On-Q Pain Pump Coding

March 3, 2016

Question:
My doctor repaired an inguinal hernia and also placed On-Q pain pumps. Can these be billed with an unlisted code?

Answer:
Good question! Any pain management provided by the operating surgeon, including placing On-Q pain pump, is part of the global package and not separately reported.

*This response is based on the best information available as of 03/03/16.

Is Unspecified Sometimes the Correct Option?

February 18, 2016

Question:
If a patient presented with symptoms of a meniscal tear in the right knee, but the type and location were not known without an MRI, would it be correct to report an “unspecified” code for right meniscal tear?

Answer:
Yes, it is correct to report the unspecified code (S83.206A Unspecified tear of unspecified meniscus, current injury, right knee, initial encounter). The ICD-10-CM guidelines state, “… unspecified codes should be reported when they are the codes that most accurately reflects what is known about
the patient’s condition at the time of that particular encounter. It would be inappropriate to select a specific code that is not supported by the medical record documentation…”

*This response is based on the best information available as of 02/18/16.

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**Billing an E/M with Placement of a Central Line**

February 18, 2016

**Question:**
In a recent coding coach, you mentioned that an E/M would be inappropriate with placement of a central line. I’m not sure that is always the case. Can you clarify?

**Answer:**
Thank you for following up on this question. The Coding Coach specifically described a situation in which a surgeon responds to a specific request to place a central line with a port. Since that code includes 35 minutes of pre-service time, the time spent evaluating the access point, etc. is included in the procedure code. It might certainly be the case that you are evaluating a patient and as part of a more comprehensive evaluation, assessment, and plan, you decide the patient would benefit from a central line. In this case, if you have a medically necessary significant and separate E/M, you could report the E/M with a 25 modifier and the central line.

*This response is based on the best information available as of 02/18/16.*
Cerumen Removal vs. E/M Code

February 18, 2016

Question:
Someone told me to bill an E/M code like 99212 or 99202, instead of 69210 when removing impacted cerumen with instrumentation. What do you think?

Answer:
Absolutely not! The ICD-10-CM code for cerumen impaction (H61.20 – H62.23) supports reporting a CPT code for the removal (69210). Also, Medicare’s payment for 69210 is higher than the payment for 99212 so you’d be losing money if you did that. You’re supposed to code for what you do which means 69210 is the correct code to report.

*This response is based on the best information available as of 02/18/16.

How to Use CPT Codes 64461, 64462 and 64463

February 18, 2016

Question:
There are three new CPT codes our physicians want to use: 64461, 64462 and 64463. What are these codes used for and what are the rules for reporting them?

Answer:
CPT codes 64461-64462 are new codes in 2016 to report a paravertebral (PVB) block and are used to treat chronic pain such as thoracic pain. The procedure involves the physician injecting analgesia in the paravertebral space and includes ultrasound and fluoroscopic guidance. Report CPT 64461 for the first injection and add-on code 64462 for each additional injection. CPT 64463 is only used when continuous infusion is performed via a catheter.

*This response is based on the best information available as of 02/18/16.

**Billing Catheterization with Lower Extremity Revascularization**

February 18, 2016

**Question:**
I still struggle with coding catheterizations with low extremity revascularizations. If I do an aortogram through the same femoral access, can I bill 36200 in addition to my iliac or femoral stent?

**Answer:**
No, that non-selective catheterization is bundled in the more selective catheterizations of the iliac or femoral artery.

*This response is based on the best information available as of 02/18/16.*
Augmentation of Pedicle Screws

February 18, 2016

Question:
My neurosurgeon recently went to a meeting where someone told him that they bill a vertebroplasty (22521) for injection of cement around pedicle screws at the time of placement. They said as long as there is a separate diagnosis of osteoporosis then it’s ok. Is this true?

Answer:
No. Augmentation of pedicle screws at the time of placement (e.g., 22840, 22842) is not separately reported and is considered inclusive to the instrumentation code billed.

*This response is based on the best information available as of 02/18/16.

Exchange of Implants After Breast Reconstruction

February 18, 2016

Question:
We have a patient who had bilateral mastectomies and had permanent implants placed several years ago. She now wants smaller implants. I have to get precertification for this
procedure and am looking at the CPT codes 19328 (implant removal) and 19325 (breast augmentation) for the procedure. Would that be right?

**Answer:**
Actually, it is best to report 19340 (Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction) for this procedure since the patient has had prior mastectomies. Precertification is important as many payers will not pay for the implant exchange without an associated medical condition (e.g., painful capsular contracture).

*This response is based on the best information available as of 02/18/16.*

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**ICD 10: Aftercare Z Codes or 7th Character Code?**

**UPDATED**
February 4, 2016

**Question:**
Patient has been seen in office during the global period after a rotator cuff repair for a sprain. No X-rays were taken. Internally we will record 99024. Would we assign Z47.89 or the sprain code to 99024?

**Answer:**
Thanks for your inquiry as your question gives us an opportunity to address documentation requirements and how sprains and strains are delineated in ICD-10-CM.
First, under ICD-10-CM descriptions, an acute injury to the rotator cuff muscle or tendon is described as a “strain”, under the subcategory S46,01- , not as a “sprain.” Although there is also an ICD code for sprain of the rotator cuff capsule, S43.42-, that is not the structure that typically injured.

If you’ve determined that the problem is an injury, you will look to the S codes; if it is a chronic or recurrent problem, you will look to the M codes.

The ICD-10-CM options for a rotator cuff strain are:
S46.011- Strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder
S46.012- Strain of muscle(s) and tendon(s) of the rotator cuff of left shoulder
S46.019- Strain of muscle(s) and tendon(s) of the rotator cuff of unspecified shoulder

Ideally the physician will document whether the strain affects the right or left shoulder; use of the unspecified code is reserved for cases when the laterality is not described.

If the patient is seen in the global period for the injury, then the 7th character D is applied to indicate routine healing following active treatment of an injury.

If the surgery was done to treat a chronic or degenerative condition coded from the M chapter, you will report Z47.89, Encounter for other orthopedic aftercare, provided the follow-up is uncomplicated.

*This response is based on the best information available as of 02/4/16.*
Joint Injection with Trigger Point Injection

February 2, 2016

Question:
If I am performing a joint injection with a trigger point injection in two different anatomic areas, can I get paid for both?

Answer:
Yes, you should get paid for both if in different anatomic areas. Modifier 59 should be used (on the lower valued CPT code) with either a modifier 59 (distinct procedure) or XS (separate structure) to identify the different anatomic area or structure. Don’t forget the J code for the medication in addition to the injection.

*This response is based on the best information available as of 02/2/16.*