**Ear Canal Debridement**

**Question:**

What CPT code would I use for a debridement of purulent debris from, with or without placement of a wick in, the ear canal such as when the patient has Swimmer’s ear?

**Answer:**

There is no CPT code for this activity and it would be considered part of the E&M code for your service that day. However, if you used the microscope for the diagnosis and treatment then you could also report 92504 (Binocular microscopy (separate diagnostic procedure)).

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**Suture Removal**

**Question:**

Our surgeon saw a patient in the ER for a fracture and reported the global fracture code. The ER physician had repaired a separate wound laceration at a different site prior to our surgeon arriving in the ER. The patient is now being seen in the office and the surgeon evaluated the wound area, and removed the sutures. Is this reportable and if yes, what CPT code would I use?

**Answer:**

There is no CPT code for suture removal in the office. If the surgeon evaluates the unrelated injury (laceration) and removes the sutures, the suture removal would be inclusive to the E&M and is reportable with an E&M services and a modifier...
Lower Extremity Revascularization Codes

December 27, 2012

Question:

The guidelines for the new lower extremity revascularization codes (angioplasty, stent, atherectomy) state that they include all radiological supervision and interpretation directly related to the intervention. Does that include diagnostic studies?

Answer:

No, diagnostic studies are separately reportable as long as all coding rules for reporting diagnostic studies have been followed. (See last months Coding Coach for rules for reporting diagnostic studies at the same session as an intervention).

Skin Grafts: Donor vs. Recipient Site

Question:
I did a paramedian forehead flap (15731) and harvested a split thickness skin graft from the arm to close the donor defect site. I want to use 15120 (Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits) for the STSG recipient site. My coder says I should use 15100 (Split-thickness autograft, trunk, arms, legs) for the STSG donor site. Please help us solve this disagreement.

Answer:

You are correct, Doctor. CPT says: “The following definition should be applied to those codes that reference “100 sq cm or 1% of body area of infants and children” when determining the involvement of body size: The measurement of 100 sq cm is applicable to adults and children 10 years of age and older; and percentages of body surface area apply to infants and children younger than 10 years of age. The measurements apply to the size of the recipient area.”

Notice the last sentence – the measurements apply to the size of the recipient site (not donor site).

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**Suture Removal**

**Question:**

Is there a CPT code for removing sutures in the clinic after a procedure?

**Answer:**

It depends on who put in the sutures. If you put them in after a procedure such as a lesion removal or adjacent tissue transfer, then you cannot charge for removing them as that is
part of your global surgical package. 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 code only (e.g., 99201, 99212).

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**Allergy Injection Supervision Requirements**

**Question:**

Does the physician have to be in the building when giving an allergy injection? Or can the allergy injection be supervised by physician assistant?

**Answer:**

Medicare’s physician supervision guidelines for incident to billing require the billing provider to be physically present in the office suite whether it is a physician or physician assistant (or even a nurse practitioner for that matter). Medicare’s will reimburse at 100% of the physician fee schedule when a physician is the billing/supervising provider and at 85% of the physician allowable when the PA or NP is the billing/supervising provider. You’ll want to check with you other payors for their guidelines.
Buttress Plate and Screws with a PEEK Device

Question:

Our neurosurgeon has a coding question regarding placement of an anterior buttress plate/screws placement when it is attached to a PEEK device. He said the vendor rep told him to bill 22845 (anterior plate) and 22851 (PEEK) even though the screws are only placed on one vertebral body. Is this correct?

Answer:

You are wise to check out this advice. The anterior instrumentation code, 22845, is reported when the plate is a separate device not attached to the PEEK device and can provide independent stabilization on its own. Many of these devices do not meet this criteria so only 22851 is appropriate to code.

Diagnostic Angiograms

December 13, 2012

Question:

I heard at a seminar that diagnostic angiograms performed at the same operative session as a stent or angioplasty can never be billed. Is that true?

Answer:

No that is not exactly true. According to CPT, diagnostic angiograms performed at the time of an interventional
procedure may be separately reported if:

- No prior catheter-based angiographic study is available and a full diagnostic study is performed and the decision to intervene is based on the diagnostic study OR
- A prior study is available but as documented in the medical record:
  - The patient's condition has changed since the prior study
  - There is inadequate visualization of the anatomy and/or pathology
  - There is a clinic change during the procedure that requires a new evaluation outside the target area of intervention

One of these conditions should be documented in the operative note; ideally in indications section. It must be clear that one of these conditions existed to justify a diagnostic study at the same time as an intervention.

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**E&M Exam**

**Question:**

I attended a recent ASPS coding course and heard you speak – you were terrific! I didn’t realize how important E&M coding was and more importantly the documentation for it. When consider level 4 and 5 new patient or outpatient consults, I see that a comprehensive physical exam is needed. Should I be using the 1995 or 1997 guidelines?

**Answer:**
Thank you so much – I love what I do and I hope it shows when I teach. Yes, E&M coding and documentation is very important. You’ve asked a good question and one that is not easily answered by me – only you can decide which exam guidelines to use based on the examination you perform.

A comprehensive examination is required for a level for level 4 and 5 new patient visits (99204, 99205) and outpatient consultations (99244, 99245). So what is a comprehensive exam?

Medicare’s 1995 guidelines are organ system-oriented; a comprehensive exam requires assessment and documentation of at least 8 of the following 12 organ systems:

1. Constitutional (e.g., vital signs, general appearance)
2. Eyes
3. Ears, nose, mouth and throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Skin
10. Neurologic
11. Psychiatric
12. Hematologic/ lymphatic/immunologic

Medicare’s 1997 guidelines are organ system-specific, meaning each organ system includes specified examination elements (also known as “bullets” or “elements”). The following organ systems have a specified exam:

1. Cardiovascular
2. Ears, Nose, Mouth and Throat
3. Eyes
4. Genitourinary (Female)
5. Genitourinary (Male)
6. Hematologic/ Lymphatic/Immunologic
7. Musculoskeletal
8. Neurological
9. Psychiatric
10. Respiratory
11. Skin

Alternatively, Medicare’s 1997 guidelines allow for a general multi-system exam. You’ll need to review each organ system’s 1997 exam elements as well as the general multi-system exam elements to determine if this works best for you.

I recommend you look at the CMS website for more detailed information about the examination guidelines.

Most plastic surgeons find that it is difficult to report level 4 and 5 consultation (9924x)/new patient codes (9920x) due to the comprehensive examination requirements. However, oftentimes these high level codes can be reported based on your face-to-face time spent counseling the patient in the office setting.

I’d be happy to review a couple of your E&M notes and work with you to determine which exam guidelines are to your benefit and whether your documentation meets the criteria for level 4 and 5 codes. Please contact Natalie Loops at KZA for more information about KZA’s professional fees (312.642.5616 or info@karenzupko.com).

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**Embolectomy With A Bypass**

**Question:**

I did a popliteal embolectomy and a fem-pop bypass with vein.
Can I report both the bypass and the embolectomy?

**Answer:**

CPT states “Primary vascular procedures include establishing inflow and outflow by whatever procedures necessary”. Since the popliteal vessel is the outflow vessel, any procedure performed in that vessel; endarterectomy or embolectomy are included in the bypass procedure.