Codify
BY AAPC

Outpatient Facility Coding Alert

You Be the Coder: Be Sure to Count Every Laminotomy

Question: How do we report if the surgeon takes a paramedian approach and does osteotomies to remove the inferior aspect of the L4-L5 facet and part of the superior aspect of the superior L5 facet. Partial laminotomy was also completed using Kerrison rongeurs in a delicate fashion. Upon completion, the nerve root could be seen exiting the foramen at L4-5. The traversing nerve root was also free of compression and there was no excessive bleeding. The patient had a previous RT L4-L5 laminotomy as well?

Florida Subscriber

Answer: You report code 63042 (Laminotomy [hemilaminectomy], with decompression of nerve root[s], including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar) if the patient has already undergone a laminotomy with discectomy in the past at L4-5. Repeat laminectomy for stenosis decompression is reported with code 63047 (Laminectomy, facetectomy and foraminotomy [unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s)], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar). For professional services billing, append modifier 22 to code 63047 if the surgeon has documented significantly increased complexity due to scarring around the nerve roots or dura.