Excision of a Skin Lesion

March 6, 2014

Question:

When coding for excision of a skin lesion (114xx, 116xx), do I use the size on the pathology report to determine the correct CPT code?

Answer:

The most accurate measurement, according to CPT, is when the lesion has not yet been excised and is still on the patient. The specimen reduces in size when it is in formalin. So reporting a CPT code with the size listed on the pathology report may result in a lower CPT code being billed and a loss of revenue.

Gynecomastia

February 20, 2014

Question:

Our staff were having difficulty obtaining precertification for a male patient with gynecomastia. When I submitted my surgical codes for the day, I gave the staff CPT code 19300 Mastectomy for Gynecomastia. My staff said I could not report this code, but had to report 19301 for a partial mastectomy. I am not in agreement with this, but am new to coding my own cases. Can you provide guidance?

Answer:
You are correct to reach out, and this is great timing. The ACS is sponsoring a Comprehensive Breast Coding Seminar in February in Orlando. Topics such as this will be discussed. The answer is “no”, you cannot report 19301 because the payor would not pre-certify. Other business activities must occur to ensure proper payment—choosing a code “just to get paid” is not acceptable. In your case, report 19300 since this is the procedure performed. There may be nothing you can do at this time to have the claim paid, but KZA can help assist you in the future.

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**Soft Tissue Tumor Codes**

*February 20, 2014*

**Question:**

I removed a lipoma from the chest that was a good size and pretty deep. I’m looking at the excision of benign skin lesion codes (114xx) and they just don’t seem to describe what I did. Please help.

**Answer:**

Good thing you asked for advice, because new codes were introduced in 2010 that better describe the procedure you performed. Look at codes 21552 – 21556 to see which code best describes your procedure. The codes are anatomical location-specific (e.g., face/scalp, neck/anterior thorax), depth-specific (e.g., subcutaneous, subfascial), and size-based (in centimeters depending on total excision length).
Cerebral Angiograms and Modifier 26

Question:

The prior cerebral angiogram codes in the 70000 series of CPT codes required a 26 modifier. Do we append a 26 modifier to the new codes?

Answer:

The new cervicocerebral angiogram codes are now surgical codes in the 30000 series of CPT codes, not radiology codes. Therefore, they do not require a 26 modifier to indicate the physician is performing the professional component only. Like other surgical codes, these new codes reflect only the physician’s work.

Postop Mastoid Debridement

February 20, 2014

Question:

My doctor did a mastoidectomy on a patient. Can we bill for the mastoid debridement using 69220 when the patient comes back to the office for a postop debridement?

Answer:

The mastoidectomy codes (e.g., 69641-69646) have a 90-day
postoperative global period and include all postoperative care related to the mastoidectomy procedure. Therefore, the postop office debridement is not separately reported.

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**Shoulder X-Rays**

February 20, 2014

**Question:**

What CPT code do I report for a shoulder X-Ray when the surgeon documented that he ordered and interpreted four views of the shoulder and documents the specific views?

**Answer:**

You will report CPT code 73030 Radiologic examination, shoulder; complete, minimum of two views since this code describes a complete radiologic examination of the shoulder. A minimum of two views must be performed to report this code as recommended.

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**Suture Removal**

February 20, 2014

**Question:**
Is there a CPT code for removing sutures in the clinic?

Answer:

It depends on who put in the sutures. If you put them in and the repair was “intermediate” or “complex” per CPT guidelines, then you cannot charge for removing them because CMS has assigned a 10-day global period to these codes. If you put in the sutures but the repair performed was “simple,” then you may charge an E&M service (e.g., 99212). If someone else put them in (e.g., ER doctor) and the patient is sent to you for suture removal, only then you may report an E&M service (e.g., 99201, 99212).

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**Additional Level Laminectomy for Spinal Cord Stimulator Electrode Placement**

February 20, 2014

Question:

The spinal cord stimulator rep told my neurosurgeon to also bill 63003 (thoracic laminectomy, 1-2 segments) or 63005 (lumbar laminectomy, 1-2 segments) when he does an additional level laminectomy to place the spinal cord stimulator electrode. He says sometimes an additional level laminectomy is necessary for the electrode placement. What do you think about the rep’s advice to report 63003 with 63655 (laminectomy for spinal cord stimulator electrode placement)?

Answer:
The code, 63655, includes all levels of laminectomy required to place the electrodes/paddle. It is not appropriate to also report 63003 or any other laminectomy code in your scenario.

Can We Bill CPT Code 76098?

February 6, 2014

Question:

The surgeon always documents examination of the specimen during her breast biopsy procedures and wants to report CPT code 76098. Is this correct?

Answer:

No, CPT code 76098 is not separately reportable when reporting the breast biopsy codes 19081-19086.

Help! Denial of Stent Codes for Treating AV Graft Stenosis.

Question:

We recently had several denials for placing a stent in an AV graft for graft stenosis. We billed 37205 and the radiology code. Both were denied. Can you help?
Answer:

The stent codes (for stents other than lower extremity, cervical carotid, extracranial vertebral or intrathoracic, intracranial, or coronary) were totally revised effective in January 1, 2014. 37205 and 75960 the associated radiological supervision & interpretation (S & I) codes were deleted and replaced with the following code:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>37238</td>
<td>Transcatheter placement of an intravascular stent(s) (except lower extremity, cervical carotid, extracranial vertebral or intrathoracic, intracranial, or coronary), open or percutaneous, including all supervision and interpretation and including all angioplasty within the same vessel, when performed; initial vein.</td>
</tr>
</tbody>
</table>

This is now the correct code to using for stenting an occluded AV graft. As stated in the code, it now includes the radiological S & I.