Add-On Codes

April 18, 2013

Question:

I am new to general surgery coding. I see that the placement of mesh for an incisional or ventral hernia has a “+” sign and a statement to “list in addition to the primary procedure.” What is an add-on code?

Answer:

An Add-on code describes additional intra-operative work typically related to a specific procedure or range of CPT code codes. Add-on codes are not stand-alone codes and as such may never be reported by themselves. The codes are only valued for additional intra-service work, thus are never subject to a multiple procedure reduction. In your case, the surgeon uses the add-on code for the additional work of placing the mesh at the time of the incisional or ventral hernia repair.

Coding For A DRIL Procedure

Question:

My surgeon documented that he did a DRIL procedure. I have never heard of that. What is it and how is it coded?

Answer:

A DRIL procedure is a distal revascularization and internal ligation (DRIL) of the upper extremity and is performed to correct “steal syndrome.” Steal syndrome is a complication of an AV fistula or graft that results in vascular insufficiency,
for example to the forearm and hand in an upper extremity AV fistula or graft. The CPT code 36838 is reported for the DRIL procedure to correct this complication.

---

**Direct Laryngoscopy with Multiple Biopsies**

**Question:**

I did 31535 *Laryngoscopy, direct, operative, with biopsy* but took multiple biopsies through the laryngoscope of the hypopharynx and base of tongue looking for an unknown primary malignancy. Can I report 31535 more than once to account for the multiple biopsies? Can I bill 42802 (*Biopsy; hypopharynx*) with the direct laryngoscopy? Lastly, what if I did a separate nasopharyngeal biopsy at the same time also looking for an unknown primary malignancy – can I bill separately for the nasopharyngeal biopsy?

**Answer:**

CPT 31535 includes any number of biopsies obtained through the same surgical exposure as the direct laryngoscopy so it would not be appropriate to also report biopsies from the hypopharynx, vocal cords, arytenoids or the larynx areas. Any biopsies taken via the scope are included in 31536 not 42802 which does not define a biopsy via a laryngoscope. If a biopsy is not taken via the scope, then it may be separately reported using the appropriate biopsy code. Be sure to make this very clear in your operative note. You may separately report a code for the nasopharyngeal biopsy since that procedure is performed through a separate surgical exposure, the nose.
**Rib Resection With Breast Reconstruction**

**Question:**
I did a breast reconstruction with a free flap, actually a DIEP flap, and billed 19364 for the breast reconstruction as well as 21600 for the rib resection. The insurance company paid me for the breast reconstruction but denied payment on the rib resection. I appealed the denial but lost – they said that the rib resection is included in the breast reconstruction code. Do you agree?

**Answer:**
Yes, we do. And, as a matter of fact, so does CPT. The CPT Assistant, July 2012 specifically states that the rib resection is included in 19364 and should not be separate reported.

---

**Reprogramming of a Shunt**

**Question:**
For the life of me, I cannot get paid on 62252 when we reprogram a VP shunt in the global period. What can I do to get these paid?

**Answer:**
It is appropriate to append modifier 58 to the reprogramming code, 62252, in this case as the patient’s condition may
How Do I Calculate The Size of An Adjacent Tissue Transfer Code?

April 4, 2013

Question:

I am inquiring how to calculate the size of a wound to determine which adjacent tissue transfer code should be reported. The surgeon excised a dematofibrosarcoma protuberans of the chest that resulted in a primary and secondary defect documented as a 16.5 x 7. The secondary defect was closed primarily. My surgeon says the size of the defect is 115.5 sq cm and I am saying the wound size is 23.5 sq cm. Who is right?

Answer:

Your surgeon is right. To report adjacent tissue transfers, the wound size is based on square centimeters (sq cm). To determine the total size of the wound defect, the defect size is determined by first multiplying the length times the width of the primary and secondary defects and adding both of them to determine the total defect size when the secondary defect is closed primarily as noted. Report CPT 14301 for the first 60 square centimeters (sq cm), add-on code 14302 for the next 30 sq cm and +14302-59 for the remaining 25.5 sq cm. Alternatively, you may report 14301 and 14302 x 2 units if you know that the payor will recognize more than 1 in the units
box and reimburse the appropriate amount. Please note, some payors may not require the modifier 59 on the second add-on code.

---

**CPT and Diagnosis Codes for a Skin Lesion**

**Question:**
A patient was sent to us by another provider who had a biopsy proven pathology report showing a basal cell carcinoma. We removed additional margins and the pathology report came back benign for us. We are confused about whether we should report the CPT and diagnosis codes for a malignant or benign lesion since we did not do the original biopsy.

**Answer:**
This is a very good question! Because you have a previous positive pathology report, even though it is from a different physician, then you may report your procedure using the excision of malignant lesion CPT code (e.g., 116xx) and a malignant skin neoplasm diagnosis code.

---

**Docking Limbs Versus Extensions In EVAR: What’s**
the Difference?

Question:

How do I know what an extension is and what’s part of the original EVAR device? I know one is separately billable and one is not.

Answer:

That is a great question! EVAR devices vary in configuration. Some have a main body and one “docking limb.” Others have a main body and two docking limbs. Some are unibody devices; i.e., all in one piece. Docking limbs are considered part of the main body of the endograft/EVAR device and are not separately reported. An extension is an extra piece of graft that further extends the area of the original device, either more distally, into the iliac, or proximally, above the device in the aorta. Physicians should be specific in their documentation to differentiate between placement of docking limbs and extensions to ensure accurate coding.

Modifier 25

Question:

Do we have to append modifier 25 to the E&M code if only an audiogram were also performed at that same visit? Or does modifier 25 not apply since the audiogram is a diagnostic test? What about when we do an in-office CT on the same day as an office visit – should we append modifier 25 modifier to the E&M code or is it not required because the CT is a diagnostic test?
Good questions! The CPT descriptor for modifier 25 is: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service. CPT states: “It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.” Recall, however, that there is no pre- or postoperative care associated with diagnostic testing such as audiograms or CT scans.

As you know, since 2008 Medicare has required audiologists to bill directly using the audiologist’s NPI as the billing provider. Therefore, it is not likely that you will have an E&M code and an audiogram on the same claim form to Medicare. So your question about appending modifier 25 to the E&M code is not applicable when the payor is Medicare.

Therefore, modifier 25 on the E&M code is not necessary when also reporting a diagnostic testing code such as an audiogram or CT scan. However, you might find that some payors require the use of modifier 25 but it is not a CPT coding requirement.

How Do I Calculate The Size of An Adjacent Tissue
Question:
I am inquiring how to calculate the size of a wound to determine which adjacent tissue transfer code I should be reported. The surgeon excised a dematofibrosarcoma protuberans of chest that resulted in a primary and secondary defect documented as a 16.5 x 7. The secondary defect was closed primarily. My surgeon says the size of the defect is 115.5 sq cm and I am saying the wound size is 23.5 sq cm. Who is right?

Answer:
Your physician is right. To report adjacent tissue transfers, the wound size is based on square centimeters (sq cm). To determine the total size of the wound defect, the defect size is determined by first multiplying the length times the width of the primary and secondary defects and adding both of them to determine the total defect size when the secondary defect is closed primarily as noted. Report CPT 14301 for the first 60 square centimeters (sq cm), add-on code 14302 for the next 30 sq cm and +14302-59 for the remaining 25.5 sq cm. Alternatively, you may report 14301 and 14302 x 2 units if you know that the payor will recognize more than 1 in the units box and reimburse the appropriate amount.