Codify
BY AAPC

Pain Management Coding Alert

You Be the Coder: Crack This Herniated Disc Tx Scenario

Question: A patient reports for surgery with a preoperative diagnosis of herniated disc. The surgeon preps and drapes in the usual fashion, and identifies L4-5 disc space. Here is the rest of the note from the surgeon:

"I injected local anesthesia using lidocaine 1 % with epinephrine with a #25-gauge 1.5 inch needle to the superficial skin and subcutaneous tissue. Once this was accomplished, the 150 mm Stryker needle was introduced in the direction of the L4-5 intervertebral space. The disc was successfully penetrated and aimed to the center of the disc at L4-5 in both AP and lateral views. Once this was accomplished under fluoroscopy, the trocar was removed from the needle and Stryker decompressor was inserted in such a way that approximately 1.5 g to 2 g of the disc material were removed with the decompressor. Two passes were accomplished of 90 seconds each. Once this was accomplished, the instruments were removed from the space and all the disc material was passed through the scrub technician. Then, the 150 mm Stryker needle was introduced in the direction of L5-Sl intervertebral space. This was successfully penetrated under fluoroscopy. The trocar was removed from the needle and the Stryker decompressor was inserted and approximately 1.5 to 2 g of disc material was removed with the decompressor. Two passes of 90 seconds were done and the material was passed to the scrub technician. Then, the instruments were removed and the patient was awakened and taken to the recovery room in satisfactory condition."

How should I code this encounter?

Tennessee Subscriber

Answer: You should use ICD-10 codes M51.26 (Other intervertebral disc displacement, lumbar region) and M51.27 (Other intervertebral disc displacement, lumbosacral region) to represent the patient's injuries.

For the surgery you describe in the surgeon's notes, 62287 (Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar) would be the most appropriate code.

Why? Since the descriptor for code 62287 includes the term" single or multiple levels," only one unit of 62287 is assigned even when the procedure is performed on more than one level.