Implantation of Biologic Code (15777) Issue

Question:
I’m using the new add-on code, 15777, for Alloderm placement when we do a breast reconstruction with tissue expander. However, we are having trouble getting paid on the code when we bill it bilaterally with modifier 50. Can you help?

Answer:
Yes, this has been a problem since the code came out in January 2012. CPT says modifier 50 is appropriate on 15777. However, Medicare (and some other payors) did not appropriately set up their payment systems to recognize modifier 50 on 15777. Medicare fixed this issue effective July 1, 2012. You should refile/appeal previous denials and hopefully be paid now.

Intraoperative Monitoring

Question:
When performing spine surgery and a physician’s assistant is assisting, can the PA bill for intraoperative monitoring?

Answer:
No, neither the surgeon or an assistant surgeon or even a co-surgeon may bill for intraoperative monitoring.
Consult In ER

November 26, 2013

Question:

Our surgeon was called to the Emergency Room to see a patient in consultation. The patient was discharged from the Emergency Room. Can you tell us how to report this?

Answer:

The correct category of CPT code will be dependent on payor rules. According to the 2013 AMA CPT rules, the service is a consultation and the 99241-99245 codes are reported. Report the consultation code for all payors still recognizing this category of codes.

Medicare no longer reimburses consultation service, thus a CPT code from the Emergency Department (ED) Codes (99281-99825) will be reported when the patient is seen in consultation in the Emergency Room and discharged to home.

Skin Lesion Removal and Closure

Question:

I have a question on lesion removal and closure coding. If two lesions the same size, same diagnosis (e.g., malignant) and same area (e.g., neck) are removed, is the code used twice or are the sizes added together for one code? I have the same question for a repair- same site (per code description), same
type of closure (e.g., intermediate) – do we add the lengths together or use the same code twice?

Answer:

We cover these exact questions in the AAOHNS/KZA coding courses. Report one CPT code for each lesion removed. Use modifier 59 on the second and subsequent same CPT codes. For example, removal of two malignant lesions of the neck each 1.2 cm in diameter are reported using 11642 and 11642-59. Be careful because some payors (including Cahaba Medicare) require the use of modifier 76 rather than 59 in the situation where more than one of the same CPT codes is billed on the same date of service.

For the repair codes, you will sum the repairs for similar types of repairs (e.g., intermediate, complex) in similar anatomic locations (per CPT code). Bottom line is lesion removal codes are never added together but the wound repair codes may be summed.

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.

**VEMP**

**Question:**

Our audiologist is doing this new test called VEMP? The equipment vendor gave me a big long list of codes to bill for this test including the ENG, EMG and other diagnostic testing codes. It just doesn’t seem right. What is your advice?

**Answer:**

We agree that billing ENG and EMG codes isn’t accurate for the VEMP test. Actually, the March 2011 CPT Assistant that is published by the American Medical Association states that there is no code for vestibular evoked myogenic potential (VEMP) testing. Therefore, an unlisted code (92700) is used to report this service.

**Breast Reconstruction**

**Question:**

I’m doing a second stage breast reconstruction revision by removing the tissue expander and placement of a permanent implant. I got two codes pre-certified, 11970 (Replacement of tissue expander with permanent prosthesis) and 19380 (Revision
of reconstructed breast). So I billed those two codes but the insurance company only paid one code, 11970. How can I appeal and also get paid for 19380?

Answer:
Actually, the CPT code for removing a tissue expander and placing a permanent breast implant is reported using only 11970. CPT 19380 is not reported until the patient has undergone final reconstruction and now requires some type of revision.

---

**Spinal Nerve Decompression**

**Question:**

I was at a meeting and a neurosurgeon told me he bills 64722 in addition to all his discectomies and laminectomies for the additional spinal nerve decompression part of the procedure. He says he gets paid on 64722 most of the time. I’ve never billed this code. Should I start? I hate to lose out on revenue!

**Answer:**

It is not appropriate to separately bill 64722, Decompression; unspecified nerve(s) (specify), for decompression of a spinal nerve. This activity is inherent in all discectomy and laminectomy codes and not separately reported.
Question:

A patient (non Medicare) presented for a screening colonoscopy. During the procedure the surgeon performed a polypectomy with hot forceps. I know I append modifier 33 for screening colonoscopy but do I also append to the CPT code when a procedure is performed (45384) and not just a screening procedure? Does KarenZupko & Associates perform audits on colonoscopy and EGD procedures?

Answer:

Thanks for your questions. First, your question is good and the answer is Yes, append modifier 33 to the colonoscopy CPT code when the patient presents for a screening colonoscopy and the procedure converts to a therapeutic procedure. The modifier is appended when the “intent” of the procedure was screening.

We appreciate your inquiring about audits on colonoscopy and EGD procedures. Mary LeGrand is KZA’s coding expert for both upper GI endoscopy and all lower “oscopy” procedures (e.g. colonoscopy, sigmoidoscoppy, proctoscopy, anoscopy).
How do I bill for bilateral internal carotid angiograms (from an internal carotid catheter position) and an arch angiogram?

Answer:

The new cervicocerebral angiogram codes, both the carotid codes (36222-36224) and the vertebral codes (36225-36226), include an arch angiogram (36221). The only time an arch angiogram is reported is when it’s performed without one of the carotid or vertebral imaging codes.