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Part B Insider (Multispecialty) Coding Alert

Spine Surgery: Tumor Or Bone Fragment Can Justify Billing For Vertebral Corpectomy

Lateral extracavitary arthrodesis includes many other procedures

If your surgeon uses the lateral extracavitary approach to perform a spinal arthrodesis (22532-22534) and must perform more than a "minimal diskectomy," then you can report **CPT 63101** (Thoracic) or 63102 (Lumbar) with 63103 for each additional segment.

The real question is how to tell the difference between a "minimal diskectomy" and a vertebral corpectomy. The descriptors for 22532-22534 make it clear that they don't include decompression, or removing part of the vertebrae or a tumor that's pressing against spinal column.

The 63101 descriptor specifies that the procedure is for "a tumor or retro-pulsed bone fragments, meaning bones that have pushed backwards, fragments of bone that have pushed backwards or are pushing against the spinal cord," notes compliance educator **Eric Sandham**.

In addition to the amount of vertebral body removed, you should pay attention to whether there was a tumor or bone fragment pressing the spinal cord. "Certainly removing a tumor would be considered more than 'minimal diskectomy to prepare entry space,'" says Sandham.

But if the physician removes just one disk, it's unclear whether you can bill anything. Sandham says it's possible you might be able to bill for an anterior diskectomy (63075), but it's definitely not a sure thing.

Palmetto GBA's spinal arthrodesis local coverage decision says that if a patient has low back pain and "associated symptoms developing in the context of routine activity," then you should document "conservative therapy" for at least three months before arthrodesis. This could include using anti-inflammatory medications, plus "physical reconditioning, lumbar stabilization, manipulation therapy, or facet or epidural injections."

The lateral extracavitary approach is "most useful in spine pathology where access to the vertebral body as well as the posterior portions of the spine would be most helpful," says surgeon **Jason Lifshutz**. The alternative is a dual anterior-posterior approach, where the surgeon performs an anterior approach, then turns the patient over and adds a posterior approach. The extracavitary approach allows anterior and posterior access "essentially through one incision," says Lifshutz.

This new approach is part of a revolution in minimally invasive surgery, according to a paper that Lifshutz and colleages wrote for Neurosurgical Focus (Vol. 16, No. 1, Mar. 10, 2004). Until recently, physicians used posterior approaches to the spine almost exclusively. But surgeons were "frustrated and disenchanted" with the results of posterior approaches to patients with anterior vertebral body disease, the article says.

Originally designed for the treatment of Pott's disease and vertebral osteomyelitis, lateral extracavitary spine surgery has become prevalent for all spinal disorders of the lumbar and thoracic spine due to trauma, neoplasm, degenerative disease and infection.

Meanwhile, it's getting harder to bill for spinal arthrodesis separately in general. "More and more payors are bundling the arthrodesis into laminectomies, hemilaminectomies, or anterior diskectomies," notes Sandham. Or else they're bundling the incision and approach into the arthrodesis.

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The Correct Coding Initiative makes 32 procedure codes components of 22532-22533, including many testing codes in the 95822-95937 range.

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