Reading an X-ray the Patient Brought In

Question:

A patient presents with a CD of an x-ray that was performed at another institution has been previously read by the radiologist, If one of my plastic surgeons looks at and interprets the x-ray can we bill for the second reading?

Answer:

Actually, the plastic surgeon’s activity or looking at and reading the x-ray is included in the medical decision making (MDM) of the Evaluation and Management code billed for that visit. The plastic surgeon gets “credit” for the x-ray review and his/her personal interpretation in the Data Reviewed element of the MDM. Reading an x-ray that was taken elsewhere, and previously read by a radiologist, is not a separately billable service for the plastic surgeon. The code 76140 (Consultation on x-ray examination made elsewhere, written report) is generally used by radiologists for over-reading an x-ray.

Laminectomy/Facetectomy/Foraminotomy for Decompression (CPT 63047)

Question:

I recently attended a coder’s meeting and the speaker said
when doing a decompression laminectomy at L4-L5 (using 63047) that we should report two codes (63047 and 63048) because L4 is one level and L5 is another. I’ve been using one code when the procedure is performed at L4-L5. Have I been coding incorrectly?

Answer:

It sounds like you have been doing it the right way. To clarify, if the procedure is performed at L4-L5, meaning the inferior L4 lamina and superior L5 lamina are removed as well as a foraminotomy at L4-L5 to decompress the exiting nerve root, you will report only one CPT code (63047). To report a second code, 63048, the surgeon will need to remove more of the lamina at either L4 or L5 and do a foraminotomy with decompression of a different exiting nerve root such as at L3-L4 or L5-S1.

Is There A CPT Code for a Wound Vac?

September 6, 2012

Question:

Our surgeon placed a “wound vac” on an open leg wound. The surgeon stated it was separately reportable but I cannot find a CPT code. Can you help?

Answer:

Yes, there are CPT codes for “wound vacs” and perhaps one of the reasons you cannot find them, is that the “wound vac” is the abbreviated terminology for the CPT code.
The codes you are seeking, CPT codes 97605 and 97606 are not found in the surgery section of CPT. Instead, they are found in the Active Wound Management section of CPT. The codes read as follows:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97605</td>
<td>Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters</td>
</tr>
<tr>
<td>97606</td>
<td>total wound(s) surface area greater than 50 square centimeters</td>
</tr>
</tbody>
</table>

Work with your surgeon to document the procedure title using CPT terminology. These codes are defined by size, thus the surgeon’s documentation must include the size to accurately select the correct CPT code.

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**Diagnostic Angiograms**

**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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**30930 and 30140**

**Question:**

Our surgeon wants to report CPT code 30930 every time he does an turbinate outfracture with his submucous resections (30140). I have explained that the outfracture is included but he disagrees. I talked to a peer in another practice and he told me that I can’t report it because there is a CCI edit in place. We code according to CPT rules, not Medicare payment rules, thus I would never use that as rationale in explaining to the surgeon why a code set is reportable together or not. Can KZA help with an explanation?

**Answer:**
Great question and thanks for reaching out to the Otolaryngology Coding Team. We checked with the team and our response follows.

In 2006, CPT revised the definition of CPT code of the turbinate codes to identify surgical procedures on the inferior turbinates only. According to a citation in the CPT Changes: An Insider’s View, “CPT codes 30130, 30140, 30801, 30802, and 30930 have been revised to clarify their widespread usage specific to the inferior turbinates and primary reporting for procedures performed for the treatment of inferior turbinate hypertrophy causing nasal airway obstruction and to eliminate frequent confusion with middle and superior turbinates when other intra-nasal surgeries (e.g., endoscopic sinus surgery) are performed.”

Additionally, codes 30801, 30802, and 30930 were revised with the removal of “separate procedure” from the descriptors. Cross-references were added in support of these revisions to indicate codes 30130 (partial or complete excision of turbinate bone) and 30140 (partial or complete submucous resection of turbinate bone), which report larger procedures for which removal of the inferior turbinates are inherent, would not be appropriately reported in conjunction with these codes.” As a result of this rule change when the codes were revised to specifically address surgery on the “inferior” turbinates, the procedures became inclusive to each other.

Finally, the CPT guidelines listed directly underneath 30930 state “(Do not report 30801, 30802, 30930 in conjunction with 30130 or 30140)”. Therefore, it is not appropriate to report 30930 with 30140 ever for procedures on the same turbinate.

Just because there is a Medicare CCI column edit of “1” doesn’t mean it is appropriate to report both codes. You must understand CPT coding rules first.
Le Fort Fractures

**Question:**

I performed open reduction internal fixation of bilateral Le Fort II fractures through multiple approaches. Would this be coded as 21347-50? Otherwise asked, does 21347 constitute a repair of a unilateral Le Fort fracture?

**Answer:**

The Le Fort fracture repair codes should not be reported with the bilateral modifier (50). A Le Fort fracture is inherently bilateral; therefore, the repair procedure (and CPT code) is also inherently bilateral.

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Craniotomy for Biopsy

**Question:**

For craniotomy for tumor biopsy-not removal, would craniotomy exploratory should be used-61304 or craniectomy for brain tumor-61510?

**Answer:**

CPT code 61510 is specifically for a craniotomy for excision of a brain tumor and is intended for tumor resection. For a craniotomy for tumor biopsy, report code, 61304, craniectomy or craniotomy: exploratory if supratentorial and 61305 if infratentorial.
Reporting Vein Harvest in Fem-pop Bypass

August 23, 2012

Question:

How do you bill for harvest of the saphenous vein from the opposite leg for a fem-pop bypass with vein?

Answer:

The harvest of saphenous vein from the same or contralateral leg is inclusive to the bypass procedure and not separately reported.

Iliac Atherectomy

Question:

If a common iliac atherectomy is performed and a stent is placed in the same vessel can both be billed? What about the catheterization and radiological supervision and interpretation?

Answer:

As of 2011, supra-inguinal arthrectomies (which include all iliac vessels) are reported with Category III codes. These codes specifically state that other interventions in the same vessel may be separately reported. So in your scenario, 0238T
would be reported for the iliac atherectomy in addition to 37721 for the iliac stent. The stent includes catheterization and radiological supervision and interpretation so neither can be reported in addition to the interventions.

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**Removal of Tube in Office**

**Question:**

How do I code for the removal of ventilation tubes when performed in the office setting?

**Answer:**

There is no separate CPT code for this activity so it is part of your E&M service. It is not appropriate to report 69200 (Removal foreign body from external auditory canal; without general anesthesia) or 69424 (Ventilating tube removal requiring general anesthesia).