

Cardiovascular System

There are a number of subsection procedures that describe the various types of surgery and locations where surgery is performed to assist in reporting major surgery within the cardiovascular section. The key operational subcategories include the following:

Heart and Pericardium (around the heart): 33010-33999

Arteries and Veins: 34001-37799

There are specific guidelines and requirements that must be followed to appropriately report procedures within the cardiovascular section. The guidelines and the subsection instructions for each area are discussed below.

Pacemakers are small devices that are implanted under the skin (in the area of the collarbone) or under the abdominal muscle just under the ribcage. The pacemaker assists the heart to maintain a regular beat when the heart rate is too rapid or too slow. Wires are attached to the pacemaker and hooked to the heart.

The pacemaker equipment consists of the pulse generator which includes the battery, electronics and the electrodes or leads. Implanted pacemakers are reported using codes 33212-33214.

When a pacemaker is placed temporarily, they are generally planted outside of the body. A battery is attached to a belt to run the pacemaker. Code 33210 is used to report a temporary pacemaker.

The pacemaker works by generating an electrical charge to the heart when the heartbeat is irregular so that the heartbeat is controlled and properly maintained.

The illustration below shows how a pacemaker is inserted and where the various components reside once implanted.



Pacemakers are inserted for less serious heart arrhythmias that is generally not life threatening.

Pacing cardioverter defibrillator (ICD) is an implantable cardiac device that uses a shock to control heart arrhythmias, primarily those that may cause cardiac arrest. ICD equipment consists of the pulse generator with wires containing electrodes on the ends that connect to your heart chambers. ICD's are reported using codes 33202-33264. If the ICD device detects an irregular rhythm in your ventricles, it will use low-energy electrical pulses to restore a normal rhythm. If the low-energy pulse does not restore normal rhythm, a higher energy pulse is activated. An ICD would be inserted for more serious heart arrhythmias and those arrhythmias that are generally life threatening if not treated. The illustration below shows an ICD and how the components work when inserted and the patient has an arrhythmia.



Pacemakers and ICD procedures are reported by **type of surgery** (insertion, replacement, upgrade, repositioning, repair and revision), **whether internal or external placement**, **equipment being inserted** (generator, leads,), **type of pacemaker** (single, dual or biventricular) and the **number of leads utilized** (single, dual or multiple leads).

There are three **pacemaker systems**; single chamber, dual chamber and biventricular pacemaker systems.

The **single chamber** pacemaker utilizes one lead positioned in either the upper or lower chamber of the heart.

The **dual chamber** pacemaker utilizes two leads, one positioned in the lower and one positioned in the upper chamber of the heart.

The **biventricular pacemaker** utilizes three leads. One lead is placed in the right atrium, one is placed in the right ventricle and one is placed in the left ventricle of the heart. For biventricular pacing, the left ventricle may require an additional electrode placement to ensure appropriate pacing. In this case, transvenous placement of the electrode is considered a distinct and separate procedure and

should be reported separately using codes 33224 or 33225. The first diagram below shows each type of pacemaker system described above (single, dual and biventricular), where they are implanted within the heart and the equipment utilized for implants including the pulse generator and leads.



A comparison of the pacemaker and ICD implant is shown in the illustration below (*National Institutes of Health*). Note the difference in the size and shape of the pulse generator for the defibrillator and pacemaker, the number of leads that are extended from each generator and the placement of the electrodes within the heart to provide a shock to the heart when the patient's heart rhythm is compromised.

Figure A shows the location and general size of an ICD in the upper chest. The wires with electrodes on the ends are inserted into the heart through a vein in the upper chest. Figure B shows the location and general size of a pacemaker in the upper chest. The wires with electrodes on the ends are inserted into the heart through a vein in the upper chest.



An Implantable Cardioverter Defibrillator and a Pacemaker

Radiological procedures performed with pacemaker or ICD procedures are not reported separately as they are considered as an integral part of the procedure to determine correct placement of the device. Radiologic procedures performed in the absence of performing an insertion, replacement or revision may be reported separately. If fluoroscopy is reported in addition to the diagnostic radiology procedure, code 76000 should be reported.

When coding pacemakers and ICD's, the following information regarding **leads** should be used to ensure accurate assignment of the code.

Single lead is reported when a pacemaker or ICD is placed in only one chamber of the heart.

Dual lead is reported when a pacemaker or ICD is placed in two chambers of the heart.

Multiple lead is reported when a pacemaker or ICD is placed in three or more chambers of the heart

A lead is a soft thin insulated wire connected to the pacemaker or ICD device. Leads carry the electrical pulse from the device to the heart and they carry information about the activity of the heart from the heart back to the device. One end of the lead is connected to the device and the other end is attached to the heart.

Coronary bypass grafting codes are reported by type of grafting performed. For venous **grafting**, codes 33510-33516 are reported; combined **arterial-venous grafting** is reported using codes 33517-33530 and **arterial grafting** is reported using code series 33533-33548. **Coronary artery bypass graft (CABG)** is reported in this code series (33533-33536, 35600).

CABG procedures repair the existing lesion (region in organ or tissue that is damaged through injury or disease) as well as addressing future lesion development.

To report **Venous CABG** procedures, refer to code range 33510-33516. **Arterial CABG** procedures are coded within the code series 33533-33536.

The following CPT Level II codes may be reported in addition to the appropriate CPT procedure for **data collection** purposes. These codes should not be reported as stand-alone codes.

- 4110F: Internal mammary artery graft performed for primary, isolated coronary artery bypass graft procedure.
- 4110F-1P: Documentation of medical reason(s) for not performing an internal mammary artery graft for primary, isolated coronary artery bypass graft procedure (e.g., not indicated contraindicated, other medical reason).
- 4110F-8P: Internal mammary artery graft not performed for primary, isolated coronary artery bypass graft procedure; reason not otherwise specified.

Percutaneous Coronary Intervention and CABG procedures are shown in the illustration below. The PCI is performed using a stent whereas the CABG reroutes (or bypasses) the area that is blocked to a healthy artery with no lesion or defect.



Endovascular repair of descending thoracic aorta is reported using code series 33880-33891. These procedures are used to report endovascular *grafting* repair of the descending thoracic aorta.

The following services are **inclusive** of the endovascular repair code procedures and should not be reported separately.

- Introduction of any devices
- Manipulation (manual treatment)
- > Positioning
- > Deployment
- Balloon angioplasty
- Stent placement

Services that can be reported separately include arteriotomy exposure and closure (34812, 34714, 34820, 34833, 34834, 34715, 34716), guide wires and catheters (36100-36140, 36200-36218) extensive repair or replacement procedures of the artery (35226, 35286), transposition of subclavian artery (33889, 33891).

Fluoroscopic codes should be reported separately using appropriate codes from series 75956-75959. Additional interventional procedures should be reported separately as well.

Heart and lung transplants are reported using procedure code series 33930-33945. There are three distinct surgical components included in the surgery procedure definitions. Each component is defined below. Each must be appropriately documented for accurate code assignment.

- 1. **Cadaver donor cardiectomy** with or without pneumonectomy including harvest, allograft and preservation (cold) (33930, 33940).
- 2. **Backbench** including **preparation of cadaver donor heart** and lung allograft prior to transplant (33933) and/or preparation of cadaver donor heart allograft (33944).
- 3. Recipient heart with or without lung allotransplantation (33935, 33945).

Ventricular Assist Devices (VAD) are used to assist a weakened heart to work normally. There are two main types of VAD devices; left ventricular assist device (LVAD), and right ventricular assist device (RVAD).

When both the LVAD and RVAD are used, it is referred to as biventricular assist device (BIVAD). VAD's may be external devices (primarily short-term used pre and post-operatively) or internal implanted devises (primarily used temporarily while awaiting replacement or permanently when replacement of heart is not an option for treatment).

The illustration below shows what the differences between the internal and external devices and the equipment used for each including the control unit, batteries and cables. The process for how the device works is shown in Illustration B. The LV assist device pumps blood it receives from the ventricle to the aorta in the example shown.



VAD procedures are reported using code series 33967-33993. VAD procedures are categorized by procedure type and include insertion, removal, repositioning and replacement procedures.

Surgical insertion of cannula is reported separately using code 36823. When performed, an open arterial exposure is reported separately using code 34812.

To report **repair of aneurysms** of arteries and veins use codes 34701-34708. An aneurysm is a bulging or enlargement of an artery caused by weakening of the arterial wall. If left untreated, aneurysms grow until they pop causing severe damage or death. When coding aneurysm repairs, the site of the aneurysm is critical. In the cardiovascular system, abdominal aortic aneurysms (AAA), femoral aneurysm and iliac aneurysm repairs are reported.

A **pseudo aneurysm** (false aneurysm) is a blood clot that forms from a leaking hole in the artery. Pseudo aneurysms are reported within the aneurysm repair code section. The pseudo aneurysm grows on the outside of the arterial wall; whereas an aneurysm grows among all layers of the arterial wall.

Aneurysm procedures of the brain are reported within the nervous system procedure area. Abdominal and thoracic aortic aneurysms (left) and an actual abdominal aortic aneurysm revealed during a AAA procedure (right) are shown in the illustrations below.



Bypass grafts (excluding CABG) are reported using codes 35500-35671. Bypass grafts are performed to allow an alternative route for blood-flow around a blocked artery.

Vascular injection procedures performed invasively are reported using code series 36000-36680. Vascular injection procedures are performed for the purpose of treating aneurysms, for injections for venography and for visualization or diagnostic purposes.

Vascular injection procedures are further categorized by *location of catheter placement*. **Intravenous** codes are reported in code series 36000-36015, **intra-arterial and intra-aortic** codes are reported in code series 36100-36299, **venous** codes are reported in code series 36400-36598 and **arterial codes** are reported in code series 36600-36660. Placement of needle for intraosseous infusion is reported using code 36680. Local anesthesia, introduction of the needle or catheter and pre-operative and post-operative care are all included in the procedure and therefore are not reported separately.

Catheters, drugs and contrast material are reported in addition to the vascular injection procedure.

Radiology supervision and interpretation codes should be reported separately utilizing codes in the radiology section.

Catheters are introduced into vessels for a number of different purposes including monitoring, blood draws, injection of contrast material and infusion. In order to accurately code catheter placement, it is critical to understand where the catheter starts and where it ends. To understand how to determine the beginning and ending point of the catheter, an understanding of how a vascular family is constructed is required.

A **vascular family** has a main trunk from which other smaller vessels branch out. Vessels connected to the main trunk are called families. There is a total of **five vascular families**.

- 1. Systemic Arterial
- 2. Systemic Venous
- 3. Pulmonary
- 4. Portal
- 5. Lymphatic

Catheter placement is designated in the CPT description as nonselective or selective.

Nonselective catheter placement means the catheter or needle is placed directly into an artery or vein and not manipulated farther along or is placed only into the aorta from any approach.

Selective catheter placement means the catheter must be moved, manipulated, or guided into a part of the arterial system other than the aorta or the vessel punctured (that is, into the branches), generally under fluoroscopic guidance. When coding selective placement for any procedure, you report the **furthest extension** into one vascular family.

The **first order** is the main artery in a vascular family. The **second order** is the branch off of the main artery. The **third order** is the next branch off the second order, and so on. A vascular family can have more than one second-order, third-order, and so on, vessel.

If the farthest extent of the placement was to the third order, only the third order code would be reported because the catheter had to go through the first and second order within the same artery to get to the third order branch.

Example, if a catheter is placed into the first order brachiocephalic artery and from there manipulated through the second-order artery, and finally into the third-order artery, you would report only the third-order artery, with code 36217, which describes an initial third-order placement within the brachiocephalic family.

The following additional vascular access guidelines should be considered when coding for invasive catheterization procedures.

- 1. If a single access catheter puncture site is established, selective catheterization should be coded over nonselective catheterization. Only the highest order of one family should be reported. If other 2nd or 3rd level catheterization is performed within the same family, the add-on code should be reported.
- 2. Code for each vascular family accessed.
- 3. Code for each vascular access.
- 4. Use codes 36215-36218 when reporting procedures above the diaphragm.
- 5. Use codes 36245-36248 when reporting procedures below the diaphragm.
- 6. Pulmonary angiography involves right and left pulmonary arteries representing two vascular families.

When coding for **selective catheterization**, the following guidelines related to vascular families apply.

- 1. Primary equals the first turn off of the main trunk (the aorta). First order vessels include innominate/brachiocephalic artery, left common carotid and left subclavian.
- 2. Secondary equals second turn off of the main trunk (the aorta). Second order vessels include the right common carotid artery, left external carotid and left vertebral aorta.

3. Tertiary equals third turn off of the main trunk (the aorta). Third order vessels include right external carotid artery and right vertebral artery.

Use the below **selective catheterization guidelines** to ensure accurate reporting for these services.

- 1. From a right femoral access, code the selective catheterization of the *right renal artery* using code 36245.
- 2. From a right femoral access, code the selective catheterization of the *left external carotid,* and the *left vertebral arteries* using codes 36216, 36216-59
- From a right femoral access, code the selective catheterization of the *right vertebral artery*, and the *right internal carotid artery* using codes 36217, 36218.



Code Series 36200-36218 can be reported using the chart below.

Intra-arterial Intra-aortic Procedure Coding



Central Venous Access (CVA) procedures are performed for the purpose of drawing blood or giving medications or nutrients without being subjected to multiple needles and different access points for obtaining or giving such care. Access devices include subcutaneous ports or pumps or catheter inserted externally. There are five surgical categories for CVA procedures defined within the code descriptions.

- 1. Insertion placement through new venous access
- 2. **Repair** device fixed without replacing device
- 3. Partial replacement replacement of catheter only, not entire device
- 4. **Complete replacement** replacement of entire access device through single access point
- 5. **Removal** of entire device



Tunneled Central Venous Access Device

Report each individual access point separately. Imaging services are reported separately using codes 76937 and/or 77001.

Endovascular revascularization procedures are performed in order to restore blood supply interrupted after a wound or injury. Codes 37220-37235 are used to report these services.

There are three arterial/vascular territories where these procedures are performed.

1. **Iliac Vascular** territory includes common iliac, internal iliac and external iliac territories.

Single primary code is used to report initial iliac artery treated in each leg (code 37220 or 37221). Other iliac vessels treated in the leg would be reported with addon codes 37222 and 37223. A maximum of two add-on codes can be reported since there are three vascular territories and therefore up to three vessels that may be treated.

2. **Femoral/Popliteal** territory includes one lower extremity reported using codes 37224-37227.

Single code is reported for territory including common, deep and superficial femoral arteries. There are no add-on codes to report since the one extremity is counted for the entire territory.

3. **Tibial/Peroneal** territory includes anterior tibial, posterior tibial and peroneal arteries.

A single primary code is reported for initial tibial/peroneal artery treated within each leg using codes 37228, 37229, 37230 or 37231. Other tibial/peroneal vessels treated should be reported using the appropriate add-on code. A maximum of two add-on codes can be reported since there are three tibial/peroneal territories within each leg and therefore up to three vessels that may be treated.

Transluminal balloon angioplasty is reported utilizing codes 37220-37222.

For additional resources for coding and billing from the cardiovascular surgery section, visit the following online resource http://www.medtronic.com/for-healthcare-professionals/products-therapies/cardiac-rhythm/therapies/coding-coverage-reimbursement-resources/physicians/.

Digestive System Surgery Guidelines

Digestive system procedures are reported using code series 40490-49999. The digestive system includes the mouth, esophagus, stomach, small intestine, large intestine—also called the colon—rectum, and anus.

Procedures in the GI System are reported by body location where procedure is performed and the type of procedure performed (i.e.: endoscopy).



Digestive System

GI transplant procedures (i.e. liver transplant codes 47133-47147) include three distinct surgical components of surgery performed.

- 1. Cadaver donor
- 2. Backbench work (preparation of graft)
- 3. Recipient liver

Hernia repairs are reported using code series 49491-49900.

Urinary System Surgery Guidelines

Urinary system procedures are reported using codes series 50010-53899. The urinary system includes two kidneys, two ureters, the bladder, two sphincter muscles, and the urethra.



Normal Anatomy of the Urinary System

Male Genital System Surgery Guidelines

Male genital system procedures are reported using codes series 54000-55899. The male genital system includes the penis, scrotum and testicles.



Female Genital System Surgery Guidelines

Female genital system procedures are reported using code series 56405-58999. The female genital system includes the external organs; the labia majora, labia manora, Bartholin's glands, the clitoris and the internal organs; vagina, uterus, ovaries and fallopian tubes. Anatomy of the Female Reproductive System



Maternity Care and Delivery procedure codes are reported using code series 59000-59899 and include all procedures performed antepartum, delivery and postpartum.

Antepartum procedures are those procedures that occur just prior to childbirth and include any patient history and exam, record of weight, BP, routine urinalysis and all monthly visits up to twenty-eight weeks of pregnancy, biweekly visits up to thirty-six weeks of pregnancy and weekly visits up to the date of delivery. Also included is any record of the heart tones of fetus throughout this entire period.

Delivery procedures are those procedures performed during delivery of the fetus. Services included in delivery care should not be reported separately from the delivery procedure codes. These include the admission to the hospital (H&P) and all management services related to a normal delivery whether by natural birth or cesarean section.

Postpartum services should be reported using code 59430 and include all office or other outpatient visits performed after the baby has been delivered.

Complications of all maternity care and delivery procedures should be reported separately within the appropriate surgery section.

Endocrine System Surgery Guidelines

Endocrine system procedure codes are reported using code series 60000-60699. The endocrine system includes a collection of glands that produce hormones. These hormones regulate the body's growth, metabolism, sexual development and function. The hormones are released into the bloodstream and transported to tissues and organs throughout the body.

Thyroid, parathyroid, thymus, adrenal glands, pancreas, and carotid body are all organs that are included within this code series. Sweat glands, salivary glands, and digestive glands are **not** included within the endocrine system.

The illustration below shows the endocrine system and the glands included that would be reported by this code range. Surgeries are separated by anatomical area (thyroid, thymus) and by the type of procedure performed (repair, removal, or biopsy).



In order to better understand the CPT code descriptions for the endocrine system, the various glands are listed and defined in the chart below.

Endocrine System Glands

Adrenal glands

Divided into 2 regions; secrete hormones that influence the body's metabolism, blood chemicals, and body characteristics, as well as influence the part of the nervous system that is involved in the response and defense against stress.

Hypothalamus

Activates and controls the part of the nervous system that controls involuntary body functions, the hormonal system, and many body functions, such as regulating sleep and stimulating appetite.

Pancreas

Secretes a hormone (insulin) that controls the use of glucose by the body.

Parathyroid glands

Secrete a hormone that maintains the calcium level in the blood.

Thymus gland

Plays a role in the body's immune system.

Thyroid gland

Produces hormones that stimulate body heat production, bone growth, and the body's metabolism.

Nervous System Surgery Guidelines

The nervous system procedure codes are reported using code series 61000-64999. The nervous system includes the two main components; the **central nervous system** (CNS)

and the **peripheral nervous system** (PNS). The nervous system is responsible for control and communication of the body.

The **CNS** consists of the brain and spinal cord. The brain is the center of the nervous system coordinating automated functions such as heartbeat and respiration, motor responses such as walking, and the learning process. The spinal cord consists of a bundle of nerves that run down the center of the back. The spinal cord is protected by the vertebral bones that surround it. The spinal cord is the main path connecting signals from the brain to the peripheral nervous system.

Both the brain and the spinal cord are covered by connective-tissue envelopes called the meninges. Cerebrospinal fluid fills the space in between the inner and outer portion of these envelopes. This fluid provides cushion for the spinal cord to keep it from being damaged when it is shocked or injury occurs.

Pain management procedures are coded in the Nervous System section utilizing the following individual codes or code series: 62273, 62320-62323, 64405, 64479, 64480, 64483, 64484, 64490-64495.

The following illustrations show the anatomy of the brain and spinal cord and the function of each key area.



The Brain

THE CENTRAL NERVOUS SYSTEM

Anatomy of the Brain

The Spinal Cord



The **PNS** consists of nerves connecting the CNS to all other parts of the body. The PNS includes motor neurons, the autonomic nervous system and the enteric nervous system.

The autonomic and enteric systems and their functional components are defined below.

Motor neurons – responsible for regulating voluntary movements.

Autonomic nervous system – comprises the **sympathetic nervous** and **parasympathetic nervous** systems and is responsible for regulating involuntary functions such as heart rate, digestion, respiratory rate, salivation, perspiration, pupil dilation, urination and sexual arousal.

Enteric nervous system – partially independent part of nervous system that is responsible for coordination of reflexes and controls the functions of the gastrointestinal system.

Peripheral Spinal Nerves

The **PNS spinal nerves** stem from the spinal cord and include the cervical spine, brachial plexus and lumbosacral plexus nerves.

Cervical Spine Nerves – there are 4 cervical spine nerves, C1-C4.

C1 – called the suboccipital nerve, this nerve provides motor function to muscles located at the base of the skull.

- C2 & C3 form many nerves of neck including the greater occipital nerve (sensation to back of head), lesser occipital nerve (sensation to back of ears) and the greater and lesser auricular nerves.
- C3 & C4 form *phrenic nerve* (arises from nerve root C3, C4 & C5) and enables breathing as it supplies the nerve to the diaphragm.

Brachial plexus nerves – there are 5 brachial plexus nerves, C5-T1. These nerves include the remaining 4 cervical spinal nerves and the T1 nerve. This bundle of nerves provides function to the upper limbs and upper back.



Lumbosacral Nerves – nerves included in the L1-S4 spinal nerves and include the lumbar, sacral and coccygeal nerves. The lumbosacral nerves are generally split into three parts; the lumbar plexus, the sacral plexus and the pudendal plexus.



Surgeries performed at the **base of the skull** are reported utilizing code series 61580-61619. Skull base surgeries are performed for the purpose of managing lesions located at the base of the anterior, middle and posterior portions of the brain. These surgical procedures require multiple physicians be involved due to the delicate nature of the surgeries and the skill and level of expertise required for such surgeries.

The following designations are needed to accurately code skull-based surgery.

- 1. **Approach** procedure reported by anatomical site (anterior, middle, posterior crania fossa, brain stem or upper spinal cord).
- Definitive procedure describes the type of procedure being performed (repair, excision, biopsy, resection). Includes closure of primary dura, mucous membrane and skin when performed.
- 3. **Repair/reconstruction** procedure reported separately of extensive grafts and/or flaps required for repair and closure.

Cranial stereotactic radiosurgery is reported using code range 61796-61800. The stereotactic radiosurgery allows the surgeon to eliminate defined mass or other area without the need for invasive surgery. The target area is treated using radiation.

The **stereotactic codes** and **application of the head frame** (61800) that delivers the treatment are reported by the neurosurgeon.



The radiation oncologist reports the codes for **delivery of the radiation** and everything included in the delivery of the radiation (pre and post) using the appropriate code from the radiation oncology subsection (77261-77790) located within the radiology section. When more than one treatment session is provided on the same tumor, only one session should be reported. Generally, only one session is required when treating the affected area.

Simple cranial lesions are reported when the mass is 3.5 cm or less. Simple lesions are reported using codes 61796 and 61797. **Complex cranial lesions** are reported for a mass greater than 3.5 cm in diameter. Complex lesions are reported using codes 61798 and 61799.

Cerebral Neurostimulators are implanted in the cranium to alleviate chronic pain that has not been alleviated by other treatment measures. To report intracranial neurostimulator implants, codes 61850-61888 should be used. The approach is the main indicator for choosing the accurate code to report.

When **another provider assists** the head surgeon with the implant procedure, the second provider should utilize codes 95961-95962 to report the service. **Injection, drainage and aspiration** procedures are reported using code series 62263-62305.

Contrast injections for fluoroscopic guidance and localizing the affected area are not reported separately.

Code 72275 should be reported for the radiological component of procedures performed within this section. The code should not be reported if separate interpretation record is not provided.

Laminotomy (hemilaminectomy) and laminectomy procedures are reported utilizing code series 63001-63051. These procedures are performed for decompression or excision of herniated discs and require open procedure ensuring direct visualization is accomplished.

The codes are reported by location of the repair (lumbar, cervical, sacral or thoracic) and the number of interspaces involved.

Note that an interspace and segment are defined differently and coding for them will follow different guidelines as to how these areas are counted per the procedure definition. CPT defines interface and segment as follows:

Vertebral segment describes the part into which the spine may be divided representing a single complete vertebral bone including its associated articular processes and laminae. *Example:* C1-C2 is **two** segments of the cervical spine.

Vertebral interspace describes the nonbony compartment between two adjacent vertebral bodies and consists of the intervertebral disc made up of the nucleus pulposus, annulus fibrosus and two cartilaginous endplates.

Example: C1-C2 is **one** interspace of the cervical spine.

The following illustration provides a view of the vertebral segment and the vertebral interspaces.



Vertebral Segments and Interspaces

If performed after laminectomy or laminotomy (63001-63048), **arthrodesis** may be reported separately. Arthrodesis is the surgical fusion of adjacent bones for the purpose of mobilizing a joint. Arthrodesis is reported using code series 22590-22634.

Spinal instrumentation is sometimes placed as part of a fusion procedure and should be reported separately from the fusion code. The spinal instrumentation codes are reported by approach and the type of instrumentation used as follows.

- > 22840-22844 (posterior instrumentation)
- > 22845–22847 (anterior instrumentation)
- > 22848 (pelvic fixation)

The application of **biomechanical devices** such Polyether ether ketone (PEEK) devices (e.g., Mosaic, LDR, GraftCage, Capstone, Zero-P, STALIF, Solitaire), HARMS cage, BAK cage and Methylmethacrylate (i.e., bone cement) may be reported using code 22851. The code should be reported per interspace or vertebral defect.

Bone grafts are reported separately using codes 20900-20938. Only one bone graft procedure per surgery session should be reported. The bone graft codes are reported by donor type. Donor types include allograft or autograft.

An **allograft** is a tissue graft from a donor of the same species as the recipient but not genetically identical. An **autograft** is a graft of tissue from one point to another of the same individual's body.

- > 20930 (allograft or osteopromotive material for spine surgery, morselized)
- > 20931 (allograft for spine surgery, structural)
- > 20936 (autograft, local)
- > 20937 (harvest of graft through separate skin incision, commonly iliac crest)
- > 20938 (autograft, structural, bicortical, or tricortical)

Spinal stereotactic radio surgery is reported using codes 63620 and 63621. The stereotactic radio surgery allows the surgeon to eliminate defined mass or other area without the need for invasive surgery. The target area is treated using stereotactic imaging.

The radiation oncologist reports treatment, planning and delivery from the radiology section of CPT using code series 77261-77790 as appropriate.

Only one session should be reported per lesion even if multiple sessions are performed.

Spinal Neurostimulators are implanted in the spine to alleviate chronic pain that has not been alleviated by other treatment measures. To report spinal neurostimulator implants, codes 63650-63688 should be used. The codes are reported by initial placement, revision, replacement or removal of the device components.

Analysis and programming codes are reported using code series 95970-95982 found in the medicine section of CPT.

Operating microscope code 69990 should not be reported separately if reporting codes 61548, 63075-63078, 64727, 64820-64823, 65091-68850 as the use of an operating microscope is inclusive of these procedures.

Eye and Ocular Adnexa Surgery Guidelines

The eye includes the pupil, sclera, iris and eyelid. The ocular adnexa include the eyebrow, eyelids and lacrimal apparatus (tear production and drainage). Procedures performed on the eye and ocular adnexa are reported using code series 65091-68899.



Auditory System Surgery Guidelines

The auditory system primarily consists of the ear flap, ear canal, eardrum, cochlea and Eustachian tube. Procedures performed on the ear are reported using code series 69000-69979. The procedures are categorized by the type of procedure being performed.



Anatomy of the Ear

The surgery procedure codes for the auditory system are separated into three main components.

1. **External** – all procedures performed on the external portion of the ear are reported using codes 69000-69399. In addition, the type of procedure (incision, excision and removal) performed determines what code is used.



2. **Middle** – all procedures performed on the middle portion of the ear are reported using codes 69420-69799. In addition, the type of procedure (introduction, incision, excision, repair, other procedures) performed determines the accurate code to report.



3. **Inner** – all procedures performed on the inner portion of the ear are reported using codes 69801-69949. The codes are further defined by the type of procedure performed (incision/destruction, excision, introduction).

