Lumbar Laminectomy Code Review Clarification

Several questions have been raised regarding the coding information included in the "Lumbar Laminectomy Code Review" article published in the July/August 2014 SpineLine (pp 29-31). NASS' Coding Committee would like to offer the following clarifications.

Reporting Additional Work on Contralateral Side of Recurrent Disc Herniation

The first item concerns the following scenario appearing on pages 30-31:

3. Posterior lumbar two level Interspace laminectomy (L3-4, L4-5) with removal of recurrent disc herniation at right L4-5 with bilateral foraminotomies, no microscope used;

History: Central stenosis L3-4 and L4-5 with recurrent HNP R L4-5 and prior microdiscectomy R L4-5 interspace

ICD-9/10: 724.02/ M48.06
Spinal Stenosis, lumbar region without neurogenic Claudication; L3-4 & L4-5
ICD-9.10; 722.1/M51.16
Lumbar disc without myelopathy; sciatica due to displacement of intervertebral disc; R L4-5

Suggested coding:

63042 Laminotomy (hemilaminectomy), with decompression of nerve roots(s); including partial facetectomy, foraminotomy and/or excision of herniated disc, re-exploration, single interspace; LUMBAR R L4-5
63047 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral) with decompression of spinal cord, cauda equina and/or nerve root(s); single LUMBAR segment L3-4
63048 left hemilaminectomy lumbar L4-5

In the above scenario, confusion is created by what to do with the opposite side of a recurrent disc level if stenosis is present. As presented, the coding accurately describes the work performed. The revision discectomy code is a unilateral code. It does not represent an additional laminectomy done on the contralateral side.

As presented, 63042 (R L4-5) is the appropriate code to be reported for the recurrent disc herniation and 63047-51 is the appropriate code to report the decompression performed at the separate interspace (L3-4).

The confusion comes in reporting the laminectomy on the contralateral side of the recurrent disc herniation at L L4-5. As presented, 63048 is appropriate to represent the work done; however, this will likely be edited out as inclusive in 63042 at the same level. There is no easy solution for reporting the additional work done on the contralateral side of the recurrent disc herniation.

Other options for reporting may include 63042 with a 22 modifier appended if the performing surgeon feels the additional laminectomy Left L4-5 represents significantly—at least 20%-25%—more work than performed for the recurrent disc herniation alone. In both options presented above, payment will likely be delayed as the reporting is likely to trigger a review.

NASS supports the accurate reporting of work performed during procedures. However, we acknowledge that at times accurately reporting what has been done will result in delays in payment due to code edits in place. It is up to the performing physician to decide whether the additional work is incidental to the greater procedure or if there has been significant, additional work to justify reporting additional procedures.

Additional Notes

The use of posterior fusion codes that encompass disc work (eg, 22630 and 22633) already take into account the removal of lamina, facets and ligamentum flavum. The interbody fusion codes also were written assuming bilateral interbody placement which requires bilateral decompression. In cases that require decompression plus fusion (L4-5 spondylolisthesis with central and lateral recess stenosis), only the fusion codes can be used.

The wording above from the original article is incomplete and has led to questions. From the AMA CPT guidelines, decompression when performed IS separately reportable with the interbody fusion codes, 22630 and 22633. The point made in the original article is that a certain amount of laminectomy is required for the approach in order to perform the interbody fusion. However, when decompression of the nerve roots requires more laminectomy than necessary for the performance of the interbody fusion, this is separately reportable. It is up to the performing surgeon to document in the operative report the areas of necessary decompression over and above the laminectomy required for interbody placement. Remember that 22630 and 22633 are valued for a bilateral procedure. If a unilateral TLIF is performed, any additional facet/hemilaminectomy work performed on the opposite side is already included in the work value of the code.

Due to Correct Coding Initiative (CCI) edits, this coding often will be edited out and may need to be appealed for manual review. When there is medical necessity for decompression of nerve roots requiring separate laminectomy or more laminectomy than would be necessary for the interbody fusion alone, this is reportable according to the AMA CPT manual.

*CCI, the Correct Coding Initiative, is a private contractor to CMS and is a separate entity from the American Medical Association.