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THE CODE

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The Difference Between Laminectomy and Laminotomy

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When a patient is found to have spinal stenosis with nerve impingement or "pinched nerve" that causes radiculopathy, which CPT code(s) should be used? I recently reviewed an Operative Report (OP Report) for a patient admitted with a right L4 to S1 stenosis with radiculopathy who underwent a right L4 to S1 minimally invasive decompression with foraminal decompression at right L4 to L5, right L5 to S1 and right S1 neural foraminal decompression. Per the OP Report: "Cranially and caudally at L4 and L5 for laminotomies and also L5 to S1 for laminotomies. We decompressed up to the pedicle face of L5 and also the pedicle face of S1. We decompressed the L4 to L5 foramen and L5 to S1 foramen on the right L4 to L5 interspace and also the L5 to S1 foramen and the S1 neuroforamen."

How would you code this? My gut instinct is that you would be tempted to Code 63030 because the word laminotomy is mentioned; but this is one of those cases where the diagnosis matters in how you pick the right CPT code.

Therefore, the difference is the purpose of the procedure: You should report 63030 when laminotomy is performed with a discectomy to treat spinal disc herniation using either an open procedure or under endoscopic assistance. By contrast, Code 63047 is used to report procedures performed for lateral recess stenosis, for example, caused by either ligamentum flavum hypertrophy or facet arthropathy.

By definition, laminotomy and laminectomy are both spinal decompression surgeries involving the lamina that covers and protects the spinal canal and the spinal cord. Laminotomy is the partial removal (or by making a larger opening) of the lamina. Laminectomy is the complete removal of the lamina. The problem is that providers tend to use the terms interchangeably and may not be aware of the coding impact.

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If you have an article or idea to share for *The Code*, please submit to:
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Each year's regrets are envelopes in which messages of hope are found for the new year.

John R. Dallas

The Difference Between Lamnectomy and Laminotomy *(Continued from page 1)*

When the laminectomy or laminotomy is performed primarily for herniated discs and the decompression procedure is not the primary reason, CPT Codes 63020/63030 are used. When the laminectomy or laminotomy is performed primarily for spinal stenosis, the decompression procedure is the primary focus and if only a minor discectomy or no discectomy is performed in the procedure, then Codes 60345 or 63047 would be used.

CPT Code 63030 is defined as laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; one interspace, lumbar (including open or endoscopically-assisted approach) and; Code 63047, laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s) (e.g., spinal or recess stenosis), single vertebral segment, lumbar. They seem the same other than the utilization of laminotomy or laminectomy and code 63030 includes "and/or excision of herniated intervertebral disc." CPT explains that laminectomy is a surgical procedure for treating spinal stenosis by relieving pressure on the spinal cord. The surgeon removes or trims the lamina to widen the spinal canal and create more space for the spinal cord and spinal nerves. So even if the surgeon uses the word laminotomy, he is still decompressing the nerve preventing radiculopathy.

Use CPT 63045 for cervical or CPT 63047 for lumbar, with additional levels billed with add-on Code +63048 unilateral or bilateral. In this procedure, the physician removes the spinous process. If the stenosis is central, the lamina may be removed out to the articular facets using a burr. If the compression is in the lateral recess, only half of the lamina is removed. The ligamentum flavum is peeled away from the dura. Nerve root canals are freed by additional resection of the facet, and compression is relieved by removal of any bony or tissue overgrowth around the foramen. Removal of the lamina, facets and bony tissue or overgrowths may be performed bilaterally, when indicated. Do not use the -RT, -LT or -50 modifiers with these codes.

So in the case above, the first listed diagnosis for this patient would be M46.07 Spinal stenosis, lumbosacral region.

ICD-9-CM	ICD-10-CM
724.4 Thoracic or lumbosacral neuritis or radiculitis, unspecified	M54.14 Radiculopathy, thoracic region M54.15 Radiculopathy, thoracolumbar region M54.16 Radiculopathy, lumbar region M54.17 Radiculopathy, lumbosacral region
724.02 Spinal stenosis, lumbar region, without neurogenic claudication	M48.036 Spinal stenosis, lumbar region M48.07 Spinal stenosis, lumbosacral region M99.23 Subluxation stenosis of neural canal of lumbar region M99.43 Osseous stenosis of neural canal of lumbar region M99.53 Intervertebral disc stenosis of neural canal of lumbar region M99.63 Osseous and subluxation stenosis of intervertebral foramina of lumbar region M99.73 Connective tissue and disc stenosis of intervertebral foramina of lumbar region
724.03 Spinal stenosis, lumbar region, with neurogenic claudication	M48.06 Spinal stenosis, lumbar region G95.29 Other cord compression

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The Difference Between Laminectomy and Laminotomy *(Continued from page 2)*

In coding the procedure, always remember the five steps in coding for spinal procedures which of course must be supported by the documentation found in the operative note.

1. Location: cervical, thoracic, lumbar or sacral.
2. Approach: anterior, posterior or lateral extra cavity or percutaneous.
3. Pathology: what was done and medical indication (decompression, discectomy, corpectomy and arthrodesis).
4. Instrumentation: rods, screws or cages.
5. Bone grafting: allograft or autograft.

Of course you also have to keep in mind that in a multiple-level decompression, the key to reporting is correlating the correct number to every root level being decompressed.

1. Location: lumbar and sacral.
2. Approach: posterior.
3. Pathology: decompression.

Since L4-5 and L5 to S1 were decompressed, the primary procedure would be CPT Code 63047 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral) with decompression of spinal cord, cauda equina and/or nerve root(s); single lumbar segment L4-5 and the secondary reported procedure would be CPT code 63048 Laminectomy, facetectomy and foraminotomy (unilateral or bilateral) with decompression of spinal cord, cauda equina and/or nerve root(s); each additional segment lumbar L5 to S1. Per CPT, "It would be appropriate to report 63047 for the procedure, even though it describes a partial laminectomy only of the left lamina and foramen. The purpose of the procedure is to relieve spinal stenosis, which is the primary use of 63047."

Always remember that lumbar decompression codes are driven by the diagnosis as opposed to the technique involved.

IT'S ALL ABOUT TIME!

Kim K. Capello
Administrative Assistant
MiraMed Global Services

Are there ever enough hours in the day? As a full-time wife, mother and employee I have often wished for just one more hour in each day. I found that my "Things To Do" were way longer than my "Just For Fun," which meant that I was all work and no play. After many years of trial and error I have found that the better the schedule, the better the life.

Positive thinking is a major part of this plan. Start each day with confidence and self-assuredness. If you adopt this attitude every morning you will be amazed at what all you can accomplish. Even if you want to shoot your alarm clock, you will fare much better if you bound out of your bed and have your first thought of the morning be: "Today is going to be fantastic." As you get ready for your day, which always includes at least one cup of coffee for me, make mental notes of everything you want to accomplish before day's end. After each of these items enter your mind, always follow up with this thought: "I will be able to handle this with no problem." Don't ever let a task go without being accompanied by a positive thought.

Pre-planning for the next day is always a time saver. I am not a list maker. I have often attempted but have often failed. I find that I either forget my list or leave off something very important. If you are a good list maker, then by all means, make that list. What works best for me is going over in my mind the night before all that I wish to accomplish the next day. Again, telling yourself that this will be a piece of cake is always advised.

Don't try and cram a large or daunting task in a short period of time. This often causes frustration and failure, and negates every positive thought you've had that day. Instead, begin work early on projects that need to be completed by a deadline. Procrastination is the death of a well-ordered day. The perfect example is this article. It will take me several days to write this as I have allotted myself only the time it will take to write a paragraph or two each day before the deadline. As I have started early, I will finish early. This allows me a proverbial pat on the back when the task is completed ahead of schedule.

Keeping focus is a must! As mentioned earlier, I am a wife, mother and employee and those jobs are completely and totally different. As an employee I keep my mind focused on the job at hand and do not let my thoughts wander to what I am going to prepare that night for dinner or what my child may need for a homework assignment that afternoon. There is plenty of time for those thoughts on my drive home from work. Getting the job done at work leaves my mind free of worries or concerns so that I can focus on family time at the end of the work day.

These are just a few suggestions to plan a well-ordered day. After incorporating these ideas into your own life, I hope that not only will you find that your days are free of stress, but that you will be amazed at all you have accomplished!

Anesthesia: An Education

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Brief History:

Did you know that surgery became one of the greatest fears of mankind? It was in the 18th century when surgery had increased in practice due to unknown diseases and conditions that took away countless lives. Unfortunately, no one wanted to undergo surgery due to its excruciating pain. Before anesthesia was introduced there were tremendous efforts done to deliver unconsciousness to a patient. Some surgeons used opium and marijuana, while others used alcohol concoctions to knock out their patients. One technique that bewildered me was that early practitioners even considered physically giving a blow to the patient's head to render unconsciousness. We all perceive that giving a blow to a patient's head has detrimental effects on our brain. So the pursuit for an effective anesthetic agent persevered.

During the 18th century, the discovery of nitrous oxide (laughing gas) by English scientist Joseph Priestly brought to medicine a drug that could alleviate pain. Other researchers introduced carbon dioxide which also has similar effects with nitrous oxide. However, these gases were not potent enough.

At last, in the year 1846, the fear of pain during surgery was cast out when a Boston dentist, William Thomas Green Morton, used another gas called sulfuric ether. He had experimented on various animals and some dental patients. On October 16, 1846, Morton and a renowned surgeon, John Collins, performed an operation to remove a tumor from a patient's neck. The operation was successful and the surgery was painless. This was the first time he utilized impervious and cogent "anesthesia."

In every milestone and accomplishment of medicine, anesthesia has become the most used; and the potential to harm humans is very minimal.

Are You a Good Auditor?

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Direction: All Medical Coding staffs are encouraged to send their correct codes based from the case provided. They must present their codes along with coding clinics, coding guidelines or any coding references applicable for any codes that are to be **Added**, **Deleted** or **Revised**. Answers to this scenario will be published in our next issue.

An eight-year-old female child born with myelomeningocele spina bifida has previously undergone multiple procedures to cover the defect at the lumbar portion of her spine. One of these procedures was an insertion of a ventriculoperitoneal shunt to drain the cerebrospinal fluid accumulation from her hydrocephalus.

She is admitted today through the emergency department with a plugged shunt. The child is rushed to the operating room for removal of the occlusion in her shunt. In the surgical suite, irrigation was attempted several times but was unsuccessful due to the dense thrombus adhered to the shunt. Therefore, the surgeon decided to remove the shunt and replace it with a new ventriculoperitoneal shunt using a percutaneous approach. The surgery was uneventful and the patient was taken to the recovery room in good condition.

Preoperative diagnosis: Plugged ventriculoperitoneal shunt.

Postoperative diagnosis: Plugged shunt due to thrombus.

	ICD-10-CM
Principal Diagnosis	Q05.9
Secondary Diagnosis	T85.86XA
Secondary Diagnosis	Z98.5
	ICD-10-PCS
Principal Diagnosis	00163K4

Correct Answer from Previous Case Scenario:

	ICD-10-CM	Audit Remark
Principal Diagnosis	N17.0	Assign N17.0 as the principal diagnosis. Patient was admitted with nausea, vomiting and cramping and after study, was found to be due to acute kidney failure/injury. As per ICD-10-CM index pathway, Failure, failed → renal → acute → with tubular necrosis = N17.0
Secondary Diagnosis	N18.2	Revise code to N18.3 for a diagnosis of chronic renal failure, stage 2.
Secondary Diagnosis	I12.9	Revise code to I12.9 for documentation of hypertension with kidney involvement. ICD-10-CM presumes a cause-and-effect relationship and classifies chronic kidney disease with hypertension as hypertensive chronic kidney disease.
Secondary Diagnosis	E86.0	Add code for documentation of dehydration which was managed by aggressive IV fluid therapy.
Secondary Diagnosis	E87.6	Add code for documentation of hypokalemia due to Lasix.
Secondary Diagnosis	T50.1X5A	Add code for the adverse effect of Lasix causing hypokalemia. As per ICD-10-CM guidelines, when coding an adverse effect of a drug that has been correctly prescribed and properly administered, assign the appropriate code for the nature of the adverse effect followed by the appropriate code for the adverse effect of the drug (T36-T50). The code for the drug should have a 5th or 6th character "5" (for example T36.0X5-) Examples of the nature of an adverse effect are tachycardia, delirium, gastrointestinal hemorrhaging, vomiting, hypokalemia, hepatitis, renal failure or respiratory failure.

Stars of MiraMed

This month's Star is …

John Felix Labay
Assistant Manager, Operations
MiraMed Philippines Group, LLC - Philippine Branch

MiraMed's brightest shining star this month is John Felix Labay.

John Felix Labay, more commonly known as Lix, is one of the pioneer coders of MiraMed Philippines, Group, LLC – Philippine Branch, having been with the company since 2011.

Lix is a graduate with a Bachelor of Science in Nursing in Our Lady of Fatima University, Valenzuela, Philippines. He passed his licensure exam in nursing and holds a Certified Coding Specialist (CCS) certification from AHIMA. His coding experience varies from outpatient coding: ancillary services, emergency room services, surgery, observation and anesthesia services. He has continued to enhance his skills in transitioning large outpatient projects.

Lix was recently promoted to Assistant Manager in Operations. In assuming his new leadership role, he will be responsible for meeting or exceeding operational performance, productivity and quality of all coding projects.

John Felix Labay

Stop thinking about the time passed by. Every moment is a new beginning. Devote your time in making the coming moment beautiful. With your endeavor, coming moments may be the most valuable treasure of life, the only point is to remain alert and committed for every moment.

Dr. Anil Kumar Sinha

Coding Case Scenario

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Direction: Code for ICD-10-CM Diagnosis and Procedure. Answers to this scenario will be published in our next issue.

A 25-year-old alcohol dependent male is admitted today from the emergency department due to upper back and neck pain. Based on the emergency physician's note, the patient was intoxicated when he arrived at the unit and was given a dose of Thiamine and Ativan. His blood alcohol level on admission was 85mg/100ml. As per past medical history, the patient suffered a fracture to his left shoulder five years ago when he was accidentally shot with a gun at a local firing range. He was then admitted at a nearby hospital where he underwent repair and fixation of his fracture. Current imaging results did not show any acute signs of shoulder fracture and the patient was discharged once pain was controlled.

Final diagnosis: Traumatic arthritis due to previous shoulder fracture

Correct Answer from Previous Case Scenario:

	ICD-10-CM	Coding Remark
Principal Diagnosis	M16.11	Assign code as principal diagnosis. Patient came in for right hip pain and swelling. Studies showed that it was caused by primary osteoarthritis for which the patient underwent surgery.
	ICD-10-PCS	**Coding Remark**
Principal Procedure	0SR9029	Report code for the total hip replacement. In a total hip replacement, both the damaged femoral head and the acetabular surface are removed and replaced with synthetic substitutes. In the operative report, the surgeon mentioned that both components were replaced with a metal on polyethylene substitute. Assign 7th character 9 as the joint replacement was done with the use of cement. As per ICD-10-PCS, the root operation ***replacement*** is defined as putting in or on biological or synthetic material that physically takes the place and/or function of all or a portion of a body part. The body part may have been taken out or replaced, or may be taken out, physically eradicated or rendered nonfunctional during the replacement procedure.