Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Apply This Expert Advice For Spinal Instrumentation Claims Success

Location and levels lead you to the correct code.

When reporting spinal instrumentation, the key is to confirm the segments where the instrumentation was done and to verify whether your surgeon was replacing or removing the instrumentation.

1. Verify the Location

You need to determine from the op note whether your surgeon performed anterior or posterior instrumentation. If this isn't clear, check with your surgeon. "Documenting the approach (anterior, posterior, direct lateral, extreme lateral) is something that spine surgeons do almost unfailingly," says **Heidi Stout, BA, CPC, COSC, PCS, CCS-P,** Coder on Call, Inc., Milltown, New Jersey and orthopedic coding division director, The Coding Network, LLC, Beverly Hills, CA.

Anterior instrumentation: You select from codes +22845 (Anterior instrumentation; 2 to 3 vertebral segments [List separately in addition to code for primary procedure]) - +22847 (Anterior instrumentation; 8 or more vertebral segments [List separately in addition to code for primary procedure]).

Posterior instrumentation: You'll select from the following options:

+22840 (Posterior non-segmental instrumentation [e.g., Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation] [List separately in addition to code for primary procedure])

+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]) - +22844 (Posterior segmental instrumentation [e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires]; 13 or more vertebral segments [List separately in addition to code for primary procedure]).

2. Count the Levels

Once you have confirmed the location of the instrumentation, the next step for you is to count at how many levels your surgeon did the instrumentation. "You simply count the number of vertebral bones from the most rostral (closest to the head) attachment point to the most caudal (closest to the tailbone) that are spanned by the instrumentation. It is important to note that fixation is not required at each bone within the span," says **Gregory Przybylski, MD**, director of neurosurgery, New Jersey Neuroscience Institute, JFK Medical Center, Edison.

Anatomy note: The spinal column is divided into cervical, thoracic, lumber, and sacral segments. There are seven cervical vertebrae, 12 thoracic vertebrae and five lumbar vertebrae. The sacrum is a single bone with five fused sacral segments.

Don't miss: When you see the descriptors of codes for anterior and posterior instrumentation, you will see the terms 'segmental' and 'non-segmental,' which is only applied to posterior instrumentation. The instrumentation is said to be non-segmental when your surgeon attaches the device to only two vertebrae in the spine, regardless of the actual span. The instrumentation is segmental if your surgeon attaches the device to at least three points on three different vertebrae. Again, this is regardless of the number of vertebrae spanned.

For posterior instrumentation, you report code +22842 for segmental instrumentation of 3 to 6 vertebrae, +22843

(Posterior segmental instrumentation [e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires]; 7 to 12 vertebral segments [List separately in addition to code for primary procedure]) for instrumentation of 7 to 12 vertebrae, and +22844 for that in 13 or more vertebrae. You also have code +22840 for posterior non-segmental instrumentation across one or more interspaces, provided that only two attachment points exist on distinct segments.

Similarly, for anterior instrumentation, you report codes +22845 (Anterior instrumentation, 2 to 3 segments...), +22846 (Anterior instrumentation; 4 to 7 vertebral segments [List separately in addition to code for primary procedure]), or +22847 depending upon whether your surgeon instrumentation in 2 to 3, 4 to 7, or 8 or more vertebrae, respectively.

Key: "In order for instrumentation to be considered segmental, there must be proximal and distal fixation points with at least one intervening fixation point," confirms Stout. "A pedicle screw construct that runs from L2 to S1 with screws placed at all intervening levels constitutes 5 segment instrumentation and is reported with code 22842. On the other hand, if a rod and screw construct spans L2 to S1 but no screws are placed at any intervening level, this is non-segmental fixation and is reported with code 22840," she adds.

3. Don't Forget the Primary Procedure

The codes for spinal instrumentation are not standalone codes. Instrumentation is inherently an additional procedure in spinal surgeries. Always make sure you are reporting the primary procedure when you report instrumentation.

"Several years ago, CPT® changed the designation of instrumentation codes from 51 modifier exempt to add-on codes (which are also 51 modifier exempt). The difference between the designations required identification of all the primary arthrodesis and decompression codes that spinal instrumentation can be "add-on" to," says Przybylski.

Example: You may read that your surgeon did a 'bilateral hemilaminectomy with diskectomy and foraminotomy for nerve decompression.' You may further read that he also performed a 'lumbar decompression with posterior lumbar interbody fusion and posterior lateral transverse fusion with pedicular screws.'

In this case, because discectomy is an inherent part of posterior interbody arthrodesis, you would not report63030 (Laminotomy [hemilaminectomy], with decompression of nerve root[s], including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; 1 interspace, lumbar).

What to report: For your primary procedure, you would report the combined code 22633, since you are performing both a posterior interbody arthrodesis and a posterolateral arthrodesis. You would not separately report the posterior lumbar interbody fusion, in which a laminectomy, facetectomy and discectomy are performed with decortications of the vertebral endplates and insertion of graft material between them. So, you do not report 22630 (Arthrodesis, posterior interbody technique, including laminectomy and/or diskectomy to prepare interspace [other than for decompression], single interspace; lumbar) for posterior interbody technique and 22612 (Arthrodesis, posterior or posterolateral technique, single level; lumbar [with lateral transverse technique, when performed]) for posterior lateral transverse fusion. The combined code was created in 2012 to reflect performing both procedures as the same interspace.

Finally, you also should report the instrumentation. If the neurosurgeon performed a single-level instrumentation (i.e., two adjacent vertebrae), you report 22840. If he performed a two-level (i.e., three-segment) instrumentation attached at L4, L5 and S1, you turn to 22842.

If he implanted the pedicle screws and attached the instrumentation at only two places, 22840 would be correct regardless of how many levels there are between the endpoints. "Typically, a single interspace combined posterior lumbar interbody and posterolateral arthrodesis would be associated with non-segmental instrumentation," says Przybylski.