Diagnosis Code for Keratoacanthoma

Question:
What diagnosis code and type of excision of lesion CPT code should I use for a keratoacanthoma? Some people say these are benign lesions while I’ve heard others say they are malignant. I’m confused.

Answer:
Actually the ICD-9-CM coding system states that a keratoacanthoma is coded as 238.2 (Neoplasm of uncertain behavior of other and unspecified sites and tissues, skin)—an uncertain behavior neoplasm. Therefore, you will use an excision of benign CPT code (114xx) code for the lesion removal procedure.

Catheterization and EVAR

Question:
How do you report two catheters placed in the aorta from bilateral femoral open exposures in an EVAR?

Answer:
If catheters are advanced into the aorta through bilateral femoral exposures, 36200-50 would be reported.
Endoscopic Zenker’s Diverticulectomy

Question:

I can’t find a code for this procedure. I found 43130 (Diverticulectomy of hypopharynx or esophagus, with or without myotomy; cervical approach) but it doesn’t say endoscopic so I’m not sure if I should use it.

Answer:

You are right to be cautious! CPT 43130 requires a skin incision so it should not be used for an endoscopic, or transoronal, procedure. You should use an unlisted code, 43499 (Unlisted procedure, esophagus) for an endoscopic resection of a Zenker’s diverticulum.

Modifier 80 vs. 62

Question:

I have a question concerning modifier 80. According to Medicare this modifier should be used when 2 different specialties are performing surgery on the same patient but not doing the same procedure. Modifier 62 can be used for 2 different specialties when performing the same procedure but also for the same specialty. Am I explaining this correctly?

Answer:

Modifier 80 is appended to the assistant surgeon’s codes, which are usually the same codes as the primary surgeon’s,
when that surgeon is assisting the other. Typically the assistant is of the same specialty but sometimes other specialty physicians (e.g., general surgeon, family practice) may assist the primary surgeon. The primary surgeon is doing all the activities described by the CPT code(s) billed — the assistant surgeon is just helping out. The assistant surgeon does not dictate an operative report. Example: partner neurosurgeon assists on a discectomy (primary surgeon bills 63030, assistant bills 63030-80).

Modifier 62 represents co-surgery between two surgeons (Medicare says they must be of different specialties even though CPT does not) when the two surgeons share the activities described by a single CPT code. Two surgeons are necessary usually when neither surgeon performs the single CPT code on his/her own. Both surgeons dictate an operative report and both have pre and postop responsibilities. Example: ENT and neurosurgeon do a trans-sphenoidal/transnasal approach to excision of a pituitary tumor (both ENT and NS bill 61548-62).

*Intraoperative Consults: Is This Consultation Separately Reportable Or Not?*

**February 21, 2013**

**Question:**

Our General Surgeon was called into an OB/GYN case to repair a small incidental enterotommy that occurred during an OB/GYN
procedure.

Can our surgeon report an intraoperative consultation service in addition to the surgical procedure to repair the enterotomy?

**Answer:**

Thanks for your inquiry. In the scenario described the intraoperative consultation service is not separately reportable as there is no request for consultation. The surgeon reports the appropriate repair or resection CPT code based on the surgical procedure performed.

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**Nasal Fracture Repair vs. Rhinoplasty**

**Question:**

I did an open treatment of a nasal fracture repair and septoplasty on a patient who was in a bar fight two years ago on spring break and had his nose broken. He now has nasal airway obstruction and deviated nasal septum as well as displaced nasal bones. I billed 21335 (Open treatment of nasal fracture; with concomitant open treatment of fractured septum) but the insurance company denied it. Did I do something wrong or should I appeal it by sending in pictures?

**Answer:**

The nasal fracture treatment codes (e.g., 21310-21337) are to be used when you are treating an acute fracture, not an old or healed fracture. The rhinoplasty codes (e.g., 30420) are more appropriate when you are treating a healed fracture. You can try to appeal the denial but we suspect the insurance company
will not pay for the procedure because they consider it to be “cosmetic.”

Cervical and Intracranial Angiograms In 2013. Can I Bill Both?

**Question:**

I am confused about the new cervicocerebral diagnostic angiogram codes. If I advance the catheter to the right common carotid and perform a cervical carotid angiogram and an intracranial angiogram, do I code both 36222 and 36223 since I did a cervical and intracranial study?

**Answer:**

The new 2013 guidelines for cervicocerebral diagnostic imaging follow a hierarchy of complexity. For the carotid circulation, 36222, cervical imaging, is bundled into 36223, intracranial imaging, the more “complex” study in the hierarchy. So in your scenario, only 36223 would be reported. Also, remember that all cervicocerebral diagnostic imaging codes also include catheterization. For more help coding the 2013 cervicocerebral diagnostic imaging codes see KZA’s GPS for Endovascular Coding which describe the accurate coding for these new codes and much more.
**Botox of the Parotid Gland**

**Question:**
What is the code for injection of Botox the parotid for hyperhidrosis or to control excessive oral secretions?

**Answer:**
The code you are looking for is 64611 (Chemodenervation of parotid and submandibular salivary glands, bilateral). The code assumes you are doing at least four injections: right parotid, right submandibular, left parotid and left submandibular). Report 64611-52 (reduced services modifier) if you do less than four injections.

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**Postop Wound Debridement**

**Question:**
My neurosurgeon did posterior lumbar decompression/fusion then 2 weeks post-op had to return to OR to treat a wound infection/abscess by debridement and wound washout. He also checked the fusion to make sure everything was ok which it was. I was going to use 10180 for this procedure but my doctor said that didn’t pay enough for what he did. Do you have any suggestions for me?

**Answer:**
It sounds like your neurosurgeon is doing 22015 (Incision and drainage, open, of deep abscess (subfascial), posterior spine; lumbar, sacral, or lumbosacral) rather than 10180 (Incision and drainage, complex, postoperative wound infection).
The I&D code, 10180, is used when the wound infection involves tissue down to the fascia while 22015 is used when the wound is opened below the fascia. Since the neurosurgeon says he checked the fusion that leads us to believe the fascia was opened and 22015 might be the more accurate code. You’ll want to ask the neurosurgeon if 22015 is what he did and make sure his documentation supports it.