Separate Procedure Codes

September 5, 2013

Question:

Our surgeons work in a productivity employed model. I want to make sure I am capturing all the possible procedures to ensure correct coding and capturing the surgeons work. Recently the surgeon performed an exploratory laparoscopy CPT code 49320 and a laparoscopic cholecystectomy, CPT code 47562. CPT code 49320 has a separate procedure designation. I am unsure of how to report these procedures and am wondering if I should or should not be reporting 49320 in addition to the cholecystectomy.

Answer:

Great question and I am sure your surgeons are glad to have you on their team! You are correct though, to question this code combination. A procedure that has a “separate procedure” designation is considered inclusive to or integral to a more extensive surgery in the same area, same surgical setting. CPT code 49320 is not separately reportable for two reasons, 1) it has the separate procedure designation as you note and 2) it is also a diagnostic procedure. All surgical procedures include a diagnostic procedure. While the surgeon’s may have documented their exploration work, it would not be correct to report both codes to the payor.
**Studies. Are They Billable?**

**Question:**

After a fem-pop bypass or a carotid endarterectomy, I always do an intra-operative duplex to evaluate vessel patency. Can I report my supervision and interpretation of that duplex study?

**Answer:**

No, assessing success of an open procedure, i.e., evaluating vessel patency, whether the procedure is a bypass, endarterectomy, etc, is part of the procedure and not separately reported. It is considered an integral part of the primary procedure.

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**ER Discharge**

**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 payer 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.

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**Placement of Mesh In Breast Reconstruction Procedures**

**Question:**
When performing a TRAM flap single pedicle or other types of breast reconstruction procedures where I close the donor site with mesh, does the breast reconstruction code such as 19367 include the mesh placement for donor site or is it separately billable with code 49568? I was told by a colleague that the mesh code is separately reportable but I just wanted to check with you to be sure before I billed it. Thank you!

**Answer:**
Actually, according to CPT rules, 49568 can only be billed with a hernia repair code so it is not appropriate to report the code with a breast reconstruction procedure code such as 19367. Because 19367 says “including closure of donor site” then placing the mesh is part of the closure and not separately reported. It would not be accurate to report 15777 for mesh placement since it is not a “biologic” as required by the CPT code.

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**Sacroiliac Joint Fusion**

**Question:**
My spine surgeon is doing a new procedure called SI Joint
Fusion and it’s a minimally invasive procedure he does under fluoroscopy. The vendor rep told us to bill 27280. You’ve always told us to be skeptical of coding recommendations from outside sources so we wanted to confirm with you if this is the correct code.

Answer:

Yay – someone finally listened to us!! Thank you for asking the question because you have been given misleading advice. CPT 27280 says “Arthrodesis, sacroiliac joint (including obtaining graft)” and describes a complex and open procedure requiring several days in the hospital for recovery. The minimally invasive, SI Joint Fusion procedure you describe is a new minimally invasive procedure performed typically as a day surgery. This procedure did not have a CPT code until recently. Historically we used an unlisted code such as 22899 for the procedure. However, the following Category III code was implemented on July 1, 2013 for this procedure:

0334T Sacroiliac joint stabilization for arthrodesis, percutaneous or minimally invasive (indirect visualization), includes obtaining and applying autograft or allograft (structural or morselized), when performed, includes image guidance when performed (eg, CT or fluoroscopic)

Survey your payors to see if it is a covered procedure because many insurance companies do not reimburse this code.

Debridement of Burn Wound

August 22, 2013

Question:
Our trauma surgeon documented that he performed a subcutaneous debridement of a 15 sq. cm third degree burn to the left foot. We are unsure if we should report 11042 or a burn code?

Answer:

Thanks for your inquiry. The appropriate CPT code range will be found in the burn section, 16020-16030. These codes define treatment of partial thickness burns and include any debridement services and dressing changes. CPT defines the burn codes (16020-16030) based on size (small, medium and large) and further defined by the percentage of the total body surface area involved.

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**Excision of Uncertain Behavior Skin Lesion**

**Question:**

If my physician excises a lesion and the pathologist says it is a diagnosis that is considered “uncertain behavior” by ICD-9, do I use the benign excision of skin lesion CPT code or the malignant CPT code when I bill?

**Answer:**

Good question! When the diagnosis is categorized with an “uncertain behavior” ICD-9 code, then you will use the excision of benign skin lesion CPT code for the removal.
HPI – My Doctors Don’t Document This, the MA Does. Is This OK?

Question:

Since we implemented our EHR, the MA completes the first part of the history, which includes the history of present illness (HPI). I assume the doctor reviews it but he does not typically document any additional HPI. Is this a problem with E & M documentation?

Answer:

Great question! This has become a fairly common occurrence, especially since the growth of EHR use by practices. And yes, it is an issue. According to E & M guidelines, the physician (or NP, PA, CNS, if they are the provider performing the service) must personally document the chief complaint and the HPI. If this information is already in the record, entered by an MA for example, the physician must personally elicit and document the reason for the visit and pertinent HPI elements in order for the service to meet minimum E & M guidelines. Without this information documented by the physician, a new visit or consultation would not be reportable.

Endoscopic Sinus Debrideaments: Reportable or
Question:

Is appropriate to bill 31237-79 at the 1 week post op for our sinus surgery patients? I can’t help but feel that service would be included in the septoplasty or the turbinate surgery performed at the same session. The physician and office manager it should be billed when performed during the global period, but I just can’t figure out why. Can you help me understand if the debridement services are or are not separately reportable during the global period?

Answer:

Thanks for your inquiry! The coding of sinus debridements and how to report is a frequently asked question. The endoscopic sinus surgery codes 31256, 31267, 31254, 31255, 31287, 31288, 31276 do not have a global period. Because there is no global period the debridement service (31237) is separately reportable after the surgery when medically necessary and supported by documentation. You are correct to question the use of the modifier 79 (unrelated surgical procedure) as the correct way to report this service. The septoplasty and turbinate surgery (30130, 30140) have 90 day global periods, thus the use of modifier 79 is required to indicate the debridement, performed at different anatomic locations is separately reportable. Remember, CPT code 31237 is a unilateral procedure and may be reported with a modifier 50.
Vertebroplasty or Kyphoplasty with Bone Biopsy

Question:
When I do a vertebroplasty or kyphoplasty I always do a bone biopsy at the same level to make sure the patient does not have cancer. I’ve never billed for the bone biopsy but I’ve been told by others that I can. What should I do?

Answer:
Listen to your instinct and not bill for the bone biopsy. If you did a bone biopsy at a different level than the primary procedure, then you may report a code (e.g., 20225) for that separate procedure. However, a bone biopsy performed at the same spinal level is not billable.