Part B Insider (Multispecialty) Coding Alert

NEUROSURGERY: Put A Stop To X-Stop Denials With Communication

Don't bill 22855 and 22845 unless you can prove they're separate

Heads up: Some Medicare carriers may try to deny your claims for cutting edge neurosurgeries.

Problem #1: Many carriers still are refusing to cover the x-stop procedure, which gained two category III codes this year: 171T (...single level) and 172T (...each additional level). These carriers view the x-stop as experimental and unproven. Approved by the **Food & Drug Administration** in late 2005, the x-stop is a titanium implant that fits between the spinous processes of the lumbar spine to relieve symptoms of spinal stenosis.

Note: New codes 171T-172T aren't in the CPT book because they came out late, but they are valid for 2007.

Problem #2: Some carriers won't pay for anterior instrumentation removal code 22855 in the same session as anterior instrumentation code 22845. They argue that removing an existing deep-buried instrumentation from the spine is an essential part of any arthrodesis, so it should be bundled with the insertion of the replacement item.

Solution: The answer to both these problems is communicating with your carrier, say experts. You may have to submit a lot of data and have your doctor write a -letter of justification,- says **Margaret Mize**, a coder with **Birmingham Neurosurgery & Spine Group**. You can also try to gather information from **Kyphon**, which makes the x-stop device.

Success story: University of Rochester Neurosurgery Group in New York won an x-stop coverage policy from its carrier, the **Upstate Medicare Division**, by discussing the procedure with the medical director early on, says **Patty Pecoraro**, the group's billing manager.

-We stressed this wasn't going to take away the bone structure,- she says. -This was less invasive than doing a fusion. It was going to be better for patient care- because the x-stop is an outpatient procedure. Also, the x-stop costs less than a fusion and has fewer complications.

The Upstate coverage policy says it will cover the x-stop only for patients aged 50 and over with lumbar stenosis that causes -moderately impaired physical function.- The patients have to have tried six months of non-operative treatment. -We usually have the patient undergo blocks, medications, physical therapy- and other conservative measures, says Mize.

(You can read this policy at www.umd.nycpic.com/medicalreview-XStop.html. See also www.medicarenhic.com/cal_prov/articles/backpaindevice_0507.pdf and www.cignamedicare.com/articles/June07/cope5903.html.)

Coding: Even though you now have two codes for the x-stop, some carriers, including **Trailblazer**, have instructed you to keep using unlisted code 22899 instead. Check with your carrier to see which code(s) it prefers.

Not-so-successful story: Pecoraro received a denial on 22855 in the same session as 22845, and decided never to bill them together again. Other coders have reported widespread denials for 22855 with 22845 as well as spinal arthrodesis codes.

The Correct Coding Initiative doesn't actually bundle 22855 and 22845, notes **Julee Shiley** with **Critical Health Systems** in Raleigh, NC.

To bill 22855 along with 22845, you may have to use a modifier, say coders. **Tyler Neurosurgical Associates** in Tyler,

TX billed 17 cases with these two codes to various payors including Medicare in 2006 and 2007. In all of those instances, the payor covered 22855, but in three cases Tyler had to appeal denials, says coder **Patricia Boudreaux.**

In most cases, Tyler used the 59 modifier, but sometimes it used the 78 or even the 51 modifier.

Alternative: If your surgeon is actually removing and replacing hardware at the same spinal levels, then you can bill 22849, for reinsertion of spinal fixation device. Carriers will usually pay for this along with 22855, notes Mize. -Sometimes the patient may have a pseudarthrosis and they will have to remove instrumentation and re-do the fusion,- she notes.

But 22849 doesn't apply if your surgeon is removing hardware from one level and placing it at another level for separate reasons.

Bottom line: You probably shouldn't bill 22855 with 22845, even with a modifier, unless you can show -that either the levels of the spine are different, or the type of hardware removed did not require additional implantation,- says Shiley.