Billing An Arch Angiogram and Cerebral Angiograms

Question:
How do I bill for bilateral internal carotid angiograms (from an internal carotid catheter position) and an arch angiogram?

Answer:

The new cervicocerebral angiogram codes, both the carotid codes (36222-36224) and the vertebral codes (36225-36226), include and arch angiogram (36221). The only time an arch angiogram is reported is when it’s performed without one of the carotid or vertebral imaging codes.

Nasal Endoscopy

Question:
I did a nasal endoscopy (31231) and adenoidectomy (42830) on a young child. The insurance company denied the nasal endoscopy but paid on the adenoidectomy. I wouldn’t think these two codes are bundled. What do you think?

Answer:

To answer your question, we requested the operative report from you to see what the documentation says. Your note lists “adenoid hypertrophy” as a pre- and post-operative diagnosis. The body of the operative report states: “The nasal endoscope was placed down into the posterior nasopharynx and there was a large adenoid pad. There was clear mucoid fluid around the
bilateral nasal cavities.” Then the operative report describes the adenoidectomy procedure.

It appears that the nasal endoscopy was a diagnostic procedure to confirm the pre-operative diagnosis of adenoid hypertrophy. The diagnostic nasal endoscopy procedure was followed by a more definitive surgical procedure (adenoidectomy). Therefore, only the definitive procedure – the adenoidectomy – is reported. It would not be appropriate to bill for the nasal endoscopy (31231) in this scenario.

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**Placement of a Stent with Aneurysm Coiling**

**Question:**

When I do a stent-assisted aneurysm coiling procedure, can I bill both 61635 and 61624?

**Answer:**

No, report only 61624. A stent is used in conjunction with coiling an aneurysm at the same operative session, then report only 61624.

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**New or Established Patient**
Visit?

October 31, 2013

Question:

Two of our surgeons (breast) are hospital employed and work within the Breast Center. Sometimes we see patients as direct consultations from the primary care physician and report consultations as appropriate. Our question is do we bill a consultation or a new patient visit when the patient is sent to the Breast Center after a mammogram and biopsy by the radiologist. The patient is then sent to our surgeons after the biopsy and we don’t have a specific referral from the radiologist.

Answer:

In your scenario, it does not appear there is a request for consultation from the radiologist but a transfer of care; report the new or established patient visit category as appropriate. The mammogram and biopsy have already been completed by the radiologist and is now being sent to your surgeons. The radiologist performs the testing and will not typically manage the long term care of the patient, thus any “opinion” by the surgeon will not affect any long term management by the radiologist who performed the mammogram and biopsy.

You may, on occasion have a situation where a consultation may be appropriate; but based on the information provided, the consultation requirements do not appear to be met.
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.

A 6 Vessel Cerebral Angiogram: How Is It Coded?

Question:

My doctor dictates “6 vessel cerebral angiogram” and the documentation describes catheterization of right and left internal carotid, right and left external carotids, and right and left vertebrals and imaging form each catheter position.
How is this coded under the new codes?

Answer:

Based on CPT 2013 cervicocerebral imaging guidelines this would be reported with the codes below:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>36226-50</td>
<td>for the bilateral vertebral catheterization and imaging</td>
</tr>
<tr>
<td>36224-50</td>
<td>for the bilateral internal carotid catheterization and imaging</td>
</tr>
<tr>
<td>+36227-50</td>
<td>for the bilateral external carotid catheterization and imaging</td>
</tr>
</tbody>
</table>

Soft Tissue Tumor Codes

Question:
I removed a lipoma from the chest that was a good size and pretty deep. I’m looking at the excision of benign skin lesion codes (114xx) and they just don’t seem to describe what I did. Please help.

Answer:
Good thing you asked for advice because new codes were introduced in 2010 that better describe the procedure you performed. Look at codes 21552 – 21556 to see which code best describes your procedure. The codes are anatomical location-specific (e.g., face/scalp, neck/anterior thorax), depth-specific (e.g., subcutaneous, subfascial), and size-based (in centimeters depending on total excision length).
Moderate Sedation with Angiograms

Question:

We don’t always have an anesthesiologist for our diagnostic angiograms. Can I bill 99144 for sedation or is that “bundled” in the new 36XXX codes?

Answer:

Good question because moderate sedation is not included in the arterial catheterization codes (e.g., 36217). However, the new angiography codes (36221-36228) have the “bulls-eye” symbol next to them so that means moderate sedation by the performing physician is included and not separately reported.

What Modifier Is Appended to CPT Code 49905?

October 17, 2013

Question:

The surgeon submitted CPT codes 44160 and 49905. We are using a code check program with our clearinghouse and it is telling us that Medicare considers these inclusive to each other. Can we report and if yes, what modifier? We have attended many courses with Mary LeGrand, who has been a fantastic help to our practice and I know we have billed this combination in the
past, so we are unsure what is occurring.

**Answer:**

Thanks for your inquiry and your comments! I am not sure what program you are using but there are no CCI edits in place for this code combination. CPT code 44160 defines a partial colectomy with removal of terminal ileum and CPT code, 49905, an add-on code describes the omental flap. CPT code 49905 does not have a specific index or parent code, thus may be reported with any procedure code when performed. Since CPT code 49905 is an add-on code, you will just report 44160 and 49905. Please check with your clearinghouse or practice management vendor to determine the source of this edit in your system.

Here is a snapshot from the third quarter 2013 CCI Validator showing an edit does not exist.

CCI Validation Report

<table>
<thead>
<tr>
<th>City</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicago, IL</td>
<td>November 10 - 11</td>
</tr>
</tbody>
</table>

**Ligation of Perforators. Which Code Should I Use?**

**Question:**

I notice there are two CPT codes for ligation of perforators. I have always used 37760 but now I see there is also, 37761 also for perforator ligation. What’s the difference?

**Answer:**
37760, ligation of perforator vein(s) subfascial, radical, is specifically for a Linton procedure, which includes a large linear medial leg incision. 37661, introduced by CPT in 2010, is for ligation of perforator vein(s) subfascial, open, including ultrasound guidance, when performed. This code is also a subfascial procedure but is less extensive than a Linton and is the procedure most commonly performed today. Unless you are doing a true Linton procedure, you should be reporting open ligation of perforators with CPT code 37761.