If you are a solo orthopedic surgeon or practice in a small group and are 55 years or older, this article is for you. The answer to the question “When is the right time to begin planning for the transition out of practice?” is now. And planning is the most important word in that sentence.

Read Full Article

Harvest of Abdominal Fat Graft

December 17, 2015

Question:
My doctor harvested abdominal fat that he then used in the nose to close the area when he did an endoscopic removal of a
pituitary tumor (62165). I want to bill 15770, but my doctor thinks the correct code is 20926. What do you recommend?

Answer:
Your doctor is correct with 20926 (Tissue grafts, other (e.g., paratenon, fat, dermis)). CPT 15770 (Graft; derma-fat-fascia) is used for a composite graft when more than one layer of tissue is harvested and placed (e.g., fat and fascia). When only one layer of tissue is harvested, such as fat, report 20926.

*This response is based on the best information available as of 12/17/15.

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Cerumen Removal

December 17, 2015

Question:
I was in attendance at the “top ten coding issues” talk that you gave in Dallas at the AAOHNS annual meeting. Great talk, Kim! We spoke regarding CPT 69210 after the session. I just want to confirm that use of magnification is not necessary for this code. My associates insist that 69210 requires using the operative microscope. I realize that simple lavage doesn’t qualify, but I use illumination and instruments and or suction. What is correct?

Answer:
Thank you for your kind words! You’re the second person this week to ask me the same question. Note the language for the code 69210 says, “Removal impacted cerumen requiring instrumentation, unilateral.” It does not say “requiring instrumentation and microscope.” The CPT vignette says that
magnification is used but does not specify that a microscope must be used; therefore, use of an otoscope is acceptable for 69210 and a microscope is not required. That said, it is never appropriate to report 69990 with 69210 because 69990 is meant for microsurgical techniques/microdissection. Be sure you document the specific type of instrumentation used (e.g., curette, forcep, suction) for the cerumen impaction removal.

*This response is based on the best information available as of 12/17/15.

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**Are Cast Re-Applications Included in the Global Period?**

**December 17, 2015**

**Question:**
We are hospital employed and are being told that we cannot bill for cast re-applications in the global period. An article posted in the AAOS coding column tells us that cast re-applications are separately reportable and to append a modifier 58. We also understand that modifier 58 restarts the global period. In my old job, I was told by a billing company that post-op casting was included in the global period and was not payable unless there was a complication with the cast. Is a cast re-application billable in the global period when medically necessary and will the global period re-start?

**Answer:**
Thanks for your inquiry. For some readers this will be a very mundane question, but we are hearing this question more and
more frequently so this is a good time to re-address how to report the services and why the services are reportable.

Let’s answer the first question first. Are cast re-applications billing during the global period? Yes! The first cast is inclusive to the global surgical CPT code, but re-applications are billable, assuming of course, that medical necessity is present. The following is the CPT citation: The very first sentence in the Application of Casts and Strapping section of CPT states, “The listed procedures apply when the cast application or strapping is a replacement procedure used during or after the period of follow-up care, or when the cast application or strapping is an initial service performed without a restorative treatment or procedure(s) to stabilize or protect a fracture, injury, or dislocation and/or to afford comfort to a patient.”

The answer to the second question is no, the global period will not re-start because splints and cast CPT codes have zero global days; as such, the global days cannot be reset or re-started.

*This response is based on the best information available as of 12/17/15.

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**Finding Medicare Reimbursement Amounts**

**December 17, 2015**

**Question:**
Where can I find Medicare reimbursement amounts for the procedures I do?
The Centers for Medicare and Medicaid Services (CMS) provides a means of computing Medicare reimbursement amounts for individual CPT codes on its website through the Medicare Physician Fee Schedule. To access the Medicare Physician Fee Schedule on the CMS website: Click here, choose “Physician Fee Schedule Search,” and follow the step-by-step instructions.

The site provides information on payment by code as well as Medicare payment policies, such as when co-surgery or assistant surgery is paid, which codes accept a bilateral modifier, and a list of relative value units (RVUs).

*This response is based on the best information available as of 12/17/15.

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**Split Thickness Skin Graft**

**December 17, 2015**

**Question:**
The doctor did a split-thickness autograft of the leg. I can’t find the CPT code for this procedure for an adult. I see only CPT codes for infants and children. Can you tell me where the codes for adults are?

**Answer:**
There are two stand-alone codes for split thickness skin grafts:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
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<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15100</td>
<td>Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children</td>
</tr>
<tr>
<td>15120</td>
<td>Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children</td>
</tr>
</tbody>
</table>

Note that the code descriptors say, “first 100 sq cm or less, or 1% of body area of infants and children.” That means the code applies to both adults and children. If an adult, you’ll use the area in square centimeters documented in the note. If an infant or child, you’ll use 1% of the body area as your guide for coding the area grafted.

*This response is based on the best information available as of 12/17/15.*

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**Parties and Promos – Advice from Healthcare Attorney Mike Sacopulos**
It is that time of year. The holidays are in full swing and many practices are hosting parties and special events. I have received the question below concerning photography at these events several times in the last 30 days. Hopefully this Q & A will be useful to your practice.

**Coding AV Access Complications**

12/03/15

**Question:**

Is an angioplasty of an AV shunt for stenosis always coded as venous?

**Answer:**

The AV shunt is considered to be venous and most interventions are coded as venous. So an angioplasty would be coded as 35476 and 75978 for radiological supervision and interpretation. The exception to this is if the stenosis is at the arterial anastomosis (where the vein meets the artery) and the stenosis extends across the anastomosis and into the artery. In this case, it would be appropriate to code an arterial
intervention, 35475 and 75962, but only one intervention may be reported in this segment of the shunt. Even if both a venous and arterial angioplasty were performed in this segment (the anastomosis through the axillary vein) only a single intervention may be reported.

*This response is based on the best information available as of 12/03/15.

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**Split Thickness Skin Graft**

12/03/15

**Question:**

Please resolve an internal debate we’re having in our office. Are the STSG codes chosen based on the recipient or the donor site?

**Answer:**

Good question, and this is always confusing. CPT says: “Select the appropriate code from 15040-15261 based upon type of autograft and location and size of the defect. The measurements apply to the size of the recipient area.” So you’ll choose the code based on the recipient/defect site and the area (in square centimeters) is of that same site. The two STSG graft codes are 15100 (recipient/defect site is trunk, arms or legs) and 15120 (recipient/defect site is face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits).

*This response is based on the best information available as of 12/03/15.*
Endoscopic Skull Base Surgery

12/03/15

Question:

We are thinking about starting an endoscopic skull base surgery program and doing skull base procedures via an expanded endonasal/endoscopic approach. I’ve looked in the CPT book for codes and it looks like CPT 61580-61619 are just what I’m looking for. Is this correct?

Answer:

That’s great that you’re starting a new program! And, we can help. There is one CPT code for an endoscopic skull base procedure – 62165, Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach. However, other procedures that you’ll do such as an endoscopic resection of a clival chordoma are not accurately coded using 61580-61619, as these existing codes are for open procedures. We wrote an article for the AAO-HNS Bulletin about this a few years ago that I think you’ll find helpful. Here are the links:

[Sample Prior Authorization, Cover Letter, or Appeal Letter for the Otolaryngologist’s Use of an Unlisted CPT Code for Endoscopic/Endonasal Skull Base Surgery](#)

[Coding and Reimbursement Strategies: Using an Unlisted Code for Endoscopic Skull Base Surgery](#)

*This response is based on the best information available as
of 12/03/15.