Total Thyroidectomy and Reimplantation of Parathyroids

May 25, 2017

**Question:**
My doctor did a total thyroidectomy and reimplanted one of the parathyroid glands into the sternocleidomastoid muscle. Can I code 60512 in addition to 60240?

**Answer:**
CPT 60240 for the total thyroidectomy is correct. However, if one or more of the parathyroid glands is reimplanted in the same surgical exposure (e.g., SCM muscle) then it is not accurate to separately code +60512. The reimplantation should be done through a separate surgical approach/incision for +60512.

*This response is based on the best information available as of 05/25/17.*

Diagnosis Code for Flap Closure

May 25, 2017

**Question:**
Can you help solve a diagnosis coding controversy we have?
Occasionally, we have a patient who had a fracture and the Orthopedic Surgeon does the fracture repair. However, the Plastic Surgeon is asked to provide flap coverage to cover the open surgical wounds. What diagnosis codes should we use? I am thinking we use the fracture diagnosis code but we aren’t treating the fracture. Another coder says we should use an unspecified open wound code. We would appreciate your thoughts.

**Answer:**

Good question! We agree that you would not use the fracture diagnosis code (S-) because you are not treating the fracture. We also would not use the S- open wound diagnosis code because the open wound was not caused by trauma – it is an open surgical wound. We recommend using and Z42.8 (Encounter for other plastic and reconstructive surgery following medical procedure or healed injury) as the primary diagnosis code. The fracture diagnosis code can be listed as a secondary diagnosis.

*This response is based on the best information available as of 05/25/17.*

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**Biopsy and Injection Coding**

May 25, 2017

**Question:**
If my physician reports a biopsy on the same date as an intralesional injection (different sites) can I report both codes? Should I use Modifier 59?
Answer:
You can report a biopsy (11100) for the first lesion and 11101 for each additional lesion biopsied. You may also report an intralesional injection (11900) on the same date of service if performed on a different lesion.

Modifier 59 should not be reported as it is not bundled under the National Correct Coding Initiative (NCCI). You should only use Modifier 59 if the two codes are bundled under NCCI and both procedures are distinct and separate. In this case since the two codes are not bundled, you should append Modifier 51 (multiple procedures) to CPT 11900 if your payor accepts the use of this modifier. Since 11900 has a lower RVU, Modifier 51 supports this as a secondary procedure. Expect payment to be reduced by 50% for the second procedure.

*This response is based on the best information available as of 05/25/17.*

Using PAs and NPs as Scribes

May 25, 2017

Question:
Our group is really having a difficult time getting all of the medical record information into the computer. Is it okay to use our PAs and NPs as scribes when they have some down time?

Answer:
We certainly understand your frustration with inputting data into the EMR. The question you ask is rather complex and will take a bit of homework for your group to determine if this is
the best use of an allied health professional. A scribe in the medical office is just like a court reporter. They may only document exactly what is stated by the physician or NPP during the encounter and just like a court reporter; they don’t get to ask any questions. You may not combine the work of a PA/NP when they are acting as a scribe with that of a physician and bill it under the MD’s NPI. The practitioner who bills for the services is expected to be the person delivering the services and creating the record, which is simply recorded by another person/the scribe. Finally, the record should be signed by both parties (the scribe and the physicians) attesting to their role in the creation of the record. The practitioner must attest to having independently performed the service and agree with the information as documented by the scribe. A PA/NP who performs part of the encounter for a patient (e.g. history) and then “scribes” the remainder of the encounter is not functioning as a scribe.

For more clarity on the issue, CGS Medicare updated their guidance article recently. Located here:


In part it states:

Record entries made by a “scribe” should be made upon dictation by the physician, and should document clearly the level of service provided at that encounter. It is inappropriate for the scribe to see the patient separately from the physician and make entries in the record unless the employee is a licensed, certified NPP billing Medicare for services under the NPP name and number.

Medicare pays for medically necessary and reasonable services, and expects the person receiving payment to be the one delivering the services and creating the record. There is no “incident to” billing in the hospital setting (in-patient or
out-patient). Thus, the scribe should be merely that, a person who writes what the physician dictates and does. This individual should not act independently, and there is no payment for this activity. The physician is ultimately accountable for the documentation, and should sign and note after the scribe’s entry, that the note accurately reflects the work done by the physician, which is reflected in the affirmation above.

*This response is based on the best information available as of 05/25/17.

How do I know if co surgeon will be paid? What about assistant surgeon?

May 25, 2017

Question:
How do I find out if an assistant surgeon or co-surgeon is paid on certain procedures that I perform?

Answer:
This information is published by Medicare on the Medicare website.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html
You can also google “Physician Fee Schedule Look up” to access the site. Once there, you can enter a single or up to four CPT codes. Follow the prompts and indicate your search is for “payment policy indicators” (see the search choices below, Table 2). The search will show the codes and several policies, including numbers (see table 3), 0, 1, 2, 9 that indicate the payment status of the code. Table 4, tells you what those codes mean; paid, paid with documentation or not paid.

**Table 1**

To start your search, go to the [Medicare Physician Fee Schedule Look-up Tool](https://www.cms.gov/PhysicianFeeSchedule).

To read more about the NPIFS search tool, go to the MLN® booklet, [How to Use The Searchable Medicare Physician Fee Schedule Brisket (April 2014)](https://www.cms.gov/Downloads/MLN-0685.pdf).
Search Criteria

Begin your search below by selecting search criteria. Additional search criteria will appear depending on which selections you choose. Once your selections are complete, you will be asked to submit your criteria. All search criteria options displayed on this page are required.

Please select a year (see 'Notes for Selected Year' box for details):

2015B

Type of Information:
- Pricing Information
- Payment Policy Indicators
- Relative Value Units
- Geographic Practice Cost Index
- All

Select Healthcare Common Procedure Coding System (HCPCS) Criteria:
- Single HCPCS Code
- List of HCPCS Codes
- Range of HCPCS Codes

Policy Indicators by Single HCPCS Code
Enter values for:

HCPCS Code: 62223

Modifier:
All Modifiers

Table 3
Table 4 Policy indicators

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Co-Surgeon (62)</th>
<th>Assistant Surgeon (80-82)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Co-surgeon not permitted</td>
<td>0 = Paid with documentation</td>
</tr>
<tr>
<td>1</td>
<td>Paid with documentation</td>
<td>1 = Not paid</td>
</tr>
<tr>
<td>2</td>
<td>Paid with two specialties</td>
<td>2 = Paid</td>
</tr>
<tr>
<td>9</td>
<td>Concept does not apply</td>
<td>9 = Concept does not apply</td>
</tr>
</tbody>
</table>

*This response is based on the best information available as of 05/25/17.*
Sphenopalatine Block Coding – #1

May 25, 2017

Question:
One of our physicians is using a device to deliver medication through the nose when a sphenopalatine ganglion block is performed under fluoroscopic guidance for patients with migraine headaches. Is 64505 appropriate? If not, what code should be used?

Answer:
There is no specific CPT code that accurately describes this service. The code set includes code 64505, which describes the injection of the sphenopalatine ganglion; however, it is inappropriate to report this code since an injection is not performed. Therefore, Per CPT, the unlisted code 64999, unlisted procedure, nervous system, should be reported.

*This response is based on the best information available as of 05/25/17.

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Coding a Vena Cava Thrombectomy with a Urologist Co-Surgeon

May 25, 2017
Question:
A urologist asked me to clear the thrombus and repair the vena cava during a radical nephrectomy for tumor resection. What code should I use?

Answer:
In this case, you are acting as a co-surgeon on code 50230, nephrectomy, including partial ureterectomy, any open approach, including rib resection; radical with regional lymphadenectomy and/or vena cava thrombectomy. You will report 50230-62 and the urologist will also report 50230-62. Note that if either surgeon also performs a lymphadenectomy, that is also included in 50230.

*This response is based on the best information available as of 05/25/17.

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**Intervertebral Device 22853**

May 25, 2017

Question:
I code for a neurosurgeon and he insists that I bill the cage code, 22853, for each interspace. However, the CPT book lists as cage(s) therefore our thinking is that no matter how many are placed this code is only allowed one time per surgery. His note states “C3-C4, C4-C5, C5-C6 anterior cervical interbody fusion using PEEK interbody spacers.” So is it 22853 x 1 unit or 22853 x 3 units?

Answer:
Your neurosurgeon is correct. CPT code 22853 is reported per
interspace to describe intervertebral biomechanical devices, including PEEK cages. The term is both single or plural, “cage(s)”, because sometimes there are two devices placed at a single spinal level.

*This response is based on the best information available as of 05/25/17.
code changes in the past several years. The changes are primarily new codes, with some code revisions, to keep the codes up to date with contemporary clinical practice.

Stay Current with Spine Procedural Coding

AAPC News – May 2017
by Kim Pollock, RN, MBA, CPC, CMDP

See how spine procedure codes, guidelines, and reporting have changed in 2017.

There are many 2017 CPT® code changes pertaining to spine procedures. Here’s a rundown of the most significant changes.

Removal of Moderate Sedation Inclusion
The moderate sedation symbol (¶) was removed from the vertebro-plasty (22510-22512) and vertebral augmentation