Chapter VIII
Endocrine and Nervous
Eye, Ear
CPT-4 60000 - 69999

A. Introduction

The section of CPT-4 codes 60000-69979 includes surgical procedures involving the endocrine and nervous systems, procedures involving eye, ocular adnexa, and ear. Because of the number of procedures involved, these sections are subdivided.

In keeping with the general policies introduced earlier, most issues of correct coding can be identified and addressed by reviewing the CPT-4 code definition for the appropriate service.

As a general guideline, when a component service, which is described by a CPT-4 code is necessary to accomplish a more comprehensive service, the component service is assumed to be included in the more comprehensive service; therefore only the more comprehensive service which was performed can be coded.

B. Endocrine and Nervous

1. A burr hole is often necessary in anticipation for intracranial surgery (craniotomy, craniectomy), either to gain access to intracranial contents, to alleviate pressure in anticipation of further surgery or to place an intracranial pressure monitoring device as part of the surgery. As these services are integral to the performance of the subsequent services, codes representing these services are not to be separately billed.

In addition, taps, punctures or burr holes accompanied by drainage procedures (e.g., hematoma, abscess, cyst, etc.) followed by other procedures, are not separately billed. Many intracranial procedures include bone grafts by CPT-4 definition and should not be billed separately.

2. Biopsies performed in the course of CNS surgery should not be billed as separate procedures.

3. Craniotomies and craniectomies always include a general exploration of the accessible field; accordingly it is not appropriate to code an exploratory surgery (e.g. CPT-4 codes 61304, 61305) when another procedure is performed at the same session.

4. When services are performed at the same session, but represent different types of services or are being performed at different sites (see example below), the "DS" modifier should be added. This modifier is attached to the CPT-4 code describing the apparent component code; it indicates this service was a distinct separate service and should not be "bundled" into the more comprehensive code.

Example: A patient with an open head injury and a contra-coup subdural hematoma requires a craniectomy for the open head injury and a burr hole drainage on the opposite side for the subdural hematoma. The performance of a burr hole in anticipation of the craniectomy would be considered part of the craniectomy. However, the contralateral burr hole would be considered a separate service not integral to the craniectomy. To correctly code the burr hole for the contralateral subdural hematoma and the more comprehensive service (the craniectomy), the burr hole should be coded with the appropriate modifier (DS, RT, LT, etc.). In this example the correct coding would be CPT-4 codes 61304 with 1 unit of service and 61154-51 DS with 1 unit of service.

5. The use of general intravascular access devices (e.g., intravenous lines, intraarterial lines, etc.), cardiac monitoring, oximetry, laboratory sample procurement and other routine monitoring for patient safety has been addressed in previous policy for general or monitored anesthesia care (MAC). These policies also apply for procedures that do not require the presence of an anesthesiologist /anesthetist. As an example, if a physician is performing a spinal puncture for intrathecal injection administers an anxiolytic agent, but the procedure does not require the presence of an anesthesiologist/anesthetist, the vascular access and any appropriate monitoring necessary is considered part of the spinal puncture procedure and is not to be billed separately.

6. When a spinal puncture is performed, the local anesthesia necessary to perform the spinal puncture is included in the procedure itself. It is recognized that frequently the purpose of the puncture is to administer local anesthesia to a specific site (e.g., face, paravertebral nerve, etc.); this is generally the primary service and should be billed accordingly. In comparison, the submission of nerve block or facet block codes for local anesthesia for a diagnostic or therapeutic lumbar puncture is inappropriate. In this example there is no independent medical necessity of the local anesthetic except for the lumbar puncture and separate codes are not to be billed.

7. The appropriate code for the open treatment of median nerve compression at the wrist (carpal tunnel syndrome) is CPT-4 code 64721; according to CPT-4 manual definition, this includes the open release of the transverse carpal ligament. Additionally, if an arthroscopic procedure (CPT-4 code 29848) fails and must be followed by an open procedure (CPT-4 code 64721), only the open, or successful, procedure can be billed.

8. Nerve repairs by suture or neurorrhaphies (CPT-4 codes 64831-64876) include suture and anastomosis of nerves when performed to correct traumatic injury to or anastomosis of nerves which are proximally associated (e.g., facial-spinal, facial-hypoglossal, etc.). When neurorrhaphy is performed in conjunction with a nerve graft (CPT-4 codes 64885-64907), neuroplasty, transections, excisions, neurectomies, excision of neuroma, etc., a separate service is not billed for the primary nerve suture.

9. In the same area of the cortex, neurostimulator electrodes can be implanted in only one fashion; accordingly, the CPT-4 code 61850 (burr hole) is included in the CPT-4 code 61860 (craniectomy). Similarly, the CPT-4 code 61855 (burr hole) is included in CPT-4 code 61865 (craniectomy). Codes describing craniotomy procedures (e.g., CPT-4 codes 62100-62121) are generally bundled into craniectomy codes (e.g., CPT-4 codes 61860-61875).

10. Because procedures necessary to accomplish a more comprehensive procedure are included in the comprehensive procedure, CPT-4 codes such as 62274-62279 (injection of anesthetic) are included in the codes describing more invasive back procedures. Additionally, in the same site, codes describing laminotomy procedures are included in laminectomy codes. CPT-4 codes 22100-22114 (partial resection

of vertebral components) represent distinct procedures, and, accordingly, are not billed with laminotomy/laminectomy procedures unless the services are performed as described in the codes. Furthermore, the group of CPT-4 codes 22100-22114, describing vertebral body excision, are not to be billed with vertebral corpectomy (CPT-4 codes 63081-63091).

11. CPT-4 codes describing the performance of a tracheostomy are not to be billed with the CPT-4 code 61576 (transoral approach to skull base including tracheostomy) as this service is included in the descriptor for the code.

C. Ophthalmology

1. When a subconjunctival injection (e.g., CPT-4 code 68200) with a local anesthetic is performed as part of a more extensive anesthetic procedure (e.g., peribulbar or retrobulbar block), a separate service for this procedure is not to be billed. This is a routine part of the anesthetic procedure and does not represent a separate service.

2. When the removal of a foreign body from the lens or anterior chamber requires the removal of the lens, a separate service for removal of a cataract is not billed. The reason for the surgery in this case is to remove a foreign body and removal of the lens is integral to accomplish the foreign body removal.

3. Iridectomy, trabeculectomy, and anterior vitrectomy may be performed in conjunction with cataract removal. When an iridectomy is performed in order to accomplish the cataract extraction, it is an integral part of the procedure, it does not represent a separate service, and is not separately billed. Similarly, the minimal vitrectomy necessary for routine cataract extraction is not to be separately billed unless it is medically necessary for a different diagnosis. If a trabeculectomy is performed as part of a cataract removal, it is not separately billed unless performed for a different reason, and performed because it is medically necessary (e.g., for glaucoma as a comorbid condition). The codes describing iridectomies, trabeculectomies, and anterior vitrectomies, when performed with a cataract extraction under a separate diagnosis, must be billed with the "DS" modifier. This indicates that the procedure was performed as a different service for a separate situation. The medical record should reflect the medical necessity

of the service if separately billed. For example, if a patient presents with a cataract and has evidence of glaucoma, (i.e., elevated intraocular pressure preoperatively) and a trabeculectomy would represent an appropriate treatment for glaucoma, a separate service for the trabeculectomy would be appropriately billed. Performance of a trabeculectomy as a preventative service for an expected transient increase in intraocular pressure postoperatively, without other evidence for glaucoma, is not to be separately billed.

4. The CPT-4 code 66250 is a general code describing revision or repair of an anterior segment operative wound. Accordingly, it cannot be billed with other anterior segment surgical procedure codes (e.g., CPT-4 codes 66500-66999).

5. All cataract removals are mutually exclusive of one another when performed on the same eye.

6. Retinal procedures (e.g., CPT-4 codes 67101-67228) include vitreous procedures (e.g., CPT-4 codes 67005-67040) as part of the comprehensive procedure.

7. CPT-4 codes 67900-67924 (repair of brow ptosis, blepharoptosis, lid retraction) include CPT-4 codes 15820-15823 (blepharoplasty) as part of the total service.

8. CPT-4 code 68440 (snip incision of lacrimal punctum) represents an integral part of lacrimal surgeries (CPT-4 codes 68400-68850) and should not be billed as a separate procedure.

9. CPT-4 codes 68020-68200 (incision, drainage, excision of the conjunctiva) are included in all conjunctivoplasties (CPT-4 codes 68320-68399).

10. CPT-4 code 67950 (canthoplasty) is included in repair procedures such as blepharoplasties (CPT-4 codes 67917, 67924, 67961, 67966).

11. Correction of lid retraction (CPT-4 code 67911) includes full thickness graft (e.g., CPT-4 code 15260) as part of the total service performed.

12. Repair of entropion/ectropion (e.g., CPT-4 codes 67917 and

67924) include the graft procedures that may be needed to complete the major procedure. These grafts are not to be separately billed.

13. In the circumstance that it is medically necessary and reasonable to inject sclerosing agents in the same session as surgery to correct glaucoma, the service is included in the glaucoma surgery. Accordingly, codes such as CPT-4 codes 67500, 67515, and 68200 for injection of sclerosing agents (e.g., 5-FU, HCPCS/CPT-4 code J9190) should not be billed with pressure reducing or glaucoma procedures.

D. Auditory System

1. When a mastoidectomy is included in the description of an auditory procedure (e.g., CPT-4 codes 69530, 69802, 69910), separate codes describing mastoidectomy are not billed.

2. Myringotomies (e.g., CPT-4 codes 69420 and 69421) are included in tympanoplasties and tympanostomies.