Central Line Placement Imaging. What’s Reportable?

**Question:**
I inserted a central line and used both ultrasound and fluoroscopic guidance for placement. Can I report this?

**Answer:**
Per CPT Assistant, January 2011, if you do both, document each and keep a permanent image of both, you may report both 76937 (ultrasound guidance for vascular access) for the ultrasound imaging and 77001 (fluoroscopic guidance for central venous access device placement).

Endoscopic Concha Bullosa Resection with Other Sinus Procedures

**Question:**
I did endoscopic sinus surgery (maxillary antrostomies and anterior ethmoidectomies) as well as endoscopic bilateral resection of concha bullosa. I told my biller to submit the following codes for me: 31254-50, 31256-50, 31240-50. My biller says the concha bullosa resection code is “bundled” into the other codes and she won’t submit the codes. I say it is a separate procedure and should be billed. What do you think?
We agree with you. The work of an endoscopic concha bullosa resection (31240) is not included in the endoscopic maxillary sinus or ethmoid sinus surgery codes (31256, 31267, 31254, 31255) and may be separately reported. There is no CCI edit that bundles 31240 into the other codes. However, some payors may have their own software that does bundle 31240 so you may need to append modifier 59 to 31240 to show this procedure was distinctly separate from other procedures performed at the same operative session.

Calculating Size for Codes

Question:
I’m new to coding. My doctor and I have a disagreement on how to calculate the size for the adjacent tissue transfer codes (140xxx). The doctor says there was a 16.5 cm by 7 cm wound that he did an adjacent tissue transfer to close. I think I should use a code for a 23.5 square centimeter code because 16.5 plus 7 equals 23.5. My physician said we are to multiply the numbers so it would be 115.5 square centimeters. Who is right?

Answer:
Your physician is right. Area is measured in square centimeters and obtained by multiplying the length times the width of the wound. You will use CPT 14301 for the first 60 square centimeters (sq cm), add-on code 14302 for the next 30 sq cm and +14302-59 for the remaining 25.5 sq cm. Alternatively, you may report 14301 and 14302 x 2 units if you know that the payor will recognize more than 1 in the units box and reimburse the appropriate amount.
RVUs

**Question:**

What is the difference between a facility versus non-facility on Medicare’s fee schedule?

**Answer:**

The difference refers to the place of service where the activity/CPT code was performed. Medicare’s physician fee schedule reimburses differently for a CPT code performed in a facility (e.g., hospital) differently than it does a non-facility (physician office). Generally, the reimbursement is higher in the non-facility setting because the physician incurs the practice expense for providing the service.

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Ultrasound Services in the Hospital

**May 30, 2013**

**Question:**

Our surgeon performs US biopsies in the office and in the ASC. When performed in the office, we report 76942 to the payor. I am told when we perform the same procedure in the ASC, I have to append a modifier 26 to CPT code 76942. I don’t understand why.

**Answer:**
CPT code 76942 is considered to be a global radiology code. The payment for this procedure includes payment for the professional component, (modifier 26) and the technical component (TC modifier). You may report the global radiology code in your office because you own the equipment and the surgeon performs the professional interpretation and documents a separate report. When you perform the same service in the ASC, you must append the modifier 26, (76942-26) to indicate the surgeon is only reporting the service associated with the professional interpretation because you do not own the equipment. The facility reports the same code with a TC modifier as appropriate.

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**Excision of Melanoma**

**Question:**

I’ve heard differing advice and hope you will clear up something for me. What CPT code do we use for excision of a melanoma? I’ve heard people say to use the excision of skin lesion code, 116xx, and others tell me to use the soft tissue or radical excision of tumor codes such as 21556 or 21557?

**Answer:**

Good question. CPT says that a melanoma is a cutaneous lesion and, therefore, an excision/resection should be reported using the excision of malignant skin lesion codes such as the 116xx codes. It is not accurate to report an excision of soft tissue tumor code (e.g., 21555, 21556) or radical resection of soft tissue tumor (e.g., 21557) code for excision of a melanoma.
AV Graft Coding: Basilic Vein Transposition In 2 Stages

Question:
I do a basilic vein transposition for AV access in two stages. The code 36819 is for doing the procedure all in the same time. How do I report it in 2 stages?

Answer:
To report this procedure in 2 stages report, 36821 for stage I, the direct basilic vein to brachial artery transposition, since it is essentially performing an AV fistula. For Stage II, the superficialization of the patent brachio-basilic vein fistula, report an AV graft revision, 36832. Report 36832 with a 58 modifier since 36821 has a 90 day global. Remember to document in the operative note for 36821 that a staged procedure is planned.

How Do I Calculate The Size of An Adjacent Tissue Transfer Code

Question:
I am inquiring how to calculate the size of a wound to determine which adjacent tissue transfer code should be
The surgeon excised a dematofibrosarcoma protuberans of the chest that resulted in a primary and secondary defect documented as a 16.5 x 7. The secondary defect was closed primarily. My surgeon says the size of the defect is 115.5 sq cm and I am saying the wound size is 23.5 sq cm. Who is right?

**Answer:**

Your surgeon is right. To report adjacent tissue transfers, the wound size is based on square centimeters (sq cm). To determine the total size of the wound defect, the defect size is determined by first multiplying the length times the width of the primary and secondary defects and adding both of them to determine the total defect size when the secondary defect is closed primarily as noted. Report CPT 14301 for the first 60 square centimeters (sq cm), add-on code 14302 for the next 30 sq cm and +14302-59 for the remaining 25.5 sq cm. Alternatively, you may report 14301 and 14302 x 2 units if you know that the payor will recognize more than 1 in the units box and reimburse the appropriate amount. Please note, some payors may not require the modifier 59 on the second add-on code.

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**Excision of a Sebaceous Cyst**

**Question:**
What diagnosis code do we use for a sebaceous cyst – is it a “benign neoplasm”?

**Answer:**
Actually, a sebaceous cyst has its own diagnosis code, 706.2, so use of a neoplasm code is not accurate. You’ll use the excision of benign skin lesion CPT code, 114xx, to report the surgical procedure. Remember, many payors do not reimburse for
excision of a sebaceous cyst as it may be considered a "cosmetic" procedure.

**Fluoroscopy**

**Question:**

Can I bill a fluoroscopy code such as 77002-26 when I do a transsphenoidal pituitary tumor removal? Or, how about billing 77003-26 when I do a discectomy?

**Answer:**

Actually, use of fluoroscopy for localization or to help you perform a surgical procedure is included in the global surgical package for that surgical CPT code (e.g., 61548, 63030) and not separately billable by the surgeon.