We are getting denials for code 64615 chemodenervation of the facial nerves for migraine headache. Any suggestions?

Answer:
Code 64615 is reported for chemodenervation of muscle(s) innervated by facial, trigeminal, cervical spinal, and accessory nerves, bilateral (e.g., for chronic migraine). Per CPT, code 64615 is used to report a chemodenervation injection procedure specifically for the treatment of chronic migraine.

To report this code, the following criteria must be met:

- 15 or more days of headache or a headache that lasts 4 hours or more per day, prior to treatment.
- Treatment must include, 31 injection sites over 7 muscle groups are typically identified on the face, head, neck and upper back (the frontalis, corrugatore, procerus, occipatlis, temporalis, trapezius, and cervical paraspinal muscle groups). The code is reported once, for injection of these sites. Ultrasound guidance may be reported with these codes using 76942.

If this procedure is performed and reported accurately (as described above), appeal the denial with appropriate documentation.

*This response is based on the best information available as of 06/22/17.*
Report actinic keratosis and seborrheic keratosis with 17000-17004 codes?

June 22, 2017

Question:
If a patient presents to the office with both AKs and SKs. The doctor destroys 11 AKs and 5 SKs. Are these all reported with 17000-17004 codes?

Answer:
No. The actinic keratosis (AKs) are considered premalignant and are reported using codes 17000-17004. The seborrheic keratosis (SKs) are considered benign and are reported using codes 17110-17111. In your case, the following codes should be reported:

17110 Destruction of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions

17000-59 Destruction premalignant lesions; first lesion

17003 X 10 Destruction premalignant lesions; second through 14 lesions, each

Make sure that you pay attention to the quantities in the code descriptors so that the proper units are billed. There is a CCI edit between 17110 and 17000 so modifier 59 (or XS) would need to be appended to 17000 to ensure proper adjudication.
Closure After Moh’s Surgery

June 22, 2017

Question:
I did the closure for a patient’s left ear defect after the Moh’s surgeon excised the basal cell carcinoma at the same operative session. I had to remove a little devitalized tissue before closing the wound with a full thickness graft. Can I code both 15260 (full thickness graft) and 11043 (wound debridement)?

Answer:
No. The 1104x codes are for debriding an open wound that will heal by secondary intention such as a chronic venous stasis ulcer. You’ll use only 15260 for your reconstructive procedure.

*This response is based on the best information available as of 06/22/17.
Post-Op hemorrhage repair. Is it billable?

June 22, 2017

Question:
Can I bill for taking the patient back to the OR to explore and repair post-op hemorrhage on day post-op? I heard that all complications are included in the payment of the original surgery.

Answer:
Yes, you may bill for this. CPT and Medicare agree that taking the patient back to the OR to treat a complication is billable. A modifier 78, unplanned return to the OR) is appended to the procedures performed to treat the hemorrhage. The appropriate ICD-10 code for a postoperative hemorrhage would also be reported.

*This response is based on the best information available as of 06/22/17.

Billing “Incident to”

June 22, 2017

Question:
Whose NPI number do we bill under when a PA sees the patient in the office under the “incident to” rules for Medicare? We bill under the NPI number of the physician who is assigned to the PA. Is that correct?
**Answer:**
No, when billing “Incident to,” bill under the NPI number of the physician in the office who is supervising. The guidelines are very clear that the physician must be present in the “office suite”. The PA’s visit must be billed under the physician who is in the “office suite” at the time the PA is managing the care of the patient not the physician the PA is assigned.

*This response is based on the best information available as of 06/22/17.*

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**Scraping the Vertebral Endplates**

June 22, 2017

**Question:**
Our spine surgeon recently attended a presentation (not KZA’s which is why I’m questioning the advice!). He said the spine surgeon speaker advised that he could bill a corpectomy code if he documented “scraping or smoothing of vertebral endplates.” He told me we had missed out on a lot of reimbursement because I was coding these as a traditional anterior cervical decompression/discectomy and fusion (ACDF) procedure. Was I wrong in how I coded these procedures, and if yes, should I go back and submit a corrected claim?

**Answer:**
You were absolutely correct in not interpreting this work as a corpectomy. The work or preparing the endplates for fusion is
Facial Nerve Monitoring with Ear Procedures

June 22, 2017

**Question:**
Can I bill for facial nerve monitoring during a cochlear implant or mastoidectomy procedures?

**Answer:**
Facial nerve, and any cranial nerve, monitoring is included in the primary procedure code (e.g., cochlear implant, mastoidectomy) for the surgeon and should not be separately reported according to both CPT and Medicare. A completely different provider, other than the surgeon or assistant surgeon or co-surgeon or anesthesiologist, may provide and bill for the monitoring.

*This response is based on the best information available as of 06/22/17.*
Aneurysm of Ulnar Artery

June 22, 2017

Question:
Our hand surgeon recently took a patient to surgery for what he thought was a cyst in the forearm. After making his incision and exploring the area, the surgeon found an aneurysm in the ulnar artery. He resected the aneurysm and repaired the defect with a vein graft harvested from the arm. We could not find a code for this in the musculoskeletal section of CPT.

Answer:
Thanks for contacting KZA! This is a great example of having to look outside the daily world in which we find so much comfort. The answer lies in the vascular section (3xxxx) section of the CPT manual. The correct code based on the question, and thank you, the review of the operative note, is CPT code 35045 (Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm, pseudoaneurysm, and associated occlusive disease, radial or ulnar artery). This CPT code includes the resection of the aneurysm and the harvest and insertion of the vein graft in your scenario for the repair of the defect.

*This response is based on the best information available as of 06/22/17.
Sphenopalatine Block Coding – #2

June 8, 2017

Question:
My physician treats migraines by using a Q-tip placed in the nose to apply anesthetic topically. How is this coded?

Answer:
This is an approach to block the sphenopalatine ganglion, where a Q-tip is used to topically apply anesthetic through the nose. There is not a code for this procedure and it is best reported as part of the E/M service.

*This response is based on the best information available as of 06/08/17.

Adjacent Tissue Transfer

June 8, 2017

Question:
If I undermine the ear to close a keloid defect of can I use the adjacent tissue transfer code 14060?

Answer:
The CPT guidelines for adjacent tissue transfer states: “Undermining alone of adjacent tissue to achieve closure,
without additional incision does not constitute adjacent tissue transfer, see complex repair codes 13100-13160”. If an additional incision is not performed you would report a complex repair code.

*This response is based on the best information available as of 06/08/17.*