Coding For Same Day Anterior-Posterior Spine Procedures: Four Myths Clarified

Coding and billing for anterior-posterior spine procedures can almost be as complex as performing the procedure, particularly if you aren’t familiar with the nuances of the American Medical Association’s Current Procedural Terminology® (CPT) codes. Many physicians and coders have received erroneous advice from well-meaning colleague physicians, coders and even coding consultants. The top four coding and billing myths for anterior-posterior spine surgery on the same day will be clarified in this article.

Myth 1: Submit two separate claims
To obtain better reimbursement, physicians and coders have been told to submit two separate claims when billing an anterior procedure followed by a posterior procedure on the same day. This myth also recommends use of modifier 58 on the CPT codes billed.

It is not accurate to append modifier 58 (staged or related procedure or service by the same physician during the postoperative period) to anterior-posterior spine CPT codes for procedures performed on the same day. CPT states that modifier 58 is used when in the global period of the first procedure. The global period would start on postoperative day one, meaning the day after, not the day of, the first procedure.

Sending the CPT codes for the anterior and posterior procedures on two separate claims to avoid the payor’s multiple procedure payment reduction is not appropriate. A payment reduction of up to 50% for secondary stand-alone CPT codes is expected when performed on the same day due to overlapping pre- and postoperative global periods.

While additional reimbursement might be obtained if two separate claims are submitted with modifier 58, incorrect coding puts revenue at risk for a take-back if the payer’s retrospective review reveals modifier misuse.

Myth 2: Report two codes for a single level decompression (CPT 63047)
Also, incorrect is reporting two codes, such as 63047 and 63048, for a decompressive laminectomy, foraminotomy and facetectomy at a single level (eg, L4-L5).

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

63048 Each additional segment, cervical, thoracic, or lumbar (List separately in addition to code for primary procedure)

In fact, if the procedure is performed at L4-L5, meaning the inferior L4 lamina and superior L5 lamina are removed as well as a medial facetectomy and foraminotomy at L4-L5 to decompress the L4 exiting nerve root, only one CPT code (63047) should be reported. To report a second code, 63048, the surgeon would need to remove more of the lamina at either L4 or L5 and do a foraminotomy with decompression of a different exiting nerve such as at L3-L4 (L3 nerve) or L5-S1 (L5 nerve).

In short, report these codes once per level of foraminotomy, as it is based on the motion segment (disc space, partial vertebra above and below) rather than per vertebral segment.

Myth 3: Assistant surgeon bills on same claim as surgeon
Physicians and coders have been inac-
curately advised to submit codes for both the primary surgeon and surgical assistant on the same claim form.

This is obviously not accurate because a claim form requires the name and national provider identification (NPI) number of the rendering provider. The services rendered by two different providers should be separately reported on different claim forms listing each as a rendering and billing provider.

For Medicare and payers who recognize modifier AS (assistant at surgery) for services provided by a Physician Assistant or Nurse Practitioner, the assistant is required to submit a claim using his/her own NPI as the rendering and billing provider. Therefore, a separate claim form is appropriate and accurate.

Myth 4: Anterior-posterior spine surgery requires two operative notes
Another piece of erroneous advice is the spine surgeon should dictate separate operative notes for each approach, anterior and posterior.

While the two procedures might require separate approaches, the fact is that both procedures were performed on a single patient under a single anesthesia at a single operative session. Therefore, a single operative note is appropriate.

It can be confusing for billing office staff to determine which operative report to send, if two are dictated, when appealing denials. Often, the first or second operative report lacks information describing the patient being turned or re-prepped for the second procedure. This creates confusion for the coders who may not know to seek out the second operative report for coding purposes.

Conclusion
Verify with your specialty society or the AMA any coding or billing advice you receive from outside sources, and consider attending a specialty society sponsored coding course, such as NASS Coding Update, on an annual basis to keep up to date with coding rules. Understanding how to code and bill anterior-posterior spine procedures performed on the same day will optimize your revenue with proper coding, and decrease your risk from improper coding.

Reference

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Disclosure Key
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Level F. $100,001 to $500,000
Level G. $500,001 to $1M
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