Reporting for Placement of a Non-biodegradable Antibiotic-impregnated Cement Spacer After Total Joint Prosthesis Removal

November 17, 2016

Question:
In a recent case review you performed for us, you reported CPT code 11981-51 (Insertion, non-biodegradable drug delivery implant) when our physician removed an infected hip prosthesis and placed a non-biodegradable antibiotic-impregnated cement spacer as part of a multi-stage revision. We had not used this code in the past because the prosthesis removal code, 27091, includes the text “with or without insertion of spacer.” Can you explain this further?

Answer:
You are correct that the definition of 27091 refers to placement of a spacer. We are able to report 11981 in addition to the prosthesis removal code because the spacer is incorporating the non-biodegradable antibiotic drug that is used to treat the patient’s infection. Refer to CPT codes 11981, 11982, and 11983 for the CPT insertion, removal, and exchange codes for non-biodegradable drug delivery implant. Remind the physicians to reference the non-biodegradable antibiotic-impregnated cement in the operative note, as placement of biodegradable drug-delivery devices is not separately reportable.

*This response is based on the best information available as of 11/17/16.*
2017 Reimbursement Reductions for Endoscopy: How Much Will It Impact My Revenues?

November 17, 2016

Question:
My partner mentioned that she heard all our endoscopy codes are being reduced in payment starting January 1, 2017. I don’t know if we can take one more major reduction in reimbursement. Can you clarify this??

Answer:
Reimbursement changes to endoscopy codes will be effective on January 1, 2017. However, if you understand how to code these procedures under the revised 2017 coding rules, the impact on your revenues could be zero. That’s the good news. However, it will be essential to code these correctly and to establish processes in your practice to ensure you capture all revenues under the new guidelines. Very simply, the value of moderate sedation has been carved out of all endoscopy codes. However, if you perform moderate sedation, you will be able to bill for this activity under a new Medicare G code (for Medicare patients) combined with new CPT Category I codes for moderate sedation.

WEBINAR ALERT:
For more detailed information about Medicare and private payer billing under these new guidelines, please join Teri Romano for a thirty minute Zipinar on December 15, 2017, focusing on the coding and reimbursement changes for endoscopy procedures. Click here for more information and registration.

*This response is based on the best information available as of 11/17/16.

Additional Information About Assistant Surgeon on 61323

November 17, 2016

**Question:**
Thank you so much for your help in getting 61323 payable for an assistant, we appreciate it! When will this become effective and can we bill retrospectively for services in the past year?

**Answer:**
You are welcome! This change becomes effective 1/1/2017 and unfortunately, retroactive payment is not likely. You can try, but we doubt it will happen.

*This response is based on the best information available as of 11/17/16.*
Diagnosis for Open Wounds as a Result of Cancer Resection

November 17, 2016

Question:
What diagnosis code do we use when we are reconstructing a defect after the Moh’s surgeon, or someone else removed the cancer? When I try to crosswalk the ICD-9-CM open wound code I used to something in ICD-10-CM, it takes me to an S code which is strange because the open wound is not the result of an injury or trauma.

Answer:
Good question! Technically, you would not use a cancer diagnosis code since you are not treating cancer (the Moh’s surgeon treated the cancer by excising it). Your diagnosis codes, as the surgeon treating an open wound/resulting defect resulting from cancer resection are:

1. Z48.1 Encounter for planned postprocedural wound closure, and
2. Z42.8 Encounter for other plastic and reconstructive surgery following medical procedure, and
3. Personal history of neoplasm code (e.g., skin Z85.82-, melanoma Z85.820). If the reconstruction occurs on the same day as the cancer removal, then the C code for malignant neoplasm can be substituted for the Z85.- code.

*This response is based on the best information available as
Extremity Angiogram (75710) With AV Graft Imaging (36147). Is It Separately Billable??

November 17, 2016

Question:
In evaluating an occluded AV graft, I punctured the graft and performed a dialysis circuit venogram, for which I billed 36147. If I had a concern about occlusive disease in the arterial inflow, and performed and documented an arteriogram of the same arm, can I bill a 75710?

Answer:
Great question! Code 36147 includes imaging of the venous outflow (up to and including imaging of the inferior and superior vena cava) and the peri-anastomotic portion of the arterial anastomosis. The peri-anastomotic section includes the short segment of the artery immediately adjacent to anastomosis and the anastomosis itself. If there is documented medical necessity to evaluate the arterial patency in the same extremity not generally considered to be part of the AV graft, that angiogram may be reported with 75710. This will also typically require more selective catheterization into the involved artery. This may be reported with a 36215 for a first order catheterization.
WEBINAR ALERT!
The codes for AV access/dialysis circuit imaging and interventions all change on January 1, 2017. Join Teri Romano for a webinar on these and other new vascular codes on December 14, 2016. Click here for more information and registration.

*This response is based on the best information available as of 11/17/16.

Zoom In On the Rules for Reporting +69990 with Ear Procedures

by Kim Pollock, RN, MBA, CPC, CMDP
CPT® tells us when not to separately report the use of an operating microscope. We’ll tell you when you should.

Many otolaryngologists use an operating microscope when performing ear procedures in the operating room. Coders often wonder if it is acceptable to report CPT® +69990 Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure) in addition to the primary ear procedure code.

Read Full Article

2017 Spine CPT Code Changes

Your Instructor:
Kim Pollock, RN, MBA, CPC, CMDP

AAOS Now – November 2016
by Kim Pollock, RN, MBA, CPC, CMDP

Spine surgeons face a multitude of Current Procedural Terminology ® (CPT) code changes, effective Jan. 1, 2017. This article provides a summary of these changes so practices can get a head start on understanding their implications. A complete listing of changes can be found in the 2017 CPT
Approach and Visualization Definitions
The Spine and Spinal Cord section of the Nervous System codes in CPT 2017 provides new definitions of key terms and surgical approaches to further clarify these CPT code descriptors, as shown in Table 1.

Surgical CPT codes are presumed to be open unless the code descriptor states otherwise.

Acromioclavicular Joint Billing

October 27, 2016

Question:
When our physician performs an injection into the acromioclavicular (AC) joint of a patient in the office, can we bill 20610 for a large joint arthrocentesis? I say yes because it is in the shoulder, which is listed as an example large joint in the code descriptor.

Answer:
No. The correct code to bill in this case would be 20605 for an intermediate joint. Although the AC joint is between the shoulder and the clavicle, it is considered an intermediate joint. If you look at the example intermediate joints in the descriptor for 20605 they include: temporomandibular, acromioclavicular, wrist, elbow or ankle, or olecranon bursa. The example large joints listed for code 20610 include: shoulder, hip, knee, subacromial bursa. If the physician
performs the AC injection utilizing ultrasound guidance with permanent recording and reporting, then you should report code 20606 instead of 20605. And don’t forget to bill the HCPCS II code for the medication itself.

*This response is based on the best information available as of 10/27/16.*
Surgical Modifiers: How Do They Impact Reimbursement?

October 27, 2016

**Question:**
What reimbursement should we expect when using the global period modifiers 58, 79 and 78?

**Answer:**
Surgical modifiers are used to indicate that a subsequent procedure was performed during the global period of a prior surgery. Modifiers tell the payer the rationale for allowing payment for this subsequent procedure. The modifiers and reimbursement impact of each is shown below:

Modifier 58: to indicate a second procedure was performed as a staged procedure. Reimbursement should be 100% of the allowable fee.

Modifier 79: To indicate an unrelated procedure was performed during the global period of the original procedure. Reimbursement should be 100% of the allowable fee.

Modifiers 78: To indicate that a complication of an original procedure was treated by a return to the operating room, catheterization or endoscopy suite. Reimbursement should be at 70-80% of the allowable fee. This reduction reimburses for the intra-operative portion of the procedure only, since the patients pre and post-operative services are paid under the original surgery’s flat fee.
*This response is based on the best information available as of 10/27/16.

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