

MUSCULOSKELETAL SPINE

Date of origin: Oct. 8, 2024

Review dates: None yet recorded

APPLIES TO

- Commercial
- Medicare
- Medicaid

DEFINITION

There are multiple procedures that could be done on the spine. This policy addresses bundling, when/how to report add on codes and documentation guidelines for spine procedures.

MEDICAL POLICY

[Spine Procedures](#) (#91581)

POLICY SPECIFIC INFORMATION**Bundling guidelines**

The following CPT codes are bundled into the main spine procedure:

- Bone marrow aspiration procedures (38220,38230,38230,38232) are always included and not paid separately when done with a spinal osteotomy, vertebral fracture repair, spinal arthrodesis, spinal fusion, laminectomy, spinal decompression, vertebral corpectomy
- Spinal exploration (22830) when done in the same anatomic area as another spinal procedure
- Intraoperative neurophysiology testing (95940,95941, G0453) when done by the same physician during the spinal procedure
- Neurophysiology testing (95822,95960,95868,95870,99507-95913,92925-95937)
- Manipulation of the spine under anesthesia (22505)
- Anterior instrumentation (22845-22847) when used to anchor an interbody biomechanical device (22853-22854) to the intervertebral disc space. (However, these codes can be reported if the instrumentation (plate or rod etc.) is unrelated to anchoring the device.)
- Removing instrumentation (22849, 22850, 22852) at the same site of reinserting instrumentation

Co-surgeon services must be documented according to guidelines outlined in [our modifier 62 guidelines](#).

- Documentation may be required when co-surgeon service CPT has a status indicator to indicate co-surgeon is payable only with supporting documentation. We align to CMS status indicator for co-surgeon so please refer to CMS PFS to confirm if medical records may be required.

Add on codes

Spinal CPT codes are grouped by “families” of codes, the families are based on the level of the spine (i.e., cervical, thoracic and lumbar). Each family has its own group of CPT codes. One code is a primary code, and each additional level is reported with an add on code.

- When one skin incision is made and the surgery is done on multiple spinal levels, the primary CPT code of the level that started the procedure should be reported. For each additional level, the add on code should be reported regardless of family of codes.
- When more than one skin incision is made and the surgery is done at multiple spinal levels, the primary procedure for that family is reported. For each additional level, the add on code for that family is reported.

Bone grafts (20930, 20931, 20936, 20937, 20938) are add on codes. Note that placing the bone graft is included in the arthrodesis/fusion codes.

Documentation requirements

While not an all-inclusive listing, the medical record should clearly document:

- Location: cervical, thoracic, lumbar or sacral
- The approach, anterior, posterior, or lateral extracavity or percutaneous
- What was done and medical indication (decompression, disc-ectomy, corpectomy, arthrodesis)
- Type of bone graft: allograft or autograft
- Type of Instrumentation: rods, screws or cages
- If implants were used and the type

Modifiers

- **59**: Distinct procedural service
- **XS**: Separate structure, a service that is distinct because it was performed on a separate organ/structure
- **62**: Co-surgeon (Note: Don't report modifier 62 on add codes.)

Resources

[Medicare NCCI Policy Manual – Chapter IV – Surgery: Musculoskeletal System \(CMS\)](#)

CHANGE / REVIEW HISTORY

Date	Revisions made