Part B Insider (Multispecialty) Coding Alert

PART B MYTHBUSTER: Just Because Something Is 'Bundled,' Doesn't Mean You Can't Bill It

Your surgeon could gain an extra $1600 for osteotomy

Myth: If two procedures are listed as -bundled,- you can never bill them together.

Reality: Every surgery is different, and you need to look at the specific circumstances, urges **Joshua Klinge** with **Neuro Revenue Solutions** in Orange, CA. Too many coders are intimidated by the idea of -unbundling- and fail to reap the rewards their physicians deserve.

Example: A neurosurgeon recently performed a revisional laminectomy a few weeks after a previous laminectomy, says Klinge. The physician encountered some additional complications because of the previous surgery, including scar tissue, atrophy and osteomyelitis (or infected bone). The patient also weighed over 400 pounds, making the surgery more challenging.

Normally, coders would consider the removal of the infected bone to be inclusive in a laminectomy performed at the same session, says Klinge. But because the surgeon had to remove additional bone beyond the lamina, Klinge suggested billing an osteotomy, via the posterior approach, in the 22210 series.

Because there were three levels involved in the osteotomy, the surgeon was able to bill about $800 for the first level and another $800 for the two additional levels, Klinge notes. The surgeon had spent -a lot of extra time- on removing the infected bone.

In this instance, Klinge also recommended billing for a structural allograft (20931) and a cortical autograft (20937). Usually the Correct Coding Initiative (CCI) treats these two codes as bundled.

But in this instance, the surgeon applied the autograft via a lateral extra-cavitary approach to the anterior portion of the spine. The surgeon also applied the allograft posteriorly over the laminectomy area. Thus, with two different sites receiving different bone grafting techniques, billing them separately made sense.

How to get paid: If you-re billing for a separate osteotomy with a laminectomy, make sure to send the documentation and use modifier 59, Klinge advises. If you receive a denial, you should definitely appeal. And be prepared to appeal for sure, if you bill 20931 and 20937 in the same session, he notes.

If you fail to appeal, you-re saying you submitted a claim that you didn't really intend to get paid for, Klinge adds.

Another view: In the case that Klinge describes, the physician definitely did more work than laminectomy code 63047 usually describes, says coder **Pat Boudreaux** with **Tyler Neurosurgical Associates** in Tyler TX. But she's not sure that it's worth billing separately for the osteotomy.

-We-ve had a few patients with the osteomyelitis most of the time we end up fusing them,- Boudreaux notes. -We don't just remove bone.-

As far as the bone grafts go, you can actually bill for more than one bone graft per session -quot; but each bone graft needs a separate procedure to go along with it. If you come in from two different approaches, posterior and anterior, then you can bill for both bone grafts, says Boudreaux. But in the case Klinge describes, what anterior procedure the

anterior bone graft is connected to is unclear.

Try this: If your neurosurgeon sends you a report showing a laminectomy plus extensive bone removal, ask whether the surgeon actually performed a corpectomy, Boudreaux notes. If the surgeon went past the lamina, he may have actually gone into vertebral body.

-When he's talking about removing bone and then he's talking about the extracavitary approach, I would wonder if he's not into some kind of corpectomy,- she adds. Medicare pays $1,012 for 63047, whereas you could bill $2,082 for corpectomy code 63102, plus $278.93 for each additional level (63103).