Orthopedic Coding Alert

Modifiers: Modifier 50 Is the Backbone to Your Bilateral Spinal Surgery Reimbursement

Ask your carriers how they want these surgeries reported to avoid reduced reimbursement.

Spine surgeons who perform bilateral surgeries such as lumbar laminotomies (63030) should append modifier 50 (Bilateral procedure) to the procedure code and double their charges rather than report multiple units.

Coders who follow this rule will be well prepared to report complex procedures, such as bilateral laminotomies, on several levels. Because 63030 (Laminotomy [hemilaminectomy], with decompression of nerve root[s], including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; 1 interspace, lumbar) refers to "one interspace," CPT® directs orthopedists to bill each additional interspace using +63035 (... each additional interspace, cervical or lumbar [List separately in addition to code for primary procedure]).

Break Down This Bilateral Laminotomy Example

Example: Your surgeon performs bilateral laminotomies on two levels, so you bill 63030 on one line and 63030-50 on the next, followed by two units of +63035. Result: You may receive less reimbursement than expected, though, because your payer saw that both line items of +63035 referred to the same spinal level, so they disallowed the second unit.

What you should do: Lumbar laminotomies performed bilaterally on four levels should be billed as follows:

- 63030-50 (for the first level double your fee)
- 63035-50 x 3 (for the additional three levels). Place the "3" in the claim form's "units" field, and double your fee, since each unit is bilateral. This is the correct billing method for CMS and many Blue Cross carriers, but you should always check with your workers' compensation and commercial carriers to confirm how they prefer bilateral procedures reported.

On your claim form, indicate the levels that the surgeon addressed, or send along the operative report. Unless the surgeon actually uses the word 'bilateral' in his notes, always double-check to determine whether he addressed each level bilaterally.

Unilateral: If the surgeon performs four unilateral levels of laminotomy, you would report one unit of 63030, indicating the side addressed (e.g., -LT for left side or -RT for right side), followed by 63035 (with the -LT or -RT modifier appended) on one line with a "3" indicated in the units field.

Know Your Anatomy

Suppose the surgeon's notes indicate anterior fusion of L1 to L3. Many coders are tempted to bill one unit of 22558 (Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace [other than for decompression]; lumbar) and two units of +22585 (... each additional interspace [List separately in addition to code for primary procedure]), thus totaling three spinal levels.

Instead, you should report one unit of 22558 with just one unit of 22585 because L1-L2 is one interspace and L2-L3 is another. Knowing your anatomy is very important.

Although L1, L2 and L3 constitute three vertebral bodies, the surgery only addresses two interspaces. The interbody fusions are reported per interspace (a vertebral interspace is the non-bony compartment between two adjacent vertebral bodies).

You should code other types of spinal surgeries, such as osteotomies (22210-22226), according to vertebral segments

not interspaces. Therefore, osteotomies to L1, L2 and L3 would warrant billing one unit of 22214 (Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar) and two units of +22216 (... each additional vertebral segment [List separately in addition to primary procedure]).

Catch this: The descriptor usually refers to either a vertebral segment or an interspace, so as long as you pay attention to the code definitions, you should be able to determine how many units of the code to bill.

No Modifiers With Instrumentation Codes

Spinal instrumentation (22840-22848 and 22851) refers to rods, screws, hooks, cages and synthetic bone materials that provide stability and often hold the spinal column together. Report spinal instrumentation insertion in addition to the primary arthrodesis procedure, but do not append modifier 59 (Distinct procedural service) or 51 (Multiple procedures).

These modifiers would cause a payment reduction or complete denial and are not necessary with the instrumentation codes. These codes should be paid at 100 percent, so report them on separate line items after the corresponding arthrodesis codes.

Ask Each Carrier for Billing Requirements

You may encounter controversy surrounding spine surgery coding because many carriers require you to submit claims differently, experts agree.

Best advice: When you're starting out with a carrier, ask them how they prefer you to code the various spine surgeries, because some request bilateral modifiers; some want separate line items; some want site modifiers; and so on.