
- T84.428A Displacement of other internal orthopedic devices, implants and grafts, initial encounter
- T84.498A Other mechanical complication of other internal orthopedic devices, implants and grafts, initial encounter
- T84.63XA Infection and inflammatory reaction due to internal fixation device of spine, initial encounter
- T84.7XXA Infection and inflammatory reaction due to other internal orthopedic prosthetic devices, implants and grafts, initial encounter
- T84.81XA Embolism due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
- T84.82XA Fibrosis due to internal orthopedic prosthetic devices, implants and grafts, initial encounter

- T84.83XA Hemorrhage due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
- T84.84XA Pain due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
- T84.85XA Stenosis due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
- T84.86XA Thrombosis due to internal orthopedic prosthetic devices, implants and grafts, initial encounter
- T84.89XA Other specified complication of internal orthopedic prosthetic devices, implants and grafts, initial encounter
- Z98.1 Arthrodesis status

AMA: 22849 2021,Jul; 2020,May; 2018,Aug; 2017,Jun

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
22849	19.17	14.45	5.61	39.23
Facility RVU	Work	PE	MP	Total
22849	19.17	14.45	5.61	39.23

	FUD	Status	MUE	Modifiers			IOM Reference	
22849	90	A	1(2)	51	N/A	62*	80	None

* with documentation

Terms To Know

bone conduction. Transportation of sound through the bones of the skull to the inner ear.

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

incision. Act of cutting into tissue or an organ.

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

internal skeletal fixation. Repair involving wires, pins, screws, and/or plates placed through or within the fractured area to stabilize and immobilize the injury.

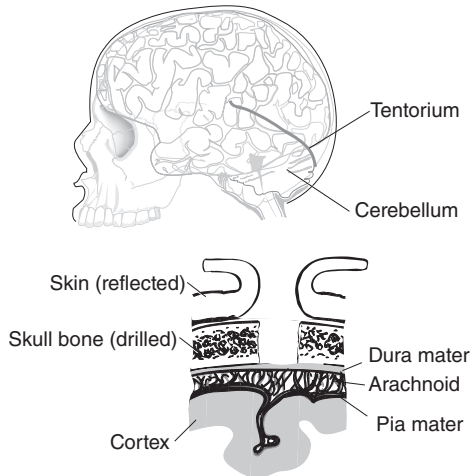
vertebral body. Disc-shaped portion of a vertebra that is anteriorly located and bears weight.

vertebral column. Thirty-three bones that house the spinal cord, consisting of seven cervical vertebrae, 12 thoracic vertebrae, five lumbar vertebrae, five fused vertebrae in the sacrum, and four fused vertebrae in the coccyx.

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
- Q28.2 Arteriovenous malformation of cerebral vessels
- Q28.3 Other malformations of cerebral vessels
- S06.34AA Traumatic hemorrhage of right cerebrum with loss of consciousness status unknown, initial encounter
- S06.35AA Traumatic hemorrhage of left cerebrum with loss of consciousness status unknown, initial encounter

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
61250	11.49	10.2	4.67	26.36
61253	13.49	11.16	5.46	30.11
Facility RVU	Work	PE	MP	Total
61250	11.49	10.2	4.67	26.36
61253	13.49	11.16	5.46	30.11

	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.

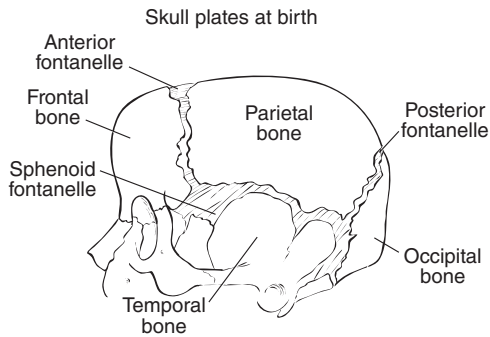
infratentorial. Located below or beneath the tentorium of the cerebellum, which is the dura mater supporting the occipital lobes and covering the cerebellum.

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.

62140-62141

62140 Cranioplasty for skull defect; up to 5 cm diameter
62141 larger than 5 cm diameter



A cranioplasty is performed to repair a skull defect

Explanation

The physician corrects a defect in the cranium. In 62140, the defect is less than 5 cm. In 62141, the defect is greater than 5 cm. The physician incises and retracts the scalp. The bone flaps are lifted and remodeled. A prosthesis may be used to reapproximate the bony edges. The skull is stabilized and the scalp is reapproximated and sutured in layers.

Coding Tips

To report cranioplasty for skull defect with reparative brain surgery, see 62145. For cranioplasty requiring autograft, see 62146–62147.

ICD-10-CM Diagnostic Codes

- M89.38 Hypertrophy of bone, other site
- Q00.0 Anencephaly
- Q00.1 Craniorachischisis
- Q00.2 Iniencephaly
- Q02 Microcephaly
- Q04.5 Megalencephaly
- Q04.8 Other specified congenital malformations of brain
- Q67.2 Dolichocephaly
- Q67.3 Plagiocephaly
- Q67.4 Other congenital deformities of skull, face and jaw
- Q75.01 Sagittal craniosynostosis
- Q75.021 Coronal craniosynostosis unilateral
- Q75.022 Coronal craniosynostosis bilateral
- Q75.03 Metopic craniosynostosis
- Q75.041 Lambdoid craniosynostosis, unilateral
- Q75.042 Lambdoid craniosynostosis, bilateral
- Q75.051 Cloverleaf skull
- Q75.052 Pansynostosis
- Q75.058 Other multi-suture craniosynostosis
- Q75.08 Other single-suture craniosynostosis
- Q75.1 Craniofacial dysostosis
- Q75.2 Hypertelorism
- Q75.3 Macrocephaly
- Q75.8 Other specified congenital malformations of skull and face bones
- Q87.0 Congenital malformation syndromes predominantly affecting facial appearance

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
62140	14.55	11.4	4.91	30.86
62141	16.07	12.61	5.83	34.51
Facility RVU	Work	PE	MP	Total
62140	14.55	11.4	4.91	30.86
62141	16.07	12.61	5.83	34.51

	FUD	Status	MUE	Modifiers			IOM Reference	
62140	90	A	1(3)	51	N/A	62*	80	None
62141	90	A	1(3)	51	N/A	62*	80	

* with documentation

Terms To Know

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

defect. Imperfection, flaw, or absence.

fracture. Break in bone or cartilage.

osteoplasty. Plastic surgery of a bone.

prosthesis. Man-made substitute for a missing body part.

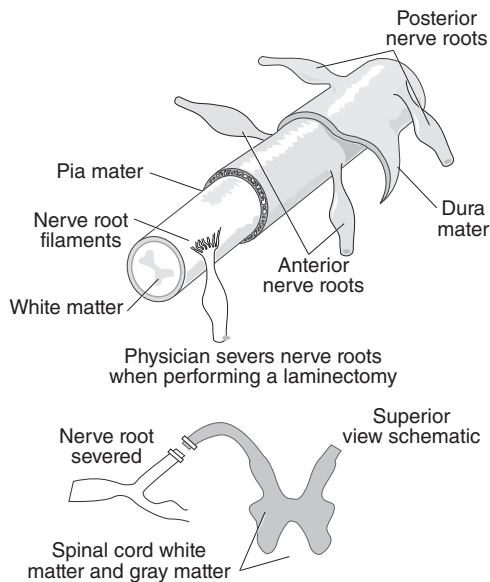
skull. Cranial and facial bones that make up the skeleton of the head. The cranial bones (8) include frontal, parietal (2), temporal (2), occipital, sphenoid, and ethmoid; facial bones (14) include nasal (2), maxillae (2), zygomatic (2), mandible, lacrimal (2), palatine (2), inferior nasal conchae (2), 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.

suture. Numerous stitching techniques employed in wound closure.

zygoma. Zygomatic process of the temporal bone that creates the cheekbone.

63185-63190

63185 Laminectomy with rhizotomy; 1 or 2 segments
63190 more than 2 segments



Explanation

A rhizotomy is performed on the anterior nerve roots to stop involuntary spasmodic movements associated with paraplegia or torticollis. It is also performed on the posterior nerve roots to eliminate pain in a restricted area. The patient is face down. The physician makes a midline incision overlying the affected vertebrae. The fascia are incised. The paravertebral muscles are retracted. Laminectomy is performed. The physician identifies the anterior or posterior nerve roots to be divided. Each is lifted with a nerve hook and severed. Fascia, muscles, and ligaments are allowed to fall back into place. The incision is closed with layered sutures. Report 63185 if the procedure includes one or two segments; report 63190 if the procedure includes two or more segments.

Coding Tips

If this procedure is completed through an operating microscope, report 69990 in addition to the primary procedure. However, head gear (e.g., loupes or binoculars) is considered an integral part of this procedure.

ICD-10-CM Diagnostic Codes

- G11.4 Hereditary spastic paraplegia
- G12.23 Primary lateral sclerosis
- G12.24 Familial motor neuron disease
- G12.25 Progressive spinal muscle atrophy
- G12.29 Other motor neuron disease
- G80.0 Spastic quadriplegic cerebral palsy
- G80.1 Spastic diplegic cerebral palsy
- G80.2 Spastic hemiplegic cerebral palsy
- G80.8 Other cerebral palsy
- G95.89 Other specified diseases of spinal cord
- M43.6 Torticollis
- M54.31 Sciatica, right side
- M54.32 Sciatica, left side
- M54.41 Lumbago with sciatica, right side

M54.42 Lumbago with sciatica, left side

AMA: 63185 2017,Mar 63190 2017,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
63185	16.49	13.3	4.59	34.38
63190	18.89	14.42	3.78	37.09
Facility RVU	Work	PE	MP	Total
63185	16.49	13.3	4.59	34.38
63190	18.89	14.42	3.78	37.09

	FUD	Status	MUE	Modifiers				IOM Reference
63185	90	A	1(2)	51	N/A	62*	80	None
63190	90	A	1(2)	51	N/A	62*	80	

* with documentation

Terms To Know

cervicalgia. Pain localized to the cervical region, generally referring to the posterior or lateral regions of the neck.

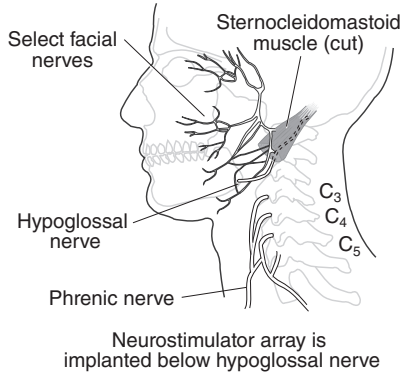
laminectomy. Removal or excision of the posterior arch of a vertebra to provide additional space for the nerves and widen the spinal canal.

neuritis. Inflammation of a nerve or group of nerves, often manifested by loss of function and reflexes, pain, and numbness or tingling.

rhizotomy. Procedure to interrupt the roots of cranial or spinal nerves. Posterior rhizotomy separates the sensory spinal nerve roots to relieve intractable pain. Anterior rhizotomy separates the motor spinal nerve roots to stop involuntary spasmodic movements associated with conditions like cerebral palsy, torticollis, or paraplegia. Trigeminal rhizotomy destroys part of the fifth cranial nerve sensory root or ganglion to relieve trigeminal neuralgia.

64582-64584

- 64582** Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array
- 64583** Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to existing pulse generator
- 64584** Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array



Explanation

The physician implants a hypoglossal (12th cranial) nerve stimulation system to treat moderate to severe obstructive sleep apnea (OSA). One proprietary system, consisting of an implantable pulse generator (IPG), stimulation lead, sensing lead, and external components including the physician and patient programmer, detects the breathing pattern of the patient and produces mild nerve stimulation to maintain an open airway. Following appropriate anesthesia and positioning, the physician exposes the hypoglossal nerve by making a 4 cm to 6 cm incision along a natural skin crease below the edge of the mandible and retracts the submandibular gland. The hypoglossal nerve is identified and stimulated at a low setting to assure nerve function. A length of the nerve is exposed, and the physician places the stimulation lead cuff by wrapping the flaps around the hypoglossal nerve. Intraoperative test stimulation is used to confirm proper placement and the lead is repositioned as necessary. The physician anchors the stimulation lead to the tissues surrounding the hypoglossal nerve using permanent sutures. Attention is then turned to the IPG pocket. A 5 cm to 6 cm incision is made, typically below the right clavicle, and a subcutaneous pocket is created. The physician uses a tunneling tool to pass the stimulation lead to the subcutaneous pocket. To place the extrapleural respiratory sensing lead, the physician makes a 4 cm to 6 cm incision, places the sensor between the ribs, and secures it with permanent sutures. The connector end of the respiratory sensing lead is tunneled between the intercostal muscle layers to the IPG pocket using the tunneling tool and the lead is connected to the IPG and tested. The physician also connects the stimulation lead to the IPG, and then implants the pulse generator into the subcutaneous pocket. The system is tested again using the physician programmer. The implantation procedure is completed by securing the IPG with permanent sutures to the fascia and closing the surgical incisions. Report 64582 for implantation of the neurostimulator array, pulse generator, and respiratory sensor electrode/array. Report 64583 for revision or replacement of the neurostimulator array and respiratory sensor electrode/array with connection to the existing pulse generator. Report 64584 for removal of the entire system.

Coding Tips

These codes should not be reported together for the same encounter. When either the hypoglossal nerve stimulator electrode OR the distal respiratory sensor is revised or replaced, modifier 52 (reduced service) should be appended to 64583. When only one or two of the three components (hypoglossal nerve stimulator electrode array, pulse generator, or distal respiratory sensor) are removed, modifier 52 (reduced service) should be appended to 64584. Do not report 64584 with 61888. For pulse generator replacement, see 61886.

ICD-10-CM Diagnostic Codes

- G47.33 Obstructive sleep apnea (adult) (pediatric)
- T85.111A Breakdown (mechanical) of implanted electronic neurostimulator of peripheral nerve electrode (lead), initial encounter
- T85.121A Displacement of implanted electronic neurostimulator of peripheral nerve electrode (lead), initial encounter
- T85.191A Other mechanical complication of implanted electronic neurostimulator of peripheral nerve electrode (lead), initial encounter
- T85.732A Infection and inflammatory reaction due to implanted electronic neurostimulator of peripheral nerve, electrode (lead), initial encounter
- T85.840A Pain due to nervous system prosthetic devices, implants and grafts, initial encounter
- Z45.42 Encounter for adjustment and management of neurostimulator
- Z96.82 Presence of neurostimulator

AMA: 64582 2022,Mar 64583 2022,Mar 64584 2022,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
64582	14.0	9.06	2.69	25.75
64583	14.5	9.26	2.07	25.83
64584	12.0	8.09	1.69	21.78
Facility RVU	Work	PE	MP	Total
64582	14.0	9.06	2.69	25.75
64583	14.5	9.26	2.07	25.83
64584	12.0	8.09	1.69	21.78

	FUD	Status	MUE	Modifiers				IOM Reference
64582	90	A	1(2)	51	50	N/A	80*	None
64583	90	A	1(2)	51	50	62*	80*	
64584	90	A	1(2)	51	50	62*	80*	

* with documentation

Terms To Know

sleep apnea. Intermittent cessation of breathing during sleep that may cause hypoxemia and pulmonary arterial hypertension.

95874

+ **95874** Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)

Explanation

Needle electromyography (EMG) guidance is a component of chemodenervation procedures performed to treat spasticity and myoclonus and dystonia disorders by injection of denervation agents that block the transmission of nerve impulses to muscle tissue. The EMG guidance provides maximum efficiency in delivery of the agents to the affected neuromuscular sites.

Coding Tips

Report 95874 in addition to 64612, 64615–64616, and 64642–64647. Do not report 95874 with 64451, 64617, 64625, 95860–95870, or 95873. For needle electromyography, see 95860–95887. Report only one guidance code per chemodenervation code.

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.

AMA: 95874 2022, Aug; 2021, Mar; 2020, Dec; 2019, Dec; 2019, Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
95874	0.37	1.93	0.01	2.31
Facility RVU	Work	PE	MP	Total
95874	0.37	1.93	0.01	2.31

	FUD	Status	MUE	Modifiers				IOM Reference
95874	N/A	A	1(2)	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

chemodenervation. Chemical destruction of nerves. A substance, for example, Botox, is used to temporarily inhibit the transfer of chemicals at the presynaptic membrane, blocking the neuromuscular junctions.

electromyography. Test that measures muscle response to nerve stimulation determining if muscle weakness is present and if it is related to the muscles themselves or a problem with the nerves that supply the muscles.

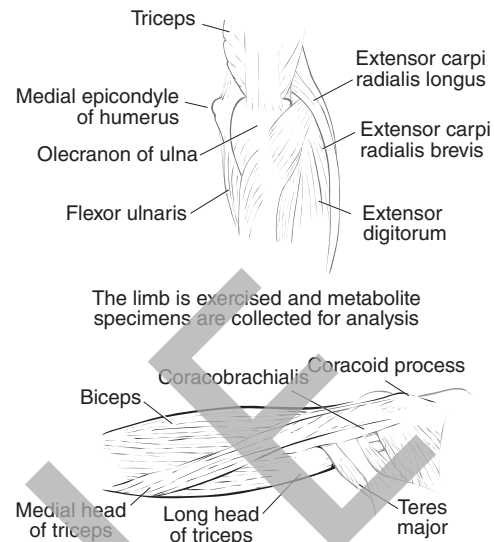
neuromuscular junction. Nerve synapse at the meeting point between the terminal end of a nerve (motor neuron) and a muscle fiber.

spasticity. Muscular rigidity, spasms, or passive stretch resistance, synonymous with being spastic.

synapse. Space between two nerve endings where information from one neuron flows to the other.

95875

95875 Ischemic limb exercise test with serial specimen(s) acquisition for muscle(s) metabolite(s)



Explanation

This test is useful in the differential diagnosis of metabolic causes of muscle weakness, fatigue, and cramps (e.g., disorders of glycolysis and myoadenylate deaminase) and in the diagnosis of patients complaining of muscle cramps and exercise intolerance. After inflation of a sphygmomanometer (blood pressure) cuff, an intravenous cannula is inserted and a baseline blood sample is drawn from the occluded limb. The patient is exercised and the cuff may be inflated every few seconds for two minutes or the cuff is inflated until a predetermined reading is reached and the limb is then exercised for a specific timeframe. The cuff is deflated and further blood samples are obtained at specific time intervals. These samples are sent to the lab for serum lactate analysis.

Coding Tips

Procedure 95875 has both a technical and professional component. 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 a complete EMG study of the extremities, see 95860–95864.

ICD-10-CM Diagnostic Codes

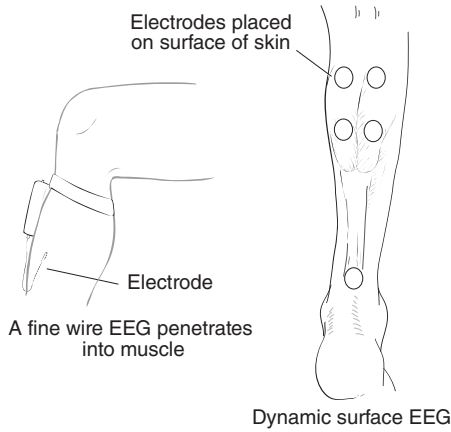
- E74.810 Glucose transporter protein type 1 deficiency
- E74.818 Other disorders of glucose transport
- E74.89 Other specified disorders of carbohydrate metabolism
- E79.2 Myoadenylate deaminase deficiency
- G12.8 Other spinal muscular atrophies and related syndromes
- G24.01 Drug induced subacute dyskinesia
- G24.02 Drug induced acute dystonia
- G24.09 Other drug induced dystonia
- G24.1 Genetic torsion dystonia
- G24.2 Idiopathic nonfamilial dystonia
- G24.3 Spasmodic torticollis
- G24.8 Other dystonia
- G70.00 Myasthenia gravis without (acute) exacerbation

96002-96003

96002 Dynamic surface electromyography, during walking or other functional activities, 1-12 muscles

96003 Dynamic fine wire electromyography, during walking or other functional activities, 1 muscle

The studies are conducted while the patient walks or performs other active functions



Explanation

Electrodes placed on the muscle belly, parallel to the grain of the muscle fiber, detects an electrical signal that comes from active muscles (the patient is in motion during the test). The strength and pattern of the signal is seen on a computer screen and the data is collected in a software program that is able to run various analyses of the data to create useful reports regarding muscle function. For example, gait analysis allows the clinician to analyze time normal activation patterns separately for stance and swing phases between conditions or against data base values. Report 96002 for a study of one to 12 muscles. Use 96003 to report dynamic fine wire electromyography for one muscle.

Coding Tips

Report 96004 in addition to these codes for physician review and interpretation of results, which includes the physician's written report. For performance of needle electromyography procedures, see 95860-95875. Do not report 95860-95866 or 95869-95872 with 96002 or 96003. For gait training, see 97116.

ICD-10-CM Diagnostic Codes

- G11.0 Congenital nonprogressive ataxia
- G11.10 Early-onset cerebellar ataxia, unspecified
- G11.11 Friedreich ataxia
- G11.19 Other early-onset cerebellar ataxia
- G11.2 Late-onset cerebellar ataxia **A**
- G11.3 Cerebellar ataxia with defective DNA repair
- G11.4 Hereditary spastic paraplegia
- G11.8 Other hereditary ataxias
- G80.0 Spastic quadriplegic cerebral palsy
- G80.1 Spastic diplegic cerebral palsy
- G80.2 Spastic hemiplegic cerebral palsy
- G80.4 Ataxic cerebral palsy
- G80.8 Other cerebral palsy
- G80.9 Cerebral palsy, unspecified
- G81.11 Spastic hemiplegia affecting right dominant side **✓**

- G81.12 Spastic hemiplegia affecting left dominant side **✓**
- G81.13 Spastic hemiplegia affecting right nondominant side **✓**
- G81.14 Spastic hemiplegia affecting left nondominant side **✓**
- G81.91 Hemiplegia, unspecified affecting right dominant side **✓**
- G81.92 Hemiplegia, unspecified affecting left dominant side **✓**
- G81.93 Hemiplegia, unspecified affecting right nondominant side **✓**
- G81.94 Hemiplegia, unspecified affecting left nondominant side **✓**
- G82.21 Paraplegia, complete
- G82.22 Paraplegia, incomplete
- G83.11 Monoplegia of lower limb affecting right dominant side **✓**
- G83.12 Monoplegia of lower limb affecting left dominant side **✓**
- G83.13 Monoplegia of lower limb affecting right nondominant side **✓**
- G83.14 Monoplegia of lower limb affecting left nondominant side **✓**
- G83.21 Monoplegia of upper limb affecting right dominant side **✓**
- G83.22 Monoplegia of upper limb affecting left dominant side **✓**
- G83.23 Monoplegia of upper limb affecting right nondominant side **✓**
- G83.24 Monoplegia of upper limb affecting left nondominant side **✓**
- G83.4 Cauda equina syndrome
- R26.0 Ataxic gait
- R26.1 Paralytic gait
- R26.2 Difficulty in walking, not elsewhere classified
- R26.81 Unsteadiness on feet
- R26.89 Other abnormalities of gait and mobility
- R27.8 Other lack of coordination
- R27.9 Unspecified lack of coordination

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96002	0.41	0.19	0.04	0.64
96003	0.37	0.11	0.01	0.49
Facility RVU	Work	PE	MP	Total
96002	0.41	0.19	0.04	0.64
96003	0.37	0.11	0.01	0.49

	FUD	Status	MUE	Modifiers				IOM Reference
96002	N/A	A	1(3)	N/A	N/A	N/A	80*	100-02,15,230.4
96003	N/A	A	1(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

ataxia. Defect in muscular control or coordination due to a central nervous system disorder, particularly when voluntary muscular movements are attempted.

gait. Manner in which a person walks.

gait analysis. Correlation of clinical findings and biomedical measures to determine the cause of a patient's postural and movement impairments when walking.