63044 each additional lumbar interspace, re-exploration

Use 63044 only in conjunction with 63042. For bilateral procedure, report 63042 with modifier 50.

Decompression (without discectomy) with removal of lamina, ligamentum flavum with facetectomy and foraminotomy ICD-9 724.02 (Spinal stenosis lumbar region) ICD 10 codes: M48.06 (Spinal stenosis lumbar region)

63047 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral) with decompression of spinal cord, cauda equina and/or nerve root(s); single lumbar segment

63048 each additional segment cervical, thoracic or lumbar

Use 63048 in conjunction with 63047

Examples

1. Lumbar Two Interspace Discectomy (eg, L3-4, L4-5) Using Microscope

History: Right sided laminotomy L4-5, L5-S1 plus discectomy with use of microscope for right HNP L4-5, L5-S1

ICD-9/10: 722.1/ M51.16

Lumbar disc without myelopathy; sciatica due to displacement of intervertebral disc

Suggested coding:

63030 Laminotomy (hemilaminectomy), with decompression of nerve roots(s); including partial facetectomy, foraminotomy and/or excision of herniated disc; 1 interspace, lumbar L4-5

63035 each additional interspace, lumbar L5-S1

69990 use when microsurgical technique is performed requiring the use of the microscope

2. Revision discectomy right L5-S1 with discectomy left L4-5 using microscope

History: New herniated disc at left L4-5 with recurrent disc right L5-S1 (microdiscectomy three years earlier).

ICD-9/10: 722.1/ M51.16

Lumbar disc without myelopathy; sciatica due to displacement of intervertebral disc

Suggested coding:

63042 Laminotomy (hemilaminectomy), with decompression of nerve roots(s); including partial facetectomy, foraminotomy and/or excision of herniated disc; 1 interspace, Left lumbar L4-5. Use modifier 59 to indicate different level.

69990 use when microsurgical technique is performed requiring the use of the microscope

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: 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; 1 interspace, Left lumbar L4-5. Use modifier 59 to indicate different level.

69990 use when microsurgical technique is performed requiring the use of the microscope
disc, reexploration, 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

4. Posterior lumbar three interspace laminectomy (L3-4 to L5-S1) with foraminotomies

**History:** Central and lateral recess stenosis from L3-4 to L5-S1

ICD-9/10: 724.02/ M48.06

Spinal Stenosis, lumbar region without neurogenic, Claudication

**Suggested coding:**

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 each additional segment lumbar L4-5

63048 each additional segment lumbar L5-S1

**Documentation must be given for additional decompression of foramen and/or facets performed.**

5. Posterior lumbar one interspace laminectomy L4-5 without foraminotomies, facet work or discectomy

**History:** Central stenosis L4-5 without lateral recess or foraminal stenosis

ICD-9/10: 724.02/ M48.06

Spinal stenosis, lumbar region without neurogenic, claudication

**Suggested coding:**

63005 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, 1 or 2 vertebral segments; lumbar 4-5

6. Gill laminectomy L5 with decompression of foramen L5-S1 bilaterally

**History:** Foraminal stenosis L5-S1 with L5 radicular symptoms; collapsed L5-S1 disc with minimal Grade I listhesis and no motion on flex/ext films

ICD-9/10: 738.4/M43.16

Acquired spondylolisthesis, Degenerative spondylolisthesis; Spondylolysis, excludes congenital

ICD-9/10: 724.4/M51.16

Thoracic or lumbosacral neuritis or radiculitis

**Suggested coding:**

63012 Laminectomy with removal of abnormal facets and/or pars inter-articulares with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure) 5

**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.

**Example:**

L4-5 interbody fusion (PEEK device) plus posterior instrumentation with bilateral laminectomy L4 plus posterolateral fusion with cancellous allograft and local bone graft.

22851 Application of intervertebral biomechanical device (PEEK device) to vertebral defect or interspace L4-5

20936 Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process or laminar fragments) obtained from same incision

20930 Allograft, morselized, or placement of osteopromotive material, for spine surgery only

**Summary**

Lumbar decompression codes are driven by the diagnosis as opposed to the technique involved. Common areas of confusion include CPT code 63042. Re-exploration at a level with a recurrent disc herniation can only use CPT code 63042. It should only be used after the global period for the first disc surgery has expired. Repeat facetectomy and lateral recess decompression at a level with a prior decompression must use CPT code 63047 if no disc work is performed. The presence of a lumbar disc herniation (722.1) drives the CPT code.

Another common misconception is code 63047. This code can be used unilaterally or bilaterally as long as the decompression involves the lateral recess and foramem. Posterior fusion codes that involve disc preparation (22630,22633) already take into account the decompression work. Using additional decompression codes (63005, 63012, 63030,63042, 63047) is not allowed.

Additional information about coding lumbar spine procedures is included in the 2014 edition of NASS’ *Common Coding Scenarios for Comprehensive Spine Care.*

**Author Disclosure**

P Saiz: Royalties: Zimmer (E); Consulting: Amedica (consulting fee $500/ hr); Speaking and/or Teaching Arrangements: Zimmer ($500/ hr), Amedica (D); Trips/Travel: Zimmer (Financial), Amedica (Financial); Board of Directors: Las Cruces Surgical Center (Nonfinancial).