CODING EDUCATION CORNER (2016/March)

Neurosurgery/Spinal Orthopedics

Hello everyone, we are very excited spring is finally here! What better time to try something new? As part of keeping up with the coding expansion and education, we're excited to launch our new coding newsletter. We have redesigned this newsletter to cover short notes on topics from coding, denials, trends, and enhanced documentation for Neurosurgery and Spinal Orthopedics. This month's issue will focus on exploration and standalone instrumentation codes (22830, 22850, 22852, and 22855) when billing definitive procedures like; new arthrodesis, fusion and spinal instrumentation. We will also take a look at Ventriculopertioneal shunts and documentation.

Exploration & Standalone instrumentation codes:

When reviewing and confirming surgery codes vs posted OR codes we have noticed a trends in exploration and standalone instrumentation codes being listed with other definitive procedures. These codes are available for standalone use, they're not intended to be reported when definitive procedures such like; arthrodesis, decompression, fusion and instrumentation are performed at the same intervening session.

- **22830-Exploration of spinal fusion.**
    - When exploration is reported in conjunction of a definitive procedure such as arthrodesis, decompression, fusion, or instrumentation we would only bill the definitive procedure.
- **22850-Removal of posterior non-segmental instrumentation (eg, Harrington rod).**
- **22852-Removal of posterior segmental instrumentation.**
- **22855-Removal of anterior instrumentation.**
    - Removal codes are not billable when new instrumentation is being inserted or revised during the same session at levels including all or part of the previously instrumented segments. (According to CPT guidelines : Do not report reinsertion (22849) or **removal (22850,22852,22855)** procedures in addition to the insertion of new instrumentation **(22840-22848)**

Coding Example: **Removal of old hardware at L4-5, with new posterior arthrodesis and fusion with autograft and decompression was performed at L3-4 and instrumentation from L3-5** (22612, 63005, 22842, and 20936)

Note: There is no code for removal of an intervertebral device- this would be part of an exploration of fusion if that is the purpose of the surgery. Not billable when new arthrodesis and or fusion/instrumentation are performed in the same session.

Ventriculopertioneal shunts:

- **62223- Insertion of new shunt**
- **62230-Replacement or Revision or** ***cerebrospinal fluid shunt, obstructed valve, or distal catheter in shunt system***
- **62225-Replacement or Irrigation,** ***ventricular catheter.***
    - (Intracranial neuroendoscopic ventricular catheter placement, use 62160)

When performing a revision of a shunt it must be the ***obstructive valve or distal catheter*** in order to report code **62230**. When ***changing out the ventricular catheter*** the correct CPT code to report is **62225**.

- **62200- Ventriculocisternostomy, third ventricle;**
- **62201-** Ventriculocisternostomy, third ventricle; ***stereotactic, neuroendoscopic method.***

ICD-10 Note: When *Shunt is infected or malfunctioning* please report condition for appropriate coding, these codes are listed in the T section of ICD-10. (Example: shunt malfunction T85.01XA vs communicating hydrocephalus G91.0 or obstructive G91.1, or MPH G91.2)

References:

ICD-10-CM 2016

AAOS/ KZA: Managing Coding and Reimbursement Challenges for Orthopedics'

AANS/KZA: Managing Coding and Reimbursement Challenges for Neurosurgery