Optum

Coding Companion

Neurosurgery/ Neurology

A comprehensive illustrated guide to coding and reimbursement

2027

optumcoding.com

Contents

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, relative value units, and Medicare edits. The Relative Value Unit/Medicare Edits table will not be included with any CPT/HCPCS code with a "0" (zero) value.

The codes in the appendix are presented in the following order:

- HCPCS
- E/M
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

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 32.3, 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 2027 edition password is: **XXXXX.** 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

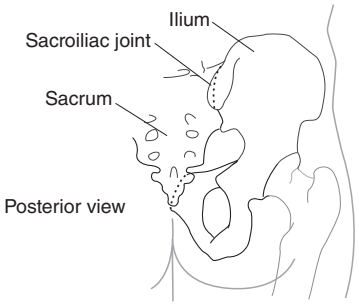
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

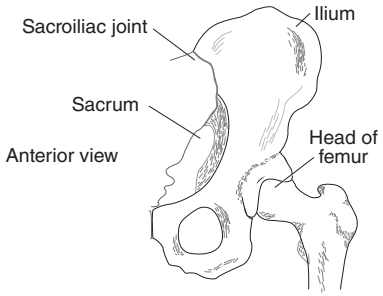
Sample Page and Key

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

27096

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





Anterior view showing sacroiliac joint

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 ☑
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	3.31	0.14	4.93
Facility RVU	**Work**	**PE**	**MP**	**Total**
27096	1.48	0.85	0.14	2.47

	FUD	Status	MUE	Modifiers				IOM Reference
27096	0	A	1(2)	51	50	N/A	N/A	None

* with documentation

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.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2027.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2027.
- ▲ This CPT code description is revised for 2027.
- ✚ 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. Note: This icon is not appended to the synchronous audio-video visit codes 98000-98007.

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	96041
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 a 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:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ☑ 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 2026.

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 when the technical (modifier TC) or professional (modifier 26) component of a procedure is provided.

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 has identified these codes as telehealth/telemedicine services. CMS requires the use of a place of service (POS) indicator: POS 02 for telehealth services 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** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99203** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99204** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99205** 2024,Sep; 2024,Mar; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.16	0.08	2.17
99203	1.6	1.59	0.16	3.35
99204	2.6	2.18	0.24	5.02
99205	3.5	2.79	0.33	6.62
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.4	0.08	1.41
99203	1.6	0.68	0.16	2.44
99204	2.6	1.13	0.24	3.97
99205	3.5	1.57	0.33	5.4

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

● New ▲ Revised + Add On ★ Telemedicine [Resequenced] ☑ Laterality

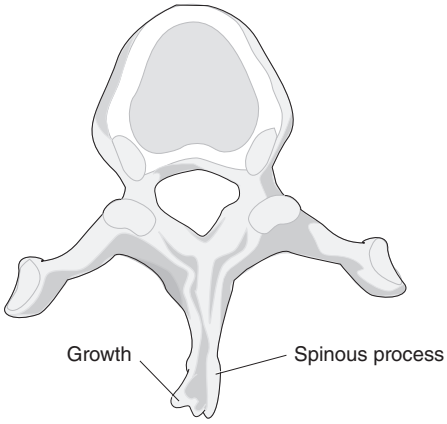
22100-22103

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

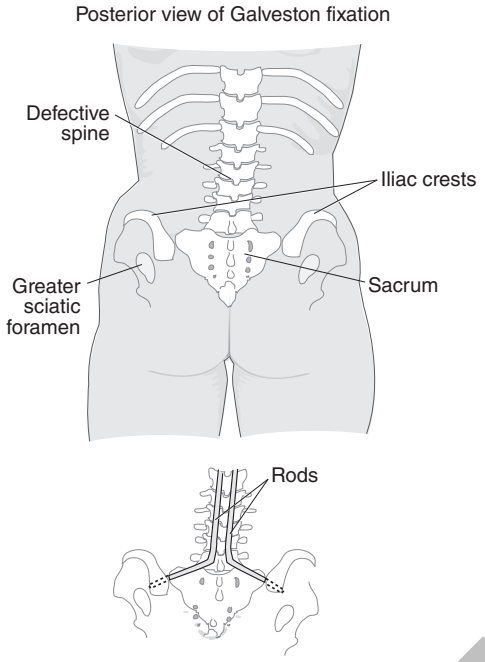
An excisional biopsy is not reported separately if a therapeutic excision is performed during the same surgical session. Report 22103 in addition to 22100–22102. For partial excision of the vertebral body, for intrinsic bony lesion, without decompression of spinal cord and/or nerve root, see 22110–22116. 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
M51.360 Other intervertebral disc degeneration, lumbar region with discogenic back pain only
M51.361 Other intervertebral disc degeneration, lumbar region with lower extremity pain only
M51.362 Other intervertebral disc degeneration, lumbar region with discogenic back pain and lower extremity pain
M51.369 Other intervertebral disc degeneration, lumbar region without mention of lumbar back pain or lower extremity pain
M51.370 Other intervertebral disc degeneration, lumbosacral region with discogenic back pain only
M51.371 Other intervertebral disc degeneration, lumbosacral region with lower extremity pain only
M51.372 Other intervertebral disc degeneration, lumbosacral region with discogenic back pain and lower extremity pain

22848

\+ **22848** Pelvic fixation (attachment of caudal end of instrumentation to pelvic bony structures) other than sacrum (List separately in addition to code for primary procedure)



Rods are inserted into the iliac spine and contoured to correct and support spine; sacrum remains unfixed

Explanation

The physician joins axial connectors, such as the tail end of spinal instrumentation devices, to a rod configured to fit along the flat of the sacrum and impacted longitudinally between the cornices of the ilium just above the greater sciatic notch. The rod is driven through the ilium and negates the need for anterior instrumentation. This procedure, usually called the "Galveston technique," often accompanies a procedure for scoliosis, myelomeningocele, or paralytic spinal defects where sacral fixation is not desirable.

Coding Tips

Report 22848 in addition to 22100-22102, 22110-22114, 22206-22207, 22210-22214, 22220-22224, 22310-22327, 22532, 22533, 22548-22558, 22590-22612, 22630, 22633, 22634, 22800-22812, 63001-63030, 63040-63042, 63045-63047, 63050-63056, 63064, 63075, 63077, 63081, 63085, 63087, 63090, 63101, 63102, 63170-63290, and 63300-63307. Any bone graft is reported separately, see 20930–20938. Report separately codes for treatment of a fracture/dislocation (22325–22328) and arthrodesis (22548–22812). According to CPT guidelines it is inappropriate to append modifier 62 to spinal instrumentation codes.

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: 22848 2021,Dec; 2021,Jul; 2020,May; 2018,Aug; 2018,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
22848	5.99	3.01	1.74	10.74
Facility RVU	**Work**	**PE**	**MP**	**Total**
22848	5.99	3.01	1.74	10.74

	FUD	Status	MUE	Modifiers				IOM Reference
22848	N/A	A	1(2)	N/A	N/A	62	80	None

* with documentation

Terms To Know

anterior. Situated in the front area or toward the belly surface of the body; an anatomical reference point used to show the position and relationship of one body structure to another.

defect. Imperfection, flaw, or absence.

graft. Tissue implant from another part of the body or another person.

instrumentation. Use of a tool for therapeutic reasons.

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

myelomeningocele. Congenital disorder in which the spinal cord and meninges herniate through a vertebral canal defect.

pelvic bones. Ilium, ischium, pubis, and sacrum together forming a bony circle to protect the pelvic contents, provide stability for the vertebral column (sacrum), and provide an appropriate surface for femoral articulation for ambulation.

pelvis. Distal anterior portion of the trunk that lies between the hipbones, sacrum, and coccyx bones; the inferior portion of the abdominal cavity.

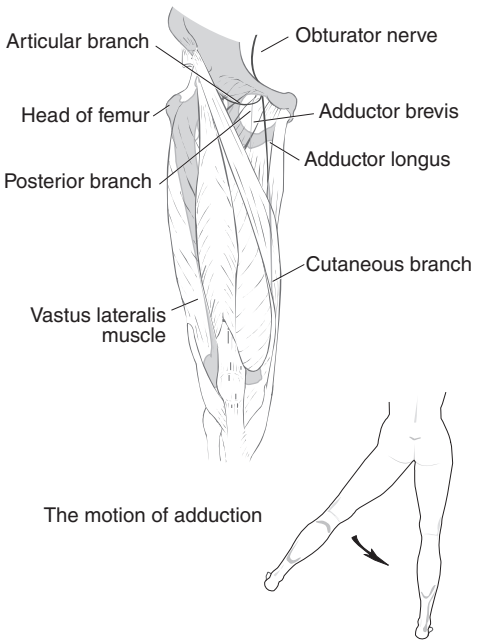
sacrum. Lower portion of the spine composed of five fused vertebrae designated as S1-S5.

scoliosis. Congenital condition of lateral curvature of the spine, often associated with other spinal column defects, congenital heart disease, or genitourinary abnormalities. It may also be associated with spinal muscular atrophy, cerebral palsy, or muscular dystrophy.

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

27003

27003 Tenotomy, adductor, subcutaneous, open, with obturator neurectomy



A subcutaneous tenotomy of a hip adductor is performed in conjunction with a neurectomy of the obturator nerve

Explanation

The physician performs a tenotomy of the adductor of the hip. An incision is made starting at the pubis and extending approximately 5 cm along the inner thigh, in line with the V adductor longus muscle. The tendinous origins of the adductor muscles are identified and separated to allow lengthening. In 27003, the adductor muscles are separated from each other and the obturator nerve is located. The anterior and posterior branches of the nerve are removed. To perform a tenotomy, the tendinous origins of the adductor muscles are divided. The physician repairs the incision in layers. A cast may be applied for three to six weeks to hold the hip in abduction.

Coding Tips

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). Note that 27003 reports procedures on adductors not abductors. According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure.

ICD-10-CM Diagnostic Codes

G80.0	Spastic quadriplegic cerebral palsy
G80.1	Spastic diplegic cerebral palsy
G80.2	Spastic hemiplegic cerebral palsy
G80.8	Other cerebral palsy
M24.551	Contracture, right hip ☑
M24.651	Ankylosis, right hip ☑
M25.651	Stiffness of right hip, not elsewhere classified ☑
M65.151	Other infective (teno)synovitis, right hip ☑
M65.251	Calcific tendinitis, right thigh ☑
M67.853	Other specified disorders of tendon, right hip ☑
M76.11	Psoas tendinitis, right hip ☑
S73.011A	Posterior subluxation of right hip, initial encounter ☑
S73.014A	Posterior dislocation of right hip, initial encounter ☑
S73.021A	Obturator subluxation of right hip, initial encounter ☑
S73.024A	Obturator dislocation of right hip, initial encounter ☑
S73.031A	Other anterior subluxation of right hip, initial encounter ☑
S73.034A	Other anterior dislocation of right hip, initial encounter ☑
S73.041A	Central subluxation of right hip, initial encounter ☑
S73.044A	Central dislocation of right hip, initial encounter ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
27003	7.81	8.89	1.61	18.31
Facility RVU	**Work**	**PE**	**MP**	**Total**
27003	7.81	8.89	1.61	18.31

	FUD	Status	MUE	Modifiers				IOM Reference
27003	90	A	1(2)	51	50	62*	80	None

* with documentation

Terms To Know

adductor. Muscle with a pulling function. a. brevis Short muscle connected to the outer, lower surface of the pubic bone and the femur that acts to pull the thigh inwards toward the midline of the body, to rotate, and flex the thigh. a. gracilis Adductor muscle of the thigh connected to the inferior ramus of the pubic bone and medial shaft of the tibia that flexes the knee joint and pulls the thigh inwards toward the midline of the body.

ankylosis. Abnormal union or fusion of bones in a joint, which is normally moveable.

cerebral palsy. Brain damage occurring before, during, or shortly after birth that impedes muscle control and tone.

contracture. Shortening of muscle or connective tissue.

neurectomy. Excision of all or a portion of a nerve.

obturator nerve. Lumbar plexus nerve with anterior and posterior divisions that innervate the adductor muscles (e.g., adductor longus, adductor brevis) of the leg and the skin over the medial area of the thigh or a sacral plexus nerve with anterior and posterior divisions that innervate the superior gemellus muscles.

subcutaneous tissue. Sheet or wide band of adipose (fat) and areolar connective tissue in two layers attached to the dermis.

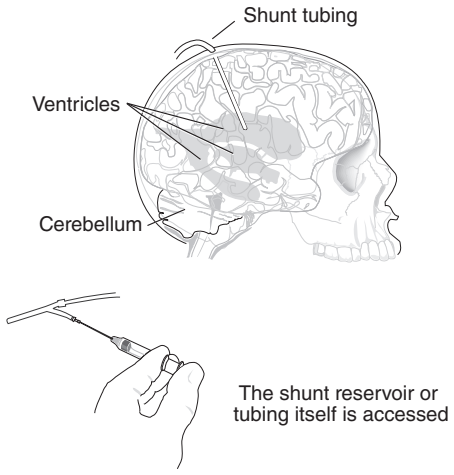
subluxation. Partial or incomplete dislocation (separation) of a joint with misalignment but maintenance of some contact between the bones.

tenosynovitis. Inflammation of a tendon sheath due to infection or disease.

tenotomy. Cutting into a tendon.

61070

61070 Puncture of shunt tubing or reservoir for aspiration or injection procedure



Explanation

The physician injects or aspirates the shunt tubing or reservoir with a needle to determine function. Shunt tubing eliminates excess cerebral spinal fluid in cases of hydrocephalus. The tubing runs behind the ear, through neck tissue, and into the gut. The physician places a needle into the tube or reservoir and injects radiologic dye, or aspirates to check for effective drainage.

Coding Tips

For radiological supervision and interpretation, see 75809. If an injection procedure is needed for cerebral angiography, see 36100–36218. If an injection procedure is needed for pneumoencephalography, see 61055. If an injection procedure is needed for ventriculography, see 61026 and 61120.

ICD-10-CM Diagnostic Codes

C71.5	Malignant neoplasm of cerebral ventricle
C71.8	Malignant neoplasm of overlapping sites of brain
C79.31	Secondary malignant neoplasm of brain
G03.0	Nonpyogenic meningitis
G91.0	Communicating hydrocephalus
G91.1	Obstructive hydrocephalus
G91.2	(Idiopathic) normal pressure hydrocephalus
G91.8	Other hydrocephalus
T85.01XA	Breakdown (mechanical) of ventricular intracranial (communicating) shunt, initial encounter
T85.02XA	Displacement of ventricular intracranial (communicating) shunt, initial encounter
T85.03XA	Leakage of ventricular intracranial (communicating) shunt, initial encounter
T85.09XA	Other mechanical complication of ventricular intracranial (communicating) shunt, initial encounter
T85.110A	Breakdown (mechanical) of implanted electronic neurostimulator of brain electrode (lead), initial encounter
T85.111A	Breakdown (mechanical) of implanted electronic neurostimulator of peripheral nerve electrode (lead), initial encounter
T85.112A	Breakdown (mechanical) of implanted electronic neurostimulator of spinal cord electrode (lead), initial encounter
T85.118A	Breakdown (mechanical) of other implanted electronic stimulator of nervous system, initial encounter
T85.120A	Displacement of implanted electronic neurostimulator of brain electrode (lead), initial encounter
T85.121A	Displacement of implanted electronic neurostimulator of peripheral nerve electrode (lead), initial encounter
T85.122A	Displacement of implanted electronic neurostimulator of spinal cord electrode (lead), initial encounter
T85.128A	Displacement of other implanted electronic stimulator of nervous system, initial encounter
T85.698A	Other mechanical complication of other specified internal prosthetic devices, implants and grafts, initial encounter
T85.79XA	Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, initial encounter
Z08	Encounter for follow-up examination after completed treatment for malignant neoplasm
Z09	Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
Z97.8	Presence of other specified devices

AMA: **61070** 2023,Sep; 2020,Oct

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
61070	0.89	0.63	0.16	1.68

Facility RVU	Work	PE	MP	Total
61070	0.89	0.63	0.16	1.68

	FUD	Status	MUE	Modifiers				IOM Reference
61070	0	A	2(3)	51	N/A	N/A	N/A	None

* with documentation

Terms To Know

aspiration. Drawing fluid out by suction.

injection. Forcing a liquid substance into a body part such as a joint or muscle.

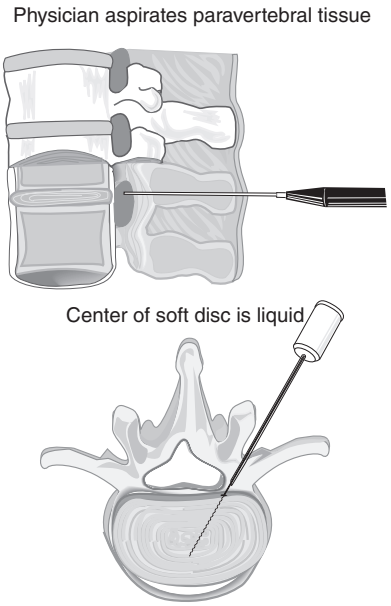
puncture. Creating a hole.

reservoir. Space or body cavity for storage of liquid.

shunt. Surgically created passage between blood vessels or other natural passages, such as an arteriovenous anastomosis, to divert or bypass blood flow from the normal channel.

62267

62267 Percutaneous aspiration within the nucleus pulposus, intervertebral disc, or paravertebral tissue for diagnostic purposes



Explanation

The physician removes contents within the intervertebral disc, nucleus pulposus, or paravertebral tissue with a needle for diagnostic purposes. Separately reportable computed tomography or fluoroscopic guidance verifies placement of the needle. A spinal needle is inserted, the contents of the targeted location are aspirated, and the needle is removed. The wound is dressed. If this procedure is performed under fluoroscopic guidance, injection of the contrast is an inclusive component and is not reported separately.

Coding Tips

Do not report 62267 with 10004-10012, 20225, 62287, 62290, or 62291. For imaging guidance of needle placement, see 77003.

ICD-10-CM Diagnostic Codes

G06.1 Intraspinal abscess and granuloma
M46.02 Spinal enthesopathy, cervical region
M46.03 Spinal enthesopathy, cervicothoracic region
M46.04 Spinal enthesopathy, thoracic region
M46.05 Spinal enthesopathy, thoracolumbar region
M46.06 Spinal enthesopathy, lumbar region
M46.07 Spinal enthesopathy, lumbosacral region
M46.08 Spinal enthesopathy, sacral and sacrococcygeal 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
M46.28 Osteomyelitis of vertebra, sacral and sacrococcygeal region
M46.32 Infection of intervertebral disc (pyogenic), cervical region
M46.33 Infection of intervertebral disc (pyogenic), cervicothoracic region
M46.34 Infection of intervertebral disc (pyogenic), thoracic region
M46.35 Infection of intervertebral disc (pyogenic), thoracolumbar region
M46.36 Infection of intervertebral disc (pyogenic), lumbar region
M46.37 Infection of intervertebral disc (pyogenic), lumbosacral region
M46.38 Infection of intervertebral disc (pyogenic), sacral and sacrococcygeal 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
M46.58 Other infective spondylopathies, sacral and sacrococcygeal region
M46.82 Other specified inflammatory spondylopathies, cervical region
M46.83 Other specified inflammatory spondylopathies, cervicothoracic region
M46.84 Other specified inflammatory spondylopathies, thoracic region
M46.85 Other specified inflammatory spondylopathies, thoracolumbar region
M46.86 Other specified inflammatory spondylopathies, lumbar region
M46.87 Other specified inflammatory spondylopathies, lumbosacral region
M46.88 Other specified inflammatory spondylopathies, sacral and sacrococcygeal region

AMA: 62267 2023,Jan; 2019,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
62267	3.0	4.59	0.3	7.89
Facility RVU	**Work**	**PE**	**MP**	**Total**
62267	3.0	1.25	0.3	4.55

	FUD	Status	MUE	Modifiers				IOM Reference
62267	0	A	2(3)	51	N/A	N/A	80*	None

* with documentation

Terms To Know

aspiration. Drawing fluid out by suction.

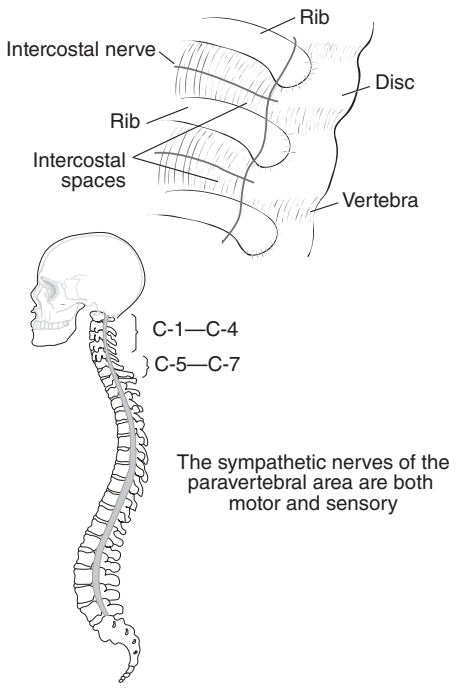
intervertebral disc. Fibrocartilaginous cushion found between the vertebral bodies of the spine and composed of the annulus fibrosus, or the outer fibrous ring, surrounding a soft, central elastic area called the nucleus pulposus.

nucleus pulposus. Semi-gelatinous mass of fine white and elastic fibers forming the central portion of the intervertebral disk, contained within the annulus fibrosus, preventing it from protruding out of the disk space.

percutaneous. Through the skin.

64802

64802 Sympathectomy, cervical



Explanation

The physician performs a cervical sympathectomy. The cervical sympathetic chain supplies sympathetic innervation to the head, neck, and upper extremities. The physician makes a midlateral incision of the neck and dissects the tissues to locate the sympathetic chain. The ganglia (nerve cell bodies that lay outside the spinal cord) are identified and resected. The incision is sutured in layers.

Coding Tips

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). To report cervical rib excision with a sympathectomy, see 21616.

ICD-10-CM Diagnostic Codes

G56.41	Causalgia of right upper limb ☑
G56.42	Causalgia of left upper limb ☑
G90.511	Complex regional pain syndrome I of right upper limb ☑
G90.512	Complex regional pain syndrome I of left upper limb ☑
G90.513	Complex regional pain syndrome I of upper limb, bilateral ☑
I47.21	Torsades de pointes
I47.29	Other ventricular tachycardia
I73.00	Raynaud's syndrome without gangrene
I73.01	Raynaud's syndrome with gangrene
L74.510	Primary focal hyperhidrosis, axilla
L74.511	Primary focal hyperhidrosis, face
L74.512	Primary focal hyperhidrosis, palms
L74.52	Secondary focal hyperhidrosis
M79.601	Pain in right arm ☑
M79.602	Pain in left arm ☑
M79.621	Pain in right upper arm ☑
M79.622	Pain in left upper arm ☑
M79.631	Pain in right forearm ☑
M79.632	Pain in left forearm ☑
M79.641	Pain in right hand ☑
M79.642	Pain in left hand ☑
S47.1XXA	Crushing injury of right shoulder and upper arm, initial encounter ☑
S47.2XXA	Crushing injury of left shoulder and upper arm, initial encounter ☑
S57.01XA	Crushing injury of right elbow, initial encounter ☑
S57.02XA	Crushing injury of left elbow, initial encounter ☑
S57.81XA	Crushing injury of right forearm, initial encounter ☑
S57.82XA	Crushing injury of left forearm, initial encounter ☑
S67.21XA	Crushing injury of right hand, initial encounter ☑
S67.22XA	Crushing injury of left hand, initial encounter ☑
S67.31XA	Crushing injury of right wrist, initial encounter ☑
S67.32XA	Crushing injury of left wrist, initial encounter ☑
S67.41XA	Crushing injury of right wrist and hand, initial encounter ☑
S67.42XA	Crushing injury of left wrist and hand, initial encounter ☑

AMA: 64802 2024,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
64802	10.37	11.31	4.31	25.99
Facility RVU	**Work**	**PE**	**MP**	**Total**
64802	10.37	11.31	4.31	25.99

	FUD	Status	MUE	Modifiers				IOM Reference
64802	90	A	1(2)	51	50	62*	80	None

* with documentation

Terms To Know

hyperhidrosis. Condition of excessive perspiration beyond what the body requires for normal temperature control.

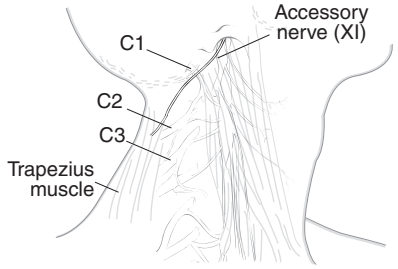
innervation. Nerve distribution to a body part.

sympathectomy. Surgical interruption or transection of a sympathetic nervous system pathway.

sympathetic nerves. Self-regulating nerves that are part of the autonomic nervous system and that innervate the involuntary motor systems that prepare the body for intense activity, such as the "fight-or-flight" response increasing heart, respiration, and metabolic rates and alertness, while inhibiting bodily secretions and digestion.

95867-95868

95867 Needle electromyography; cranial nerve supplied muscle(s), unilateral
95868 cranial nerve supplied muscles, bilateral



Examples of cranial nerve supplied muscles that may be examined by needle EMG

Explanation

Needle electromyography (EMG) records the electrical properties of muscle using an oscilloscope. Recordings, which may be amplified and heard through a loudspeaker, are made during needle insertion, with the muscle at rest, and during contraction. These codes are specific to the 12 nerves that emerge from or enter the cranium. These codes are reported when there are no nerve conduction studies performed in conjunction with these procedures during the same day. Report 95867 for unilateral studies and 95868 for bilateral studies.

Coding Tips

Procedures 95867 and 95868 have both technical and professional components. 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 EMG of the thoracic paraspinal muscles, see 95869.

ICD-10-CM Diagnostic Codes

G12.23 Primary lateral sclerosis
G12.24 Familial motor neuron disease
G12.25 Progressive spinal muscle atrophy
G12.29 Other motor neuron disease
G37.0 Diffuse sclerosis of central nervous system
G37.1 Central demyelination of corpus callosum
G37.2 Central pontine myelinolysis
G37.3 Acute transverse myelitis in demyelinating disease of central nervous system
G37.4 Subacute necrotizing myelitis of central nervous system
G37.5 Concentric sclerosis [Balo] of central nervous system
G54.3 Thoracic root disorders, not elsewhere classified
G60.2 Neuropathy in association with hereditary ataxia
G60.3 Idiopathic progressive neuropathy
G60.8 Other hereditary and idiopathic neuropathies
G70.00 Myasthenia gravis without (acute) exacerbation
G70.01 Myasthenia gravis with (acute) exacerbation
G70.1 Toxic myoneural disorders
G70.2 Congenital and developmental myasthenia
M47.13 Other spondylosis with myelopathy, cervicothoracic region
M47.14 Other spondylosis with myelopathy, thoracic region
M47.15 Other spondylosis with myelopathy, thoracolumbar region
M47.23 Other spondylosis with radiculopathy, cervicothoracic region
M47.24 Other spondylosis with radiculopathy, thoracic region
M47.25 Other spondylosis with radiculopathy, thoracolumbar region
M48.03 Spinal stenosis, cervicothoracic region

AMA: **95867** 2021,Mar **95868** 2021,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
95867	0.79	2.35	0.05	3.19
95868	1.18	2.91	0.06	4.15
Facility RVU	**Work**	**PE**	**MP**	**Total**
95867	0.79	2.35	0.05	3.19
95868	1.18	2.91	0.06	4.15

	FUD	Status	MUE	Modifiers				IOM Reference
95867	N/A	A	1(3)	N/A	N/A	N/A	80*	None
95868	N/A	A	1(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

cerebral palsy. Brain damage occurring before, during, or shortly after birth that impedes muscle control and tone.

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.

hemiplegia. Paralysis of one side of the body.

idiopathic. Having no known cause.

monoplegia. Loss or impairment of motor function in one arm or one leg.

myelopathy. Pathological or functional changes in the spinal cord, often resulting from nonspecific and noninflammatory lesions.

neuropathy. Abnormality, disease, or malfunction of the nerves.

quadriplegia. Loss or impairment of the nerves and muscles of the arms and legs that impedes normal activity or movement or results in paralysis.

syringomyelia. Progressive condition that may be either from developmental origin or caused by trauma, tumor, hemorrhage, or infarction. An abnormal cavity (syrinx) forms in the spinal cord and enlarges over time, resulting in symptoms of muscle, weakness and stiffness in the back, shoulders, arms, or legs, atrophy, headaches, dissociated memory loss and a loss of sensory ability to feel pain and extremes of hot or cold temperatures.

Correct Coding Initiative Update 32.3

❖Indicates Mutually Exclusive Edit

0075T 01924-01926, 0213T, 0216T, 0708T-0709T, 34713-34716, 34812-34820, 34833-34834, 35201-35206, 35226, 35261-35266, 35286, 36000, 36100, 36140, 36200, 36215-36217, 36410, 36591-36592, 36620-36625, 36831-36833, 36860-36861, 37236, 37246-37247, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 69990, 75600, 75605, 76000, 76380, 76942, 76998, 77001-77002, 77012, 77021, 93050, 96360, 96365, 96372, 96374-96377, 96523, 99446-99449, 99451-99452

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