POCKET GUIDE TO SPINE SURGERY DOCUMENTATION

General Principles of Spine Surgery Documentation

The principles of documentation listed below are applicable to spinal surgery documentation for both the physician and hospital setting.

» Patient’s name, BMI, medical record number, date of operation

» Failure of conservative treatments

» Planned procedure

» Co-surgeons and/or assistants

» Clinical findings during the procedure to include any intraoperative complications

» Clinical findings during the procedure that may have prolonged or increased level of difficulty

» Radiological findings

» Patient’s condition at the end of surgery

» Estimated blood loss

» Summary of the procedure(s) performed

» Pre and post-operative diagnoses supporting medical necessity of the procedure

Documentation Components for Common Spinal Surgeries

Fusion

» Operative approach used (e.g., anterior, posterior, transforaminal)

» Area of spine addressed during surgery (cervical, lumbar, thoracic)

» Number of spine levels involved in surgery (e.g., L1–L5)

» Type of fusion (interbody or posterolateral)

» Type of bone graft used, if applicable (e.g., autogenous, allograft, morselized, structural)

» Insertion of interbody construct, if applicable (e.g., PEEK, titanium cage)

» Location and approach of spinal instrumentation (e.g., anterior, posterior)

» Type of spinal instrumentation used (e.g., rod, screws, plates)

» Number of levels instrumented/points of fixation (segmental, non-segmental)

» Hardware removal and reinsertion, if applicable

» Exploration of previous spinal fusion, if applicable

» Discectomy performed to prepare the interspace for fusion or for decompression of nerve root, if applicable

» Additional fusion performed during operative session

Discectomy

» Condition of disc

» Area of spine surgery (e.g., cervical, lumbar)

» Number of interspaces affected (e.g., L1–L5)

» Approach (anterior, posterior)

Laminectomy

» Unilateral or bilateral

» Area of spine surgery (e.g., cervical, lumbar)

» Re-exploration, if applicable

» Additional procedures performed (e.g., facetectomy, foraminotomy)

Arthroplasty

» Operative approach used (e.g., anterior)

» Area of spine addressed during surgery (e.g., cervical)

» Number of interspaces affected (e.g., C5–C6)

» Discectomy performed to prepare interspace or for decompression of the nerve root, if applicable

» Placement of arthroplasty device
Complications and Comorbidities

The Centers for Medicare & Medicaid Services (CMS) complication and comorbidity structure has two categories of codes, Major Complications and Comorbidities (MCC) and Complications and Comorbidities (CC). The tiers are based on the severity of the condition and the impact it would have on resource consumption. The assignment of a secondary diagnosis from the CC or MCC list will affect the MS-DRG assignment in most cases. Documentation is very important and any condition that the patient has should be clearly identified in the medical record. The CMS website provides lists of all MCC/CC codes.

Common Reasons for Denial

» Incorrect diagnosis and/or procedure code(s)
» Lack of prior authorization or pre-certification
» Not meeting medical necessity according to the payers coverage criteria
» Not documenting conservative therapies
» Incomplete progress notes (both office and hospital)

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Medtronic
Spinal and Biologics Business
Worldwide Headquarters
2600 Sofamor Danek Drive
Memphis, TN 38132
1800 Pyramid Place
Memphis, TN 38132

(901) 396-3133
(800) 876-3133
Customer Service: (800) 933-2635

For more information go to www.myspinetools.com
For additional coding information contact the Reimbursement Support Center at (866) 743-1220.