



Neurosurgery Coding Alert

The practical adviser for ethically optimizing coding, reimbursement, and efficiency for neurosurgery practices



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Coding Case Study

Unlock Payment For Burr Hole Drainage Of Subdural Hemorrhage

Tip: Appropriate modifiers are the best rescue for your claims.

You can confidently report your surgeon's burr hole drainage of subdural or extradural hematomas if you understand when you can append modifiers to codes for these services. Reviewing how to code multiple burr holes and identifying the appropriate sites will also strengthen your reporting of burr hole drainage procedures.

Examine This Case

Read the operative note below for an example how your surgeon may document the burr hole drainage of a subdural hematoma:

“The patient’s head was partially shaved and was firmly held in the neutral position using Mayfield head pins. The area was then prepped and draped using an antibiotic solution. A transverse linear incision of around 3 cm in length was made over the frontal and parietal convexities to reflect the scalp over the area of the hematoma. An air powered drill was then used to make a hole around 2 cm in diameter in the skull in the frontal region and another one in the parietal region. The dura was opened with a cruciate incision and the clot was visible. Bipolar cautery was used during the dual opening and to shrink the dural leaflets. The clot was decompressed slowly with close monitoring of the blood pressure and fluid infusions. A Silastic catheter of 2.5 mm outer diameter and 2 mm inner diameter was introduced into the subdural space. Irrigation was done with Hartmann’s solution until clear fluid returned. The catheter was then brought out through a stab scalp incision made approximately 2.5 cm posterior to the frontal scalp incision. The scalp incisions were then closed in two layers.”

61154 Implies Multiple Burr Holes

In the operative note above, you read that the surgeon made two burr holes, one in the frontal and another in the parietal region. You report these services with code 61154 (*Burr hole[s] with evacuation and/or drainage of hematoma, extradural or subdural*).

Caveat: You will not report two units of 61154 for this procedure. “Drainage of a single subacute or chronic subdural hematoma is typically accomplished through paired burr holes. However, one should only report 61154 once, even if several holes are used to evacuate the hematoma,” says **Gregory Przybylski, MD**, director of neurosurgery, New Jersey Neuroscience Institute, JFK Medical Center, Edison. The code descriptor for 61154 clearly mentions that you may report the code for one or more burr holes that your surgeon makes to drain a hematoma.

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On the other hand, your surgeon may be draining multiple small hematomas through multiple burr holes. “The only time when you may consider multiple units of 61154 would be if there are several injuries/bleeds in different parts of the brain, which would require a possible repositioning of the patient or separate incisions. If you are dealing with a single bleed, even if it crosses over to different parts of the brain, it would still be used only once, even with multiple burr holes performed,” says **Rena Hall, CPC**, Kansas City Neurosurgery, North Kansas City, Missouri.

Also, the same code applies for drainage of both subdural and extradural hematomas. These hematomas differ in their location in relation to the dura. The subdural hematoma lies below and the extradural hematoma lies above the dura. “However, since most symptomatic extradural hematomas are treated acutely with craniotomy or craniectomy, the technique of burr hole drainage is most commonly applied to subacute or chronic subdural hematomas,” says Przybylski.

Report Any Repeat Procedures

A spontaneous recurrence of a subdural hematoma may further challenge your coding. You should remember that the global period for 61154 starts the day prior to surgery and extends for 90 days postoperatively. If you read that your surgeon had to repeat the drainage of the subdural hematoma in the global period, say six weeks after the initial drainage, you will need to know if you can report another unit of 61154. You may append modifier 78 (*Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period...*) to 61154. You will, however, need to confirm in the clinical note if the second hemorrhage was a consequence of the first surgical drainage. “For example, if a recurrent hemorrhage developed as a consequence of removing a subdural catheter, performing a second drainage of the recurrent subdural would be considered related to the original procedure,” says Przybylski.

Sometimes, you may need to report the second hemorrhage as an entirely independent procedure, though it occurred in the global period of the first drainage. You may report code 61154 for the second time in such a case.

Do this: Your surgeon will need to document very clearly that the second drainage wasn’t related to the initial procedure. In this case, you report 61154 and append modifier 76 (*Repeat procedure or service by same physician or other qualified health care professional...*).

Spontaneous recurrence of a subdural hematoma often occurs as a consequence of the disease process itself. “The fragility of vascularized tissues along with incomplete cerebral expansion contribute to the development of spontaneous recurrence. In this circumstance, the recurrent drainage should be reported with the 76 modifier,” says Przybylski.

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Append Modifiers To Boost Payment

When your surgeon makes one or more burr holes on both sides of the head to drain hematoma(s), you append modifier 50 (*Bilateral procedure...*) to 61154. “Chronic and subacute subdural hematomas can occur bilaterally as delayed manifestation of previous head injury in the older population. This may necessitate bilateral evacuation,” says Przybylski.

Example: You may read that a patient who was diagnosed with epilepsy had a craniotomy 61533 (*Craniotomy with elevation of bone flap; for subdural implantation of an electrode array, for long term seizure monitoring*) to implant an electrode array for monitoring of seizure activity. Several weeks later, the

patient developed symptoms of a subdural hematoma. The patient then underwent a burr hole drainage of the subacute subdural hematoma.

Here, you report 61154 for the drainage of the hematoma. Code 61154 applies to burr hole drainage of subdural and extradural hematoma(s), regardless of the cause of the hematoma. You append modifier 78 to indicate that it was a complication due to the original surgery. “Modifier 78 can be used if the patient must be taken to the OR a second time for an additional bleed in the same area,” says Hall.

Don’t forget: In addition, you would also report diagnosis code 997.02 (*Iatrogenic cerebrovascular infarction or hemorrhage*) to specify that the subdural hematoma occurred as a consequence of another procedure. □

ICD-10 Update

Confirm Chronicity For Nontraumatic Subdural Hemorrhage

Make sure your surgeon documents acute, subacute, chronic.

ICD-9 offers a single code for reporting a nontraumatic subdural hematoma, 432.1 (*Subdural hematoma, nontraumatic*). In 2014, when you implement ICD-10, you will have a choice of more than one code. Follow these fundamentals to improve your reporting of nontraumatic subdural hematoma in ICD-10.

Verify the Age of the Hematoma

ICD-10 necessitates that you determine how old the nontraumatic subdural hemorrhage is. Depending upon whether the hemorrhage is acute, subacute, or chronic, you will choose to report codes I62.01 (*Nontraumatic acute subdural hemorrhage*), I62.02 (*Nontraumatic subacute subdural hemorrhage*), or I62.03 (*Nontraumatic chronic subdural hemorrhage*). “It is nontraumatic subacute and chronic types of subdural hematoma that are typically amenable to treatment by burr hole drainage,” says **Gregory Przybylski, MD**, director of neurosurgery, New Jersey Neuroscience Institute, JFK Medical Center, Edison.

Your surgeon will determine the chronicity of the hemorrhage through history obtained from the patient and then by confirming the density in a CT scan. An acute subdural hemorrhage is one that is less than three days old and appears diffusely hyperdense in the CT scan. A subacute subdural hematoma is 3-21 days old, and a chronic subdural hematoma is more than 21 days old. The chronic hematoma appears diffusely hypodense on a CT whereas a subacute hematoma is usually heterogeneous and isodense.

You will need to ascertain that your surgeon adequately documents the age and the CT density of the subdural hematoma in the clinical note. “Acute hematoma is a new bleed and easy to identify,” says **Rena Hall, CPC**, Kansas City Neurosurgery, North Kansas City, Missouri. “The subacute and chronic hematomas may pose a problem. A subacute hematoma is one that may not require immediate intervention and can be either newly or recently diagnosed. A chronic hematoma may have necessitated numerous treatments and still continues to be an issue for the patient.”

You may also come across an acute bleed in a patient who has a chronic history of a subdural hematoma. Such an acute-on-chronic subdural hematoma appears as areas of hyperdensity within a hypodense hematoma on the CT scan. You report this as acute and file code 162.01 in this case. “This usually occurs after a second head injury in a patient with a previously untreated subdural hematoma or in a patient who did not fully resolve a prior subdural hematoma after surgical evacuation,” says Przybylski.

If your surgeon does not document the adequate details for the chronicity of the nontraumatic subdural hematoma, you report code I62.00 (*Nontraumatic subdural hemorrhage, unspecified*) stating that the precise chronicity of the hemorrhage has not been determined or documented. “It will be important to educate surgeons concerning the need to specify the age of subdural hematomas once the more granular diagnostic codes become available,” says Przybylski. □

CPT® 2013

Use These Codes To Strengthen Your Unlisted Procedure Reporting

Do not forget to confirm with your payer.

Are you reporting a service that is rare, unusual, variable, or new? You may need to report an ‘unlisted procedure’ code. In 2013, you may turn to new and discrete codes for unlisted procedures. The unlisted procedure codes for the procedures on spine and cranium include the following:

- » **22899** — Unlisted procedure, spine
- » **69979** — Unlisted procedure, temporal bone, middle fossa approach
- » **21499** — Unlisted musculoskeletal procedure, head

Before you report any of these, do not forget to confirm with your payer if the service is covered. You may even

try obtaining a precertification stating that your payer accepts the procedure as medically necessary procedure and is not a covered service.

Also, make sure your surgeon documents the procedure. You may request your surgeon to prepare a letter explaining the need and extent of the procedure and comparing it with a standard CPT® code.

Editor’s note: Look for more on 2013 codes in the next issue of *Neurosurgery Coding Alert*. □

Modifier Tips

Unravel the Mysteries of Modifier Use for Postop Procedures

Check global period for initial procedure and reason for second procedure.

You may be leaving payment on the table for your surgeon’s work if you do not append the correct modifiers for postoperative period procedures. Read on for guidance on how different modifiers can impact global period calculations and your reimbursement.

Know the Common Postoperative Modifiers

Below are the two important modifiers you will append for the procedures your surgeon does in the postoperative period of another.

- » 58 — Staged or related procedure or service by the same physician during the postoperative period
- » 78 — Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period

Note: The descriptors of both the modifiers share common terminologies like “related procedure” and “during the postoperative period.” You will need to understand what relation is implied by each of the two modifiers.

Example: You may read that your surgeon repeated a craniotomy for a patient who earlier underwent a craniotomy for tumor resection. You will report this re-

exploration depending upon the timing and the reason of the re-exploration.

In this case, you check if the re-exploration is performed within the global period of the original craniotomy as a consequence of a postoperative complication. You would then report the craniotomy code with modifier 78. However, if your surgeon did the re-exploration as a part of a planned staged resection of the tumor, you report the craniotomy code with modifier 58.

Use Modifier 58 for Staged Procedures

According to CMS guidelines, you should use modifier 58 when a second procedure in the postoperative period of the initial surgery is:

- » planned or "staged"; or
- » more extensive than the original procedure; or
- » for therapy following a diagnostic surgical procedure; or
- » for the reapplication of the cast within the 90-day global period.

Note: The second procedure will share a common underlying cause or condition with the first procedure. The second procedure may not always be planned.

However, the second procedure will be a part of the overall treatment of the underlying problem. Also, modifier 58 does not necessarily need the patient to be taken to the OR for the treatment. “You use modifier 58 when your surgeon either plans a new encounter or another procedure or when the patient requires additional services for the same problem,” says **Rena Hall, CPC**, Kansas City Neurosurgery, North Kansas City, Missouri.

Example: You may read that your surgeon did a craniotomy and a month later returned the patient to the OR to do a cranioplasty with the original craniotomy flap that was placed in a subcutaneous abdominal pocket for later retrieval. You report 62143 (*Replacement of bone flap or prosthetic plate of skull*) as well as the add-on code for bone graft retrieval 62148 (*Incision and retrieval of subcutaneous cranial bone graft for cranioplasty [List separately in addition to code for primary procedure]*).

Since this is performed one month after the craniotomy and falls within that global period, you would report both codes appended with the 58 (*Staged or related procedure or service by the same physician during the postoperative period*) modifier for staged surgery.

Check the global period: When you report the second procedure with modifier 58, you will begin to again count for another global period. “For an example, you may read that a skull base tumor is partially resected and then three months later, stereotactic radiosurgery is performed to treat the remaining tumor. Since it is the same problem in the same anatomical area with the original diagnosis, the second service, which is an extension of the first,

you would utilize modifier 58. This starts a new global period,” says Hall.

Modifier 78 Implies Complications

You append modifier 78 when the second procedure is for a complication that develops consequent to the initial procedure. The return of the patient to the OR in this case is not planned. You should clearly document that the patient was returned to the OR and that the second procedure was to treat the complication. “Modifier 78 is used when there is a complication of the initial surgery,” Hall confirms.

The Medicare payers are specific about the return of the patient to the OR. If the patient does not need to be taken to the OR, the service may fall under the initial procedure’s global package. Example, a surgical dressing of the infected postoperative wound may be done in an office visit in the global period but may not necessitate the patient’s return to OR. This will fall under the global package.

Example: You may read that 40 days following a skull base surgery, your surgeon had to return the patient to the OR for repair of dura to arrest a CSF leak. In this case, you report 61618 (*Secondary repair of dura for cerebrospinal fluid leak (CSF) leak, anterior, middle or posterior cranial fossa following surgery of the skull base; by free tissue graft [e.g., pericranium, fascia, tensor fascia lata, adipose tissue, homologous or synthetic grafts]*) for such a repair of dura. Additionally, you will append modifier 78 to indicate a return to the operating room to treat a complication of the original skull base procedure as this is performed within the 90 day global period.

(Continued on next page)

You Be the Coder

Get Definitive Diagnosis for Post-op Complaints

Question:

We have case where the patient was admitted back to the hospital during the global period. The patient was having physical therapy and went home. The patient complained of persistent pain and was reevaluated for continuing physical therapy (PT). Is the consultation considered part of the post op when the patient was re-admitted to the hospital for an evaluation of continued PT. Urinary tract infection (UTI) was diagnosed during the evaluation.

Ohio Subscriber

Answer: See page 79. □

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- What can we improve on?

We’d love to hear from you.

Please email **Tarveen Jandoo** at tjandoo@codinginstitute.com

Thank you in advance for your input!

Note: Modifier 78 does not mean that a new global begins after the second procedure. The global period of the initial period continues until 90 days or as applicable. “Because the second procedure is directly related to the original procedure rather than an extension of it, only the global period of the initial procedure applies to both,” says **Gregory Przybylski, MD**, director of neurosurgery, New Jersey Neuroscience Institute, JFK Medical Center, Edison. “For an example, you may read that an aneurysm is clipped and three days later, there is a leak requiring an intracranial monitor. In this case, you append modifier 78. This does not start a new global period,” says Hall.

Watch this: Make sure the second procedure is a complication of the initial procedure and the same is documented by your surgeon. You do not use modifier 78 when the patient’s condition that requires a second procedure is not related to the original condition or a complication of the original surgery. In this case, you will rather use modifier 79 (*Unrelated procedure or service by the same physician during the postoperative period...*). “This situation is a bit more complicated with respect to the effect of global periods. There may be services that

occur within the global period of the second procedure that are related to the first procedure and its diagnosis that would be separately reportable,” says Przybylski.

Measure the Payment Difference

Your choice of correct modifier affects your payment. This is because modifier 58 but not 78 means a new beginning for the global period. You earn 100 percent of allowable reimbursement for the second procedure when you append modifier 58.

Your reimbursement for the second procedure with modifier 78 will be less as the fee is assigned to the ‘intraoperative’ work and your surgeon gets no payment for the preoperative and postoperative work for the second surgery. “This payment policy is consistent with the fact that the global period is not extended and that the postoperative services would be a continuation of the services included in the original procedure,” says Przybylski.

Remember, you should always confirm the global period for the initial procedure before you report any subsequent procedures with modifiers 58 and 78. □

Reader Questions

Do Not Report Burr Holes For Ventriculoperitoneal Pump

Question:

One of our surgeons is looking at placing a “VENTRICULO-PERITONEAL” baclofen pump. We are looking at using 62223 (Creation of shunt; ventriculoperitoneal, -pleural, other terminus) and 62362 (Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming). The idea of the pump is that the medication gets directly dispersed in the brain not the spine. Please opine of our choice of codes.

Wisconsin Subscriber

Answer:

It is difficult to understand a scenario in which a pump is placed for intrathecal cranial infusion but a catheter system is placed between the ventricle and peritoneum. Infusion pumps and catheters are by nature unidirectional to a site(s). Code 62362 is applicable for spinal infusion pumps, but not pumps for cranial infusion. If the procedure performed was a ventricular catheter placement for intrathecal cranial infusion from an implantable pump, you would report 61215 (*Insertion of subcutaneous reservoir; pump or continuous infusion system for connection to ventricular catheter*) for the pump placement

and 61210 (*Burr hole[s]; for implanting ventricular catheter, reservoir, EEG electrode[s], pressure recording device, or other cerebral monitoring device [separate procedure]*) for placement of the ventricular catheter through a burr hole for infusion. The latter code would be appended with the 51 (*Multiple procedures...*) modifier. □

Earn For Every Level In Spinal Fusion

Question:

Our surgeon does a T10-L2 posterior lumbar fusion in addition to open vertebroplasty at T10 and L2. Please advise how to report this. We are reporting diagnosis codes 737.10 (Kyphosis [acquired] [postural]) for acquired Kyphosis and 733.13 (Pathological fracture of vertebrae) for pathologic fracture.

Ohio Subscriber

Answer:

Assuming that a posterolateral rather than posterior interbody fusion is performed, the choice of the primary stand-alone code is up to the provider. Since the lumbar posterolateral fusion code is valued higher than the comparable thoracic code, one would report 22612 (*Arthrodesis, posterior or posterolateral technique, single level; lumbar [with lateral transverse technique, when*

performed]) for the L1-L2 posterior arthrodesis and 3 units of 22614 (*Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment [List separately in addition to code for primary procedure]*) for the T12-L1, T11-T12, and T10-T11 posterior arthrodesis.

Since thoracic vertebroplasty is valued higher than lumbar vertebroplasty, you would report 22520 (*Percutaneous vertebroplasty [bone biopsy included when performed], 1 vertebral body, unilateral or bilateral injection; thoracic*) with 51 (*Multiple procedures...*) for the T10 vertebroplasty and 22522 (*Percutaneous vertebroplasty [bone biopsy included when performed], 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body [List separately in addition to code for primary procedure]*) for the L2 vertebroplasty.

Although the vertebroplasty codes describe a percutaneous procedure, the technique and physician work are similar when performing this in conjunction with an open procedure. Although not specified in the vignette, other separately reportable procedures than may have been performed include bone graft harvest and spinal instrumentation. □

Get Specific for Instrumentation and Grafts in Spinal Procedures

Question:

Our surgeon did the following procedures using the posterior thoracolumbar approach:

“Open reduction of L1 burst fracture; T12, L1, L2 pedicle screw segmental instrumentation for stabilization; T12-L2

posterolateral arthrodesis using cancellous allograft bone chips and DBM putty.”

Below is how the operative note reads:

“...posterior elements of T12, L1 and L2 were exposed. Using the DePuy EXPEDIUM system, we inserted 7.0 x 50 screws at T12 bilaterally as well as L2 bilaterally and 7.0 x 45 screws at L1 bilaterally. We went ahead and connected two appropriate size rods and final tightened set screws on there to complete the T12-L2 stabilization and in the process reduction of the L1 burst fracture.then decorticated the posterior elements of T12, L1 and L2 using a high-speed match stick drill. We then went ahead mixed allograft cancellous bone chips with DBM putty and laid it on the posterior element to complete the T12, L1, L2 posterior arthrodesis. There was excellent hemostasis.”

Can we bill 22614 (Arthrodesis, posterior or posterolateral technique, single level; each additional vertebral segment [List separately in addition to code for primary procedure]) twice in this case?

New Jersey Subscriber

Answer:

Your operative note describes a posterolateral arthrodesis at L1-L2 that would be reported with 22612 (*Arthrodesis, posterior or posterolateral technique, single level; lumbar [with lateral transverse technique, when performed]*) and an additional level arthrodesis at T12-L1 that would be reported with 22614. Since only two joints have been fused, a second additional level was not performed and would not be reported.

The segmental posterior pedicle screw instrumentation would be reported with 22842 (*Posterior segmental instrumentation [e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires]; 3 to 6 vertebral segments [List separately in addition to code for primary procedure]*). The incidental reduction with placement and connection of the spinal instrumentation would be considered incidental to the instrumentation placement and not separately reportable. The cancellous allograft and demineralized bone matrix would be reported with 20930 (*Allograft, morselized, or placement of osteopromotive material, for spine surgery only [List separately in addition to code for primary procedure]*). □

— Answers to You Be the Coder and Reader Questions were reviewed by **Gregory Przybylski, MD**, director of neurosurgery at the New Jersey Neuroscience Institute, JFK Medical Center in Edison.

You Be the Coder

Get Definitive Diagnosis for Post-op Complaints

(Question on page 77)

Answer:

The patient was admitted for “back pain.” Since this was post-surgical after treatment of back problem, it seems to be a post-op issue and would not be separately reportable. If, during the course of the evaluation the cause of the pain was a UTI AND if this is unrelated to the surgical procedure (no catheterization was performed), you may separately report this as an unrelated visit with modifier 24 (*Unrelated evaluation and management service by the same physician during a postoperative period...*). Make sure that it is well documented and that the diagnosis really is UTI. □

Neurosurgery

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