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Coding Companion

Neurosurgery/ Neurology

A comprehensive illustrated guide to coding and reimbursement

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2017

ICD-10

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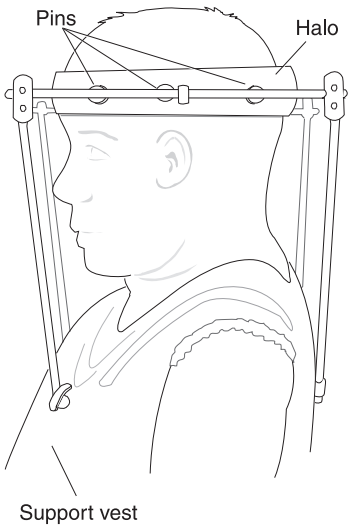
20664

20664 Application of halo, including removal, cranial, 6 or more pins placed, for thin skull osteology (eg, pediatric patients, hydrocephalus, osteogenesis imperfecta)



The halo is mounted to provide support and traction for a condition known as thin skull osteology

Explanation

The physician places a cranial halo on the skull of a child whose skull is unusually thin because of a congenital or developmental problem. The physician sterilizes the skin and scalp with a povidone-iodine solution. The halo is positioned on the patient's head with six or more pins, which are advanced until firm, but not to the tension allowed by a normal skull. Diagonally opposed pins are tightened simultaneously. All are secured with nuts. This code includes the removal of the halo.

Coding Tips

Report 20664 for patients with thin skull osteology where additional pins (six or more) are required for halo application. This procedure includes removal of the device. For application of a cranial halo with fewer than six pins, see 20661.

ICD-10-CM Diagnostic Codes

Q03.0	Malformations of aqueduct of Sylvius
Q03.1	Atresia of foramina of Magendie and Luschka
Q03.8	Other congenital hydrocephalus
Q03.9	Congenital hydrocephalus, unspecified
Q05.0	Cervical spina bifida with hydrocephalus
Q05.1	Thoracic spina bifida with hydrocephalus
Q05.2	Lumbar spina bifida with hydrocephalus
Q05.3	Sacral spina bifida with hydrocephalus
Q05.4	Unspecified spina bifida with hydrocephalus
Q05.9	Spina bifida, unspecified
Q07.01	Arnold-Chiari syndrome with spina bifida
Q07.02	Arnold-Chiari syndrome with hydrocephalus
Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus
Q75.0	Craniosynostosis
Q75.1	Craniofacial dysostosis
Q75.2	Hypertelorism
Q75.3	Macrocephaly
Q75.4	Mandibulofacial dysostosis
Q75.5	Oculomandibular dysostosis
Q75.8	Other specified congenital malformations of skull and face bones
Q75.9	Congenital malformation of skull and face bones, unspecified
Q78.0	Osteogenesis imperfecta
Q87.0	Congenital malformation syndromes predominantly affecting facial appearance
T84.226A	Displacement of internal fixation device of vertebrae, initial encounter
T84.89XA	Other specified complication of internal orthopedic prosthetic devices, implants and grafts, initial encounter
T84.9XXA	Unspecified complication of internal orthopedic prosthetic device, implant and graft, initial encounter

HCPCS Equivalent Codes

N/A

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
20664	25.56	25.56	90	A	1(2)

	Modifiers				Medicare Reference
20664	51	N/A	N/A	N/A	None

* with documentation

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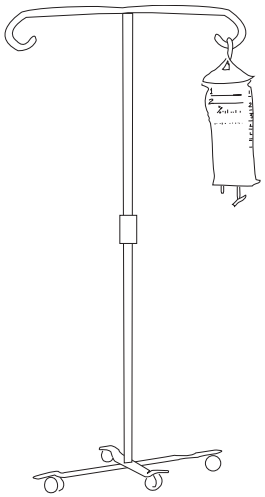
37195

37195 Thrombolysis, cerebral, by intravenous infusion



Code 37195 reports the infusion of a thrombolytic agent into a vein to break up a cerebral clot. The infusion is systemic with an intravenous line started or tapped to deliver the agent

Explanation

The physician remedies a stroke-causing blood clot obstructing blood flow to the brain. The physician infuses a thrombolytic ("clot-busting") drug through an intravenous catheter to help dissolve the clot and restore normal blood flow to the brain.

Coding Tips

Codes for catheter placement and the radiological supervision and interpretation should also be reported in addition to the code for the therapeutic aspect of the procedure.

ICD-10-CM Diagnostic Codes

G45.8 Other transient cerebral ischemic attacks and related syndromes
G45.9 Transient cerebral ischemic attack, unspecified
G46.0 Middle cerebral artery syndrome
G46.1 Anterior cerebral artery syndrome
G46.2 Posterior cerebral artery syndrome
I63.30 Cerebral infarction due to thrombosis of unspecified cerebral artery
I63.311 Cerebral infarction due to thrombosis of right middle cerebral artery
I63.312 Cerebral infarction due to thrombosis of left middle cerebral artery
I63.319 Cerebral infarction due to thrombosis of unspecified middle cerebral artery
I63.321 Cerebral infarction due to thrombosis of right anterior cerebral artery
I63.322 Cerebral infarction due to thrombosis of left anterior cerebral artery
I63.329 Cerebral infarction due to thrombosis of unspecified anterior cerebral artery
I63.331 Cerebral infarction due to thrombosis of right posterior cerebral artery
I63.332 Cerebral infarction due to thrombosis of left posterior cerebral artery
I63.339 Cerebral infarction due to thrombosis of unspecified posterior cerebral artery
I63.39 Cerebral infarction due to thrombosis of other cerebral artery
I63.40 Cerebral infarction due to embolism of unspecified cerebral artery
I63.411 Cerebral infarction due to embolism of right middle cerebral artery
I63.412 Cerebral infarction due to embolism of left middle cerebral artery
I63.419 Cerebral infarction due to embolism of unspecified middle cerebral artery
I63.421 Cerebral infarction due to embolism of right anterior cerebral artery
I63.422 Cerebral infarction due to embolism of left anterior cerebral artery
I63.429 Cerebral infarction due to embolism of unspecified anterior cerebral artery
I63.431 Cerebral infarction due to embolism of right posterior cerebral artery
I63.432 Cerebral infarction due to embolism of left posterior cerebral artery
I63.439 Cerebral infarction due to embolism of unspecified posterior cerebral artery
I63.50 Cerebral infarction due to unspecified occlusion or stenosis of unspecified cerebral artery
I63.511 Cerebral infarction due to unspecified occlusion or stenosis of right middle cerebral artery
I63.512 Cerebral infarction due to unspecified occlusion or stenosis of left middle cerebral artery
I63.519 Cerebral infarction due to unspecified occlusion or stenosis of unspecified middle cerebral artery
I63.521 Cerebral infarction due to unspecified occlusion or stenosis of right anterior cerebral artery
I63.522 Cerebral infarction due to unspecified occlusion or stenosis of left anterior cerebral artery
I63.529 Cerebral infarction due to unspecified occlusion or stenosis of unspecified anterior cerebral artery
I63.531 Cerebral infarction due to unspecified occlusion or stenosis of right posterior cerebral artery
I63.532 Cerebral infarction due to unspecified occlusion or stenosis of left posterior cerebral artery
I63.539 Cerebral infarction due to unspecified occlusion or stenosis of unspecified posterior cerebral artery
I63.59 Cerebral infarction due to unspecified occlusion or stenosis of other cerebral artery
I63.6 Cerebral infarction due to cerebral venous thrombosis, nonpyogenic
I66.01 Occlusion and stenosis of right middle cerebral artery
I66.02 Occlusion and stenosis of left middle cerebral artery
I66.03 Occlusion and stenosis of bilateral middle cerebral arteries
I66.09 Occlusion and stenosis of unspecified middle cerebral artery
I66.11 Occlusion and stenosis of right anterior cerebral artery
I66.12 Occlusion and stenosis of left anterior cerebral artery

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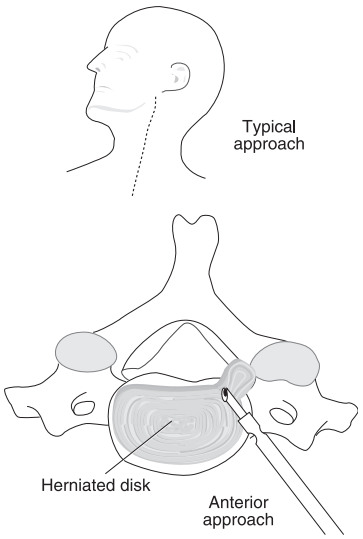
63075-63076

63075 Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace

63076 cervical, each additional interspace (List separately in addition to code for primary procedure)



Physician removes herniated cervical disc

Report 63075 if cervical, single interspace; report 63076 for each additional cervical interspace

Explanation

The physician performs a cervical discectomy to remove all or part of a herniated intervertebral disc. The patient is placed supine with a head halter on the jawbone (mandible). The physician makes a transverse incision overlying the intervertebral disc. The sternocleidomastoid muscle and the carotid artery are retracted. The physician excises the anterior anulus of the disc and uses pituitary forceps to remove as much disc material as possible. A spreader and microscope are used to enhance the evacuation. A drill is used to remove the transverse bar above and below. Graft material is obtained from the ilium and fashioned into a T-shape. The graft is placed into the disc space and traction is released. The muscles fall back into place and the incision is closed with layered sutures. Report 63075 if the discectomy is in a single interspace. Report 63076 for each additional cervical interspace.

Coding Tips

As an "add-on" code, 63076 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as a stand-alone code. Use 63076 in conjunction with 63075. Any bone graft is reported separately, see 20930–20938. For anterior thoracic discectomy, see 63077–63078. Do not report 22554 in conjunction with 63075 or 63076 for single or multiple surgeons. When anterior cervical discectomy and interbody fusion are performed at the same operative session and the same level, only 22551 or 22552 should be reported. If the services of two primary surgeons performing separate and distinct components of the procedure are required, a co-surgery scenario exists. Both surgeons should report the primary procedure with modifier 62 and submit the claim with operative notes attached. The use of the operating microscope is not reported separately for 63075–63076.

ICD-10-CM Diagnostic Codes

M43.02	Spondylolysis, cervical region
M43.03	Spondylolysis, cervicothoracic region
M43.12	Spondylolisthesis, cervical region
M43.13	Spondylolisthesis, cervicothoracic region
M45.2	Ankylosing spondylitis of cervical region
M45.3	Ankylosing spondylitis of cervicothoracic region
M46.23	Osteomyelitis of vertebra, cervicothoracic region
M47.12	Other spondylosis with myelopathy, cervical region
M47.13	Other spondylosis with myelopathy, cervicothoracic region
M47.22	Other spondylosis with radiculopathy, cervical region
M47.23	Other spondylosis with radiculopathy, cervicothoracic region
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.892	Other spondylosis, cervical region
M47.893	Other spondylosis, cervicothoracic region
M48.02	Spinal stenosis, cervical region
M48.03	Spinal stenosis, cervicothoracic region
M48.8X2	Other specified spondylopathies, cervical region
M48.8X3	Other specified spondylopathies, cervicothoracic region
M50.01	Cervical disc disorder with myelopathy, high cervical region
M50.02	Cervical disc disorder with myelopathy, mid-cervical region
M50.03	Cervical disc disorder with myelopathy, cervicothoracic region
M50.11	Cervical disc disorder with radiculopathy, high cervical region
M50.12	Cervical disc disorder with radiculopathy, mid-cervical region
M50.13	Cervical disc disorder with radiculopathy, cervicothoracic region
M50.21	Other cervical disc displacement, high cervical region
M50.22	Other cervical disc displacement, mid-cervical region
M50.23	Other cervical disc displacement, cervicothoracic region
M50.31	Other cervical disc degeneration, high cervical region
M50.32	Other cervical disc degeneration, mid-cervical region
M50.33	Other cervical disc degeneration, cervicothoracic region
M50.81	Other cervical disc disorders, high cervical region
M50.82	Other cervical disc disorders, mid-cervical region
M50.83	Other cervical disc disorders, cervicothoracic region
M54.12	Radiculopathy, cervical region
M54.13	Radiculopathy, cervicothoracic region

HCPCS Equivalent Codes

N/A

Terms To Know

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

cervicobrachial syndrome. Neuropathy of the brachial plexus causing pain leading from the neck and radiating down the arm.

decompression. Release of pressure.

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

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spondylosis. Noninflammatory degenerative changes of the spine with excessive bone growth of the vertebra (osteophytes). Can be associated with stress microfractures of the pars articularis, known as Gill fragment, pars defect, or pars stress fracture.

Medicare Edits

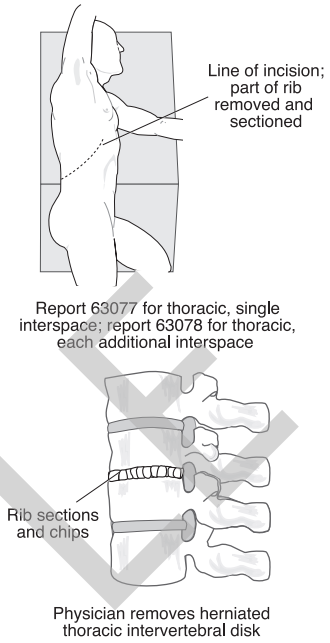
	Fac RVU	Non-Fac RVU	FUD	Status	MUE
63075	39.53	39.53	90	A	1(2)
63076	7.08	7.08	N/A	A	3(3)

	Modifiers				Medicare Reference
63075	51	N/A	62	80	None
63076	N/A	N/A	62	80	
* with documentation					

63077-63078

63077 Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; thoracic, single interspace

63078 thoracic, each additional interspace (List separately in addition to code for primary procedure)



Explanation

The physician makes an incision along the rib corresponding to the second thoracic vertebra above the involved intervertebral disc, except in cases involving the top five discs. The rib is removed for access and eventually used in the graft, which is obtained through an extrapleural or transpleural approach. Vessels are tied away from the spine. The disc is removed to the posterior ligament using a microscope and nibbling instruments. The end plates are stripped of their cartilage. The physician makes a slot in one vertebral body and a hole in the other to accept the graft, which is made of several sections of rib. The physician ties the grafts together with heavy suture material and closes the tissue with layered sutures. A chest drain may be inserted. Report 63077 for a single thoracic interspace. Report 63078 for each additional thoracic interspace.

Coding Tips

As an "add-on" code, 63078 is not subject to multiple procedure rules. No reimbursement reduction or modifier 51 is applied. Add-on codes describe additional intraservice work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as a stand-alone code. Use 63078 in conjunction with 63077. Arthrodesis is reported separately, see 22554–22585. Any bone graft is also reported separately, see 20930–20938. The use of the operating microscope is not reported separately for 63077–63078. For anterior cervical discectomy, see 63075–63076. When an anterior approach to the spine is achieved using the skills of two surgeons of different specialties (e.g., a thoracic or general surgeon provides exposure and the neurosurgeon provides the definitive procedure), this is a co-surgery scenario. Both surgeons report the primary procedure with modifier 62 and submit the claim with operative notes attached.

ICD-10-CM Diagnostic Codes

M43.03 Spondylolysis, cervicothoracic region

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